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:	Belmont House Private Nursing Home
Name of provider:	Belmont Care Limited
Address of centre:	Galloping Green, Stillorgan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	05 February 2025
Centre ID:	OSV-0000014
Fieldwork ID:	MON-0046120

About the designated centre

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

Belmont House is a 156-bed centre providing residential, respite and short-stay convalescent care services to male and female residents over the age of 18 years. The centre was originally a Georgian country house and was owned by a religious order. The building has been extended and completely refurbished while retaining some of its older features. It is located on the Stillorgan dual carriageway, close to the village of Stillorgan, with access to local amenities, including shopping centres, restaurants, libraries, public parks and coffee shops and good access to public transport. Accommodation for residents is across seven floors. There are also areas for residents to socialise and relax, including activity rooms, a coffee dock and quiet areas. The majority of bedrooms are single rooms, and there are 25 twin rooms. There is 24-hour nursing care with access to both in-house and specialist healthcare as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	136

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
Wednesday 5 February 2025	08:15hrs to 17:00hrs	Laurena Guinan	Lead
Wednesday 5 February 2025	08:15hrs to 17:00hrs	Manuela Cristea	Support
Wednesday 5 February 2025	08:15hrs to 17:00hrs	Yvonne O'Loughlin	Support

What residents told us and what inspectors observed

Residents reported being very happy with the care they received in Belmont House. They complimented the staff on their kindness and inspectors saw many positive interactions throughout the day. One resident said that Belmont House 'is everything I need' and visitors said that staff were excellent at communicating with them.

After an introductory meeting with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) where the purpose of the inspection was outlined, the inspectors went for a walk around the centre.

The reception area was bright and clean and had a coffee shop which was busy for most of the day. There was a lively, social atmosphere here and many residents and visitors said that it gave them great opportunity to socialise. All teas and coffees served here are free for residents. The reception area led to a beautifully decorated dining room, through to a quiet room with couches and a piano, and then into a library. The library had armchairs set out in rows facing a large screen. Staff said that residents had chosen this layout to replicate the feeling of a cinema when they are watching a movie. A spacious activity room and hairdressing salon were also on this floor. The salon was seen to be used by a number of residents during the day.

The lower ground floor, where the high dependency unit is located, gives access to an appropriately equipped smoking area, and laundry facilities. Access to the high dependency unit is controlled by a keypad for residents safety. Residents were seen engaging in one to one, and group activities in a large dining/living area. Soft music was playing and there was a calm, relaxed atmosphere. The residents had access to an enclosed outdoor courtyard that had attractive planting, seating areas, and safe pathways.

The upper floors had bedrooms, clinical areas, and living and dining rooms. Residents' artwork was on display in many areas, and each floor was seen to be clean, warm and well-maintained. Many bedrooms were seen to be personalised by residents with their own furniture and soft furnishings. Information for residents on topics such as advocacy, the complaints procedure, activities schedule and menus were available throughout the centre. Residents on all floors were seen to be engaging in activities either in communal areas or in their bedrooms and there was an overall pleasant, homely feel. Residents told inspectors that there was 'always something going on' and staff were very proactive in assisting them to take part. The terraces on the fifth and first floors all had appropriate raised safety screens which had been installed since the last inspection, and a secure walkway to give further access to the outdoor area on the ground floor was underway.

Inspectors observed lunch being served and from what they saw and what residents told them, there was good choice and quality of food on offer. Residents requiring

assistance were seen to receive it in a respectful manner and while appropriately seated.

Visitors reported that the management team were approachable and responsive to any questions or concerns they may have. There were no visiting restrictions on the day of the inspection and visitors were seen coming and going throughout the day. Visitors said they were made to feel welcome and there was a choice of areas for them to use. Inspectors observed that in the lift there was a QR code which was available to the visitors to access an app the centre has developed to keep visitors up-to-date with events and changes in Belmont House.

Inspectors observed that several fire doors were being installed in the centre on the day of inspection and noted that the provider had taken steps to improve fire safety in the centre since the last inspection. However, a number of actions remained outstanding and these are further detailed under Regulation 28: Fire safety.

While the centre was very clean, further improvements in the management of equipment and oversight of staff practices in respect of infection prevention and control (IPC) was required, as further reported under Regulation 27.

The next two sections of the report will present the findings of this inspection in relation to the governance and management arrangements in place and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

Overall, this was a well run centre with a good management structure that had clear lines of responsibility and accountability to provide a safe and effective service, which contributed to sustained good levels of regulatory compliance. Notwithstanding the positive findings, this inspection also identified opportunities for further improvements in respect of infection prevention and control (IPC) and fire safety, as detailed further in this report.

