Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Aperee Living Churchtown
Name of provider:	Aperee Living Churchtown Limited
Address of centre:	Churchtown, Mallow, Cork
Type of inspection:	Unannounced
Date of inspection:	10 August 2023
Centre ID:	OSV-0000266
Fieldwork ID:	MON-0041103

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Aperee Living Churchtown is a purpose built nursing home and is located close to the village of Churchtown in Co. Cork. The centre is built on large landscaped grounds with adequate parking for visitors and staff. The centre is registered to accommodate fifty residents in forty four single bedrooms and three twin bedrooms. All bedrooms are en suite with toilet, shower and wash hand basin. The centre provides long-term nursing care, predominately to people over the age of 65, but can also provide convalescent and respite care. The centre caters for residents with varying degrees of dependency from low to maximum. The person in charge is responsible for the day-to-day operation of the centre with the support of an assistant director of nursing and a clinical nurse manager. Care is provided by a team of nurses, healthcare care assistants, activity staff, catering staff, and housekeeping staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	39

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 10 August 2023	10:45hrs to 19:00hrs	Niall Whelton	Lead

What residents told us and what inspectors observed

Aperee Living Churchtown is located within the community of Churchtown village. It is within a single storey building, with accommodation connected centrally by the main communal spaces and entrance area. The centre comprises three twin ensuite rooms and 44 single ensuite rooms. There was a central atrium area with a glazed roof inside the main entrance. From here corridors led to resident bedrooms. The main dining room and day spaces were close to the central area. There was a smaller sitting room on one bedroom corridor and another small sitting room and hair salon on another bedroom corridor.

There were 39 residents living in the centre on the day of inspection.

The inspector held an introductory meeting with the person in charge at the start of the inspection, at which the purpose of the inspection was outlined. Following the introductory meeting, the inspector, accompanied by the person in charge, did a walk through of the centre.

The building was divided up into fire compartments to facilitate horizontal evacuation and illustrated on floor plans displayed, however they did not align with those explained to the inspector by staff. For example the door midway through St. Bridget's was not a compartment boundary but was being used as such.

A number of exit doors had a threshold on the line of the door that would hinder evacuation. This included a protruding lip or drop outside the door. One exit to the outside led to a pathway which required assisting residents around the building in one direction. The alternative route, which was a shorter route to the assembly point through the garden, had a fence in its path. The inspector saw that when some exit doors were opened out, it would be difficult to manoeuvre identified evacuation aids around the door when open.

Exit doors were secured with magnetic devices, which released on activation of the fire detection and alarm system. The inspector checked final exits and found two that were difficult to open and required excessive force to operate the doors. There was a gate from the secure garden, the key for which was not readily available. It took staff a number of minutes to find the key.

The notice board in the nurse base identified the name of the fire marshal on duty. The fire marshal on duty was required to carry an emergency phone and this was found to be implemented in practice. The emergency phone contained speed dial allocations for required contacts in the case of emergency.

There were two garden areas; one was secured with a gate and was available for residents to use. Owing to the lack of a gate, the second garden was only available to residents when supervised and was not secured. While some maintenance was required, this was a pleasant garden and would provide an additional outdoor space

for residents if secured. In the area adjacent to this garden, there were two donkeys , originally sourced from a donkey sanctuary. The inspector was told these are often brought towards the secure garden for residents. In the secure garden, planting had been trimmed to tidy up the garden. There was a covered area outside one of the dayrooms and this had seating for residents to go outside in all weather. There was a structure housing a barbeque and another covered bench area.

Overall, the upkeep of the building required improvement. Walls and ceilings were marked or had holes, carpets were worn and residents furniture was worn and damaged.

The inspector saw some bedrooms had been painted, with further rooms identified for improvements. The centre was homely with photographs and art work displayed throughout the communal areas and corridors.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

The overall findings of this inspection were that the local management team in Aperee Living Churchtown nursing home had adequate systems of fire safety management in the centre, however improvements were required in the day-to-day identification of fire safety risks, as detailed in the quality and safety section of this report. The inspector found that action was required in relation to fire precautions and premises.