Belmont Care Limited is the registered provider of Belmont House Private Nursing Home, which is part of the wider Emeis Group. The person in charge is supported by two ADONs and five clinical nurse managers (CNMs). A third ADON had been recruited and was due to commence employment shortly. Supervision and on-call arrangements were in place for weekends and evenings to support good governance and management oversight at all times. Additional support was provided to the management team through the group directors and a regional director, who visited the centre on a weekly basis. There was evidence of regular governance and oversight of the centre with clinical governance meetings held on a regular basis.

This was an unannounced inspection to monitor ongoing regulatory compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older

People) Regulations 2013 (as amended) and to inform the registration renewal process.

The management team were supported by nurses, an activities co-ordinator, and health care, cleaning, catering, laundry, administrative and maintenance staff. Inspectors saw evidence of sufficient staffing, with call bells being responded to quickly, and the centre being well-maintained and clean. The skill-mix and qualifications of staff were appropriate to the needs of the residents. Staff had access to training and records were provided which showed a comprehensive system of induction and supervision.

Inspectors saw a comprehensive audit system in key areas such as hand hygiene, responsive behaviour (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and falls. These were followed up by action plans. Some audits did not pick up on all areas for improvement, however, and this will be dealt with further under Regulation 23: Governance and Management. There were oversight systems in place, and these were seen to be effective, in both fire safety and laundry procedures. The management team were seen to make efficient use of resources such as staffing and activities. The provider had a number of assurance processes in place in relation to the standard of environmental hygiene. These included cleaning specifications and checklists. Cleaning records viewed confirmed that residents' rooms were cleaned each day.

While there were no volunteers on placement on the day of inspection, a policy on volunteers was available which included provision for training and supervision, and Garda vetting requirements.

Regulation 15: Staffing

There was an appropriate number and skill-mix of staff to meet the needs of the residents

Judgment: Compliant

Regulation 16: Training and staff development

Staff were supported and facilitated to receive mandatory and relevant training for their roles. This included induction training and training updates. A staff training record was maintained. There was a robust system of supervision across all departments.

Judgment: Compliant

Regulation 23: Governance and management

While a comprehensive management system of auditing was in place, some audits did not identify areas for improvement. For example, care plan audits did not effectively identify areas for improvement. For example:

- Regular care plan audits were being completed, however deeper qualitative review of care plans was required to ensure that the content of the care plans was reflective of residents' current assessed needs, to effectively guide staff in the delivery of care. This is further detailed under Regulation 5: Individual assessment and care plan.
- Notwithstanding the robust programme of fire safety works undertaken in the designated centre, a number of actions that the registered provider had committed to achieve in respect of fire safety by 31st of January 2025, remained outstanding. These included actions in respect of: fire containment measures and fire detection in all areas. Inspectors received assurances that all outstanding actions will be completed by 31st of March, including the installation of all fire doors. In addition, improved oversight of fire safety records was required to ensure all checks were carried out in line with local policy and regulatory requirements.

Judgment: Substantially compliant

Regulation 30: Volunteers

A comprehensive policy on volunteers is available in the centre.

Judgment: Compliant

Quality and safety

Overall, this was a centre where residents received a high standard of care from staff who were familiar with, and responsive to, their needs. Further improvements in the area of fire safety and IPC are detailed under their respective regulations.

Inspectors looked at a sample of care plans on each floor, focusing particularly on nutritional care, falls and pressure area care. Staff spoken with were knowledgeable about the residents they cared for and used validated assessment tools to guide

them. However, a number of care plans had information in them that did not reflect the resident's current condition, which posed a risk that residents would not receive care in line with their assessed needs. This will be discussed further under Regulation 5: Individual assessment and care plan.

Inspectors also spoke with staff and looked at care plans with regard to managing responsive behaviours. Staff displayed good awareness of residents who may display responsive behaviours, and how best to assist the resident. Factors that may distress a resident were detailed in their care plan, as well as measures to relax and reassure them. The use of restrictive practices was limited to the least restrictive measure and the implementation of this was done after appropriate consultation and consent. There was evidence that alternatives were trialled and the measures in place were reviewed regularly.

Residents spoken with did not report any issues with missing clothing. Staff had been retrained in the use of the laundry labelling machine and the laundry systems were overseen by the household manager. These systems were being kept under review to ensure effective safekeeping of residents' clothes and personal possessions. There was ample storage in bedrooms, including locked storage should this be required. Residents who held money in the centre's safe could access it at any time and there were appropriate records held for each account.

Inspectors looked at instances where residents had been transferred to and from another health care facility. There was a robust system to ensure that correct documentation and full information was handed over at each stage.

The DON had overall responsibility for Infection Prevention and Control (IPC) and antimicrobial stewardship (AMS). The provider had nominated an ADON to the role of IPC link nurse, and they were awaiting a certificate of completion of an accredited IPC course. Some examples of good practice in the prevention and control of infection were identified. Staff spoken with were knowledgeable of the signs and symptoms of infection, and knew how and when to report any concerns regarding a resident. Used laundry was observed to be segregated in line with best practice guidelines. Documentation reviewed relating to *Legionella* control provided the assurance that the risk of *Legionella* was being effectively managed in the centre. For example, unused outlets were regularly flushed and routine monitoring for *Legionella* bacteria in the hot and cold water systems was undertaken. The provider had ensured that hand hygiene facilities appropriate to the setting were provided, but not all were in good repair or had suitable waste bins. Appropriate use of personal protective equipment (PPE) was observed during the course of the inspection, however, further improvements in relation to standard precautions was required. This is discussed under Regulation 27: Infection control.

Significant work had been undertaken since the last inspection which had greatly improved fire safety in the centre, although some further action was required. A hoist storage room had been built on the lower ground floor but inspectors saw hoists being charged on the corridor outside this room, and on other corridors, which could pose a potential fire hazard. An enhanced suite of fire training, audits and safety checks had been implemented. These need continued oversight as

inspectors saw gaps in safety checks and staff spoken with, while familiar with fire evacuation procedures, were unclear on compartmentalisation. Fire doors were being installed on the day of inspection but other fire containment and detection measures were still to be completed in line with provider's compliance plan from the last inspection in 30 July 2024, specifically in respect of escape stairways within the centre. These will be discussed further under Regulation 28: Fire precautions.

Inspectors saw safe storage of medicines, with medication trolleys, clinical rooms, and medication presses and fridges kept locked. Medication that required to be administered in crushed format was prescribed as such by the doctor, and was appropriately dispensed in a suitable format to ensure safe administration.

Regulation 11: Visits

Adequate arrangements were in place for residents to receive visitors and there was no restriction on visiting. Visitors spoken with were complimentary of the care provided to their relatives and were happy with the visiting arrangements in place.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate space to store their belongings and there was continued oversight of the laundry system. Residents had access to and control over money kept in the centre's safe.

Judgment: Compliant

Regulation 17: Premises

The registered provider provided premises which were appropriate to the number and needs of the residents living there. The premises conformed to the matters set out in Schedule 6. The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs.

There was good storage facilities within the centre and resident's equipment was clean and tidy.

Judgment: Compliant

Regulation 20: Information for residents

There was a resident's guide which included information on advocacy and the complaints procedure. This guide was clearly written and readily available to residents and visitors.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

There is a robust system to ensure that all relevant information about a resident is relayed at each point of a transfer to another health care facility.

Judgment: Compliant

Regulation 26: Risk management

The provider had a risk policy that was centre specific and had recently been updated. This included specific risks and hazard identification. There was a comprehensive risk register which was updated and current. An emergency plan with contingency measures was also in place.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27: Infection control and the *National Standards for infection prevention and control in community services* (2018), but further action is required to be fully compliant. For example;

- The sink in the sluice room on the third floor was out of order.This meant that staff had no facilities to wash their hands if visibly soiled.
- Four of the hand hygiene sinks did not a have a non-risk waste bin to dispose of paper towels following hand hygiene.
- The provider had not substituted traditional needles with safety engineered sharps devices to minimise the risk of a needle stick injury in line with best practice guidelines.

- The urinals used to empty catheter bags were visibly soiled, this meant that staff were not using the bedpan washer for cleaning. This practice increased the risk of catheter associated infections.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had taken significant measures to improve fire safety in the centre since the last inspection, however, action was required in respect of the following:

- Inspectors observed several hoists and batteries charging on several corridors throughout the centre. These pose a high fire safety risk and by virtue of their location on escape corridors, they could compromise the means of escape in the event of fire.
- Inspectors reviewed service records and fire safety checks and found a number of gaps in respect of the required daily and weekly checks.
- While staff carried out regular drills and had completed fire safety training, in conversation with inspectors there was a lack of understanding in respect of fire compartment demarcations. Staff reported that in the event of fire they will evacuate the residents behind the nearest fire door. As some of these doors were 30 minute fire rated doors, this did not provide assurance that residents' would be evacuated in line with local policy which was horizontal progressive evacuation by compartment, and that residents' safety would be ensured.
- Fire rated doors and fire containment measures had not been introduced to the storage cabinets and electrical service cupboards/ mains switch panels. This action was due to be completed by 31st December 2024.
- A sluice room on Maple 1 where the bedpan washer was located and some of the storage spaces/built-in cabinets along the protected corridors did not have smoke detectors fitted, as per previous commitments given by the registered provider.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Medicinal products are stored securely and administered in accordance with the directions of the prescriber.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Although staff were familiar with the residents care needs and used validated assessment tools, care plans were not always updated to reflect the resident's current care needs. This lead to conflicting information on the resident's care plan. For example:

- One resident had a MUST (Malnutrition Universal Screening Tool) score of both 2 and 3 recorded in their care plans and it was unclear which was the current score, and therefore the level of risk and intervention associated with that could mean the resident receives the incorrect care.
- A resident was documented as requiring a walking frame to mobilise but this had been discontinued by the physiotherapist in December 2024.

There is a risk that residents would not receive care appropriate to their needs.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Staff had received training in responsive behaviours and care plans showed person centred management of responsive behaviours. Use of restrictive practices was in accordance with national policy.

Judgment: 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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 30: Volunteers	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 26: Risk management	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant

Compliance Plan for Belmont House Private Nursing Home OSV-0000014

Inspection ID: MON-0046120

Date of inspection: 05/02/2025

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An enhanced schedule of training and audit is now underway to implement identified improvements in care planning. This training is supported by our quality team and delivered by the managers in the centre and will we completed by 31st March 2025 Clinical managers have been reminded of the importance of documenting identified deficits through audit and sharing the learning- complete Frequency of care plan audits has been increased to monthly and will be reviewed by the PIC and Regional Director to ensure that audits are robust and identified improvements are actioned- complete and ongoing All outstanding actions in respect of fire containment measures and fire detection and the installation of remaining fire doors will be completed by 31st of March 2025.	
Regulation 27: Infection control	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Infection control: Traditional needles have been replaced with safety engineered sharps devices to minimise the risk of a needle stick injury in line with best practice guidelines. Procurement have been requested to eliminate the option to inadvertently order the traditional needles to reduce risk further- complete.	

Staff have received refresher training regarding appropriate use of bed pan washers for equipment disinfection and correct disposal techniques - complete

From 1st March 20025, an improvement in communication and escalation processes has been initiated to ensure equipment requiring repair is actioned in a timely manner. This includes focussed daily walkabouts by clinical nursing managers alongside increased supervision and monitoring by the housekeeper and maintenance staff- complete and ongoing

From 1st March 2025, the electronic system used to identify any repairs or remedial actions required to premises or equipment will be audited monthly by PIC to ensure actions required have been addressed in a timely manner. The audit and identified actions will be reviewed at monthly governance meetings- complete and ongoing

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

An alternative charging location for hoists which does not present a risk to the means of escape will be identified by 31st March 2025.

From 1st March 2025, fire safety records will be reviewed weekly by the PIC to ensure all checks are carried out in line with local policy and regulatory requirements. The fire safety check records will be audited at monthly governance meetings and the outcome and learnings from audits will be shared with staff to improve compliance.

In respect of fire containment measures and fire detection in all areas and the installation of all fire doors all outstanding actions will be completed by 31st of March.

Staff have received additional training and education to ensure they are clearly aware of the compartments in each area and to support them to safely evacuate residents in the event of an emergency, in line with the agreed policy. This training is re-iterated during regular drills for staff- complete

Fire rated doors and fire containment measures have been applied to the storage cabinets and electrical service cupboards/ mains switch panels- complete

Smoke detectors have been fitted in all locations identified and in line with requirements- complete

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

An enhanced schedule of training and audit is now underway to implement identified improvements in care planning. This training is supported by our quality team and delivered by the managers in the centre and will be completed by 31st March 2025

Clinical managers have been reminded of the importance of documenting identified deficits through audit and sharing the learning- complete

Frequency of care plan audits has been increased to monthly and will be reviewed by the PIC and Regional Direct

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 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.	Substantially Compliant	Yellow	31/03/2025
Regulation 27	The registered provider shall ensure that procedures, consistent with the standards for the prevention and control of healthcare associated infections published by the Authority are implemented by staff.	Substantially Compliant	Yellow	28/02/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all	Substantially Compliant	Yellow	31/03/2025

	fire equipment, means of escape, building fabric and building services.			
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	31/03/2025
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	31/03/2025
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	Substantially Compliant	Yellow	31/03/2025

	practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/03/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/03/2025