Aperee Living Churchtown Ltd was the registered provider for this designated centre. The clinical management of the centre was led by the person in charge (PIC) who was supported by a team of nursing, care, maintenance and administration staff.

The registered provider arranged for a fire safety risk assessment, the report for which was produced in January 2022. This report included a schedule of significant findings. The person in charge had addressed risks that were within their control and these were documented within the centre,

Notwithstanding the actions taken locally by the person in charge to address fire safety risks within their control, the registered provider still had not taken action to address known fire safety risks since January 2022. The compliance plan from the inspection in May 2022 had committed to completing requisite fire safety works by September 2022. At the inspection in May this year, this had not yet started. At this inspection, the inspector found that the required fire safety works had not yet commenced, nor was there any schedule of works or start date available to the

inspector. The outstanding risks were dependent on the registered provider to address, including;

- Servicing and/or replacement of inadequate fire doorsets and internal screens
- Upgrade fire rating to roof window tunnels
- Provision of passive fire protection to all ventilation outlets and penetrations passing through fire rated construction
- Provision of external emergency lighting as required based on lux level testing
- Provision of additional emergency lighting over double doorsets

Regulation 23: Governance and management

In consideration of the findings of the fire safety risk assessment of January 2022 and the findings of this inspection in relation to Regulation 28, the inspector found that the provider had failed to ensure that the management systems in place ensured the safety of residents in the centre. The was evidenced by;

- failure to date to address, and failure to have a time bound plan of action for, the fire safety risks identified in the aforementioned fire safety risk assessment dated January 2022
- day-to-day fire safety risks not being identified, as detailed in this report

Judgment: Not compliant

Quality and safety

While there were some good practices in relation to fire safety, they did not fully mitigate the risk of fire to residents living in the centre, which was identified in the providers own fire safety risk assessment of January 2022. Significant action was required by the provider to come into compliance with the regulations in relation to fire precautions.

The person in charge had addressed risks within their control. For example, curtains had been removed where they obstructed exits, storage sheds obstructing escape routes had been relocated and furniture was re-arranged so as not to prevent fire doors from closing.

The inspector saw a folder which the person in charge had developed. This included pertinent information such as the evacuation procedure, how to respond to the fire alarm, a list of relevant contacts and the associated speed dial number and utility

safety shut off points. This was written in a manner that was well laid out and easy to navigate for staff.

There were four bedrooms, where the resident expressed their wish to have their door open at night. While there was a risk assessment in place, at least three of the doors had a device which was connected to the fire alarm system and would hold the door open, but these were not being used. Instead doors were propped open with furniture, preventing the door from closing.

There was an addressable fire detection and alarm system which identified the location of an activated fire detector. The service records were not up-to-date. The emergency lighting system didn't provide sufficient coverage externally along external escape routes. It was being serviced at the appropriate intervals, however the annual certificate to confirm the system was free of fault or deviation was not available within the previous twelve months.

Fire doors in the centre required either upgrade or replacement to ensure they would effectively contain fire and smoke. For example the fire door to the treatment room did not have smoke seals or an automatic self-closing device.

The inspector saw records of fire evacuation drills and they were completed frequently, however there was no record to demonstrate that the external escape routes had been tested, to ensure the evacuation aids in use would freely fit through final exits and along external escape routes. The evacuation aids in use were ski-sheets under the mattress or in a wheelchair. The inspector looked a sample of beds and ski sheets were fitted correctly to the bed in most cases. Staff spoken with knew the evacuation procedure. The evacuation procedure included the use of an emergency phone and the inspector saw that the fire marshal had the phone with them.

Some storage presses on bedroom corridors were in the process of being converted into a recessed space to accommodate a clinical handwash sink. This work was not yet complete and as a result there were exposed concrete sections of floor and unpainted sections of wall. Issues with storage was impacting on residents use of communal spaces. There was some storage of in the small sitting room in St. Catherine's, detracting from the use of the room.

There were some improvements with the premises from the previous inspection, however further action was required to come into compliance and this is explored further under regulation 17.

Regulation 17: Premises

Notwithstanding work already completed, further action was required to come into compliance with Regulation 17 and Schedule 6:

- the smoking area for staff was located in manner that may lead to smoke permeating into resident's bedrooms through openable windows
- there was general wear and tear on walls, skirting and doors that required action
- the threshold at the main entrance had a lip and may be difficult to access the building independently
- The ceiling inside the main reception was stained and sagging from a water leak
- lockers and wardrobes in a number of bedrooms were not in good condition and impacted effective cleaning
- some recessed storage cupboards on corridors, had been removed resulting in exposed concrete floors, doors removed and rough edges to the door frames. There was also exposed plasterwork where shelving was removed
- the windows to bedrooms along the path in the garden opened out unrestricted and may cause injury to those passing the window
- the inspector saw holes which had been cut in ceilings to some ensuites and had not been repaired. This also impacted the fire containment of the ceilings
- the layout of the laundry area on the registered floor plans did not align with the layout as it exists
- storage arrangements were not adequate. The quiet room was used for some storage
- the store opening onto the quiet room, had a light fitting with no cover
- there was a drain protruding from the ground in the non-secure garden, which created a risk of tripping
- the cover to a floor drain in the laundry room was missing

Judgment: Substantially compliant

Regulation 28: Fire precautions

Under this regulation, the provider was required to address immediate risks that were identified on the day of inspection.

- There were two exits which were not openable; the exit from the dining room and one leaf of final exit from a bedroom corridor
- The key to the locked gate on the external escape route was not readily available
- There were inconsistencies in the personal emergency evacuation plans (PEEPs) for residents. For example the PEEP for one resident had not changed since they moved room and included incorrect information.

The manner in which the provider responded to the risk on the day of the inspection did provide assurance that the risk was adequately addressed.

Improvements were required by the provider to ensure adequate precautions against the risk of fire and for reviewing fire precautions:

- Fire doors to high risk rooms were propped open
- The gas cooker in the kitchen was missing a dial to operate the gas, and another dial was not the correct one for the cooker. This was poor practice and may result in the gas not being turned off correctly. There was no record available to show the gas cooker was serviced.
- The closing force on some doors was excessive and may cause injury
- A store room contained electrical panels. Assurance and risk assessment was required, to assess the risk and determine any required control measures, including any operational controls and nature of items (if any) that can be safely stored.
- While there were no residents who smoke at the time of inspection, the smoking area for potential residents that smoke was not adequate. There was no call bell at the area identified to the inspector as the resident smoking area.

The arrangements for providing adequate means of escape including emergency lighting were not effective:

- The threshold to some exits was high. This meant that egress may be hindered where mobility aids and evacuation aids were used
- The gate providing escape from the garden, had a padlock and the key was not available to open the lock. Some exits from the building led to this garden.
- External escape routes were not adequate. They consisted of a concrete pathway following the line of the building and there were corners and pinch points which would not be conducive for mobility aids or evacuation aids.
- The shorter external route from one exit was obstructed by a fence across the path, resulting in residents being assisted along a protracted escape path to the assembly point
- At some final exits, there was insufficient space to manoeuvre around the door when it was in the open position
- escape corridors did not provide a fire protected means of escape
- the provision of emergency lighting along external escape routes was not adequate to safely guide occupants from the exits to a place of safety
- the provision of exit signage was not adequate. St. Bridgets corridor did not have an exit sign at one end of the corridor

The arrangements for evacuating residents required improvement:

- While the centre was sub-divided with fire compartment boundaries, not all practiced drills reflected the correct fire compartment boundaries. For example a corridor door which was not within a compartment boundary was being used for horizontal evacuation. Confirmation was required from the registered provider that the correct fire compartment boundaries have been identified to inform evacuation practice in the centre

- There was one drill simulating the evacuation of residents when staffing levels were lowest. This simulated the evacuation of four residents which reflected the current occupancy of the compartment. It did not provide assurance regarding the evacuation of the compartment when at full occupancy with eight residents
- assurance was required that evacuation aids in use, would fit through exits and could be manoeuvred along external escape routes. This had not been tested in evacuation drills or training
- residents evacuation needs were assessed in their personal emergency evacuation plan (PEEP). Oversight of the PEEPs required improvement. In one room, where a resident had changed room, the PEEP was not reviewed and contained incorrect information on their evacuation requirements. In another room, two different versions of the PEEP was in the room. The day following the inspection, the person in charge confirmed all PEEPs had been reviewed.

The measures in place to contain fire were not effective, for example

- fire doors to rooms were not adequate and would not all be effective to contain the uncontrolled spread of fire and smoke. While some fire compartment and cross corridor doors were in good condition, deficits were observed to some such as gaps where the doors meet, and the door leaf not fully closing
- The inspector observed holes and gaps in the ceiling to the boiler rooms. Assurance was required that the attic above the boiler is fire separated from the attic above the bedroom accommodation
- there were service penetrations through fire resisting construction which were not adequately sealed up
- fire containment of the ceilings throughout were compromised; attic access hatches were not fire rated and light wells through ceilings were also not adequately fire rated

The measures in place to detect fire were not adequate:

- the store room which opens from the quiet room did not have fire detection
- The small staff changing rooms were not fitted with fire detection
- The manner of storage in the small storage presses along corridors meant that there was not enough free space around the smoke detector head to ensure it would function correctly

The arrangements for maintaining fire equipment were not effective:

- there was a work docket to show that the fire alarm was serviced recently, however the last service report available was from January.
- While there was documentary evidence to show that the emergency lighting system had quarterly servicing completed, there was no annual certificate within the last twelve months available for review
- Fire doors were not being maintained to ensure they were effective to contain the spread of fire

• two exit doors were not freely openable
Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Aperee Living Churchtown OSV-0000266

Inspection ID: MON-0041103

Date of inspection: 10/08/2023

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Current Governance and management systems in place is undergoing change/ review to include addition of further Director/s and a new RPR. Management restructure will include a process to provide robust review arrangements and oversight of the service provided in Aperee Living Churchtown. Timelines for the above are currently unconfirmed and will be updated to the Regulator with further information. ***The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations***	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The center will assess and evaluate, using this report as guidance, what needs to be purchased, renovated or replaced in the building, including fire stopping, furniture, hand wash facilities, carpets etc. and set priorities of what is most immediate in line with the financial resources available to us. This assessment will be completed by 8th December 2023. The centres Fire Safety Consultant is currently identifying a contractor who can meet the scope of this work. Timelines for same are currently unconfirmed and will be updated to	

the Regulator on receipt of further information.

The below items will be further addressed:

- The drain protruding from ground in non-secure garden to be made secure
- A contractor with a crane has been asked to reposition the staff smoking shed away from the main building. He is the same contractor who previously moved other sheds. We are awaiting him to reply to us with a date.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The storage of items in the small presses along the corridors has been rearranged to allow free space around the smoke detector heads to reduce the risk of them not functioning correctly.
- Several items in the quiet room which were there temporarily on the day of the inspection, while the home was re-organizing the contents of a shed to store the activities equipment have been removed and now stored in this shed.
- We intend to expand our storage area and plan to purchase another shed for the rear of the building.

The floor drain cover in the laundry room has been replaced.

Fire drills have been redesigned and now been conducted with the night duty staff numbers, as these are the lowest number of staff on a shift. The practiced drills now reflect the correct fire compartment boundaries. A different compartment is used for each drill.

The Fence in the path of the alternative exit route by the donkey's enclosure has been replaced with a gate with a key coded lock.

The unrestricted window openings have been repaired.

Evacuation aids have been tested to establish that they fit through exits and can be maneuvered along escape routes. The positive and negative results of this test/procedure are documented.

Remedial Works required:
- The threshold at entrance door has elevated lip which can make it difficult to access/egress the building independently, - this will be remedied with remedial works
- The sagging ceiling at the main reception will be repaired with remedial works
- A replacement/repair programme will be implemented for worn Lockers and wardrobes
- Exposed concrete floors, plasterwork where shelves have been removed and rough

edges where doors have been removed will be repaired in the remedial works.
- Holes in ceilings will be repaired with remedial works.
- The light fitting in the storage area in the quiet room needs a cover. If this cannot be sourced the fitting will be replaced.
- The registered floor plans will be updated to reflect the laundry area accurately.

The 2 exits which were identified on the day as not being openable.
- The exit from the dining room
- The exit from a bedroom corridor – both these exits have been repaired by the maintenance man and are now in working order.

The padlock with the key to the locked gate in the garden which leads to an external escape route has been replaced with a key code pad lock and the staff have been trained into using it.

- The PEEP sheets have all been revised and updated where necessary.

- Staff have been educated not to prop open fire doors in high-risk rooms

- The gas cooker was missing a dial and there was another incorrect dial in situ to replace a missing one – replacement dials have been ordered from a kitchen equipment company – these will be fitted the week of October 31st.

- Gas cooker service record missing – a kitchen equipment company have carried out a service on the cooker – service records will be available by the end of the week of October the 31st.

- The closing force of some of the bedroom doors is excessive – this will be reviewed and adjusted in conjunction with remedial works.

- Storeroom by bird cage contains electrical panel – the advised risk assessment has been developed and required control measures in situ as advised. This will be looked at further when completing remedial works – at present we have no date.

- There is no smoking area for residents. There are currently no residents who smoke. The home is planning a smoking area for the future potential residents who smoke. Until this is created, we will not admit residents who smoke.

- the building fire preventative checks are currently under review.

- Planned remedial works will address all items listed in this report including:
(Timeframes for same to be confirmed – this will be informed to the Regulator on further information)
• Inadequate bedroom fire doors
• Holes and gaps in the ceilings of the boiler houses
• Assurance that the attics are fire separated from attic of bedroom accommodation.
• Fire resisting construction through service penetrations
• Fire containment of the ceilings throughout the building

• Attic hatches to be fire rated.
• Light wells in Ceilings to be adequately fire rated.
• Instillation of fire detector head in storeroom in quiet room
• Instillation of fire detector heads in the two small staff changing rooms
• Documentation of most recent fire alarm service and emergency lightening service has been requested (November 12th)
• Maintain fire doors to ensure that they are effective in containing the spread of fire
• The thresholds of exit doors repair to ensure that they would not hinder evacuation.
• The magnetic devices on all doors in the building require servicing and where necessary repair or replacement.
• At some final exits there was insufficient space to maneuver residents around the exit door – the solution to this will be addressed in the remedial works by the Fire Safety Consultant.
• Emergency lightening along external escape routes will be addressed in the remedial works, so in the event of fire the residents will be sufficiently guided from the exit points to a place of safety.
• The lack of an exit sign at one end of St. Bridget's corridor will be addressed in the remedial works.

The compliance plan response from the registered provider does not adequately assure the chief inspector that the action will result in compliance with the regulations

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/12/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	30/10/2023
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability,	Not Compliant	Orange	

	specifies roles, and details responsibilities for all areas of care provision.			
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	
Regulation 28(1)(c)(iii)	The registered provider shall make adequate	Not Compliant	Orange	30/11/2023

	arrangements for testing fire equipment.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/10/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Not Compliant	Orange	30/11/2023