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:	St Joseph's Care Centre
Name of provider:	Health Service Executive
Address of centre:	Dublin Road, Longford, Longford
Type of inspection:	Unannounced
Date of inspection:	21 May 2026
Centre ID:	OSV-0000466
Fieldwork ID:	MON-0050604

About the designated centre

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

St Joseph's Care Centre provides 24-hour nursing care for up to 65 residents of all dependency levels, male and female, predominantly over 65 years of age. The centre can provide care to a range of needs of various complexity, including dementia care and cognitive impairment, acquired brain injury, palliative and palliative respite care. The centre is single-storey and comprises of two buildings containing five units. There are communal rooms and internal gardens available to residents as well as a large chapel. The centre's philosophy and motto is to 'add life to years when you cannot add years to life' and aims to address the physical, emotional, social and spiritual needs of all residents with a holistic approach of empathy and kindness. The centre is located in Longford town within easy reach of nearby shops and restaurants. Parking facilities are available on site.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	53

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 21 May 2026	10:00hrs to 17:30hrs	Gordon Ellis	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out over one day. There were 53 residents accommodated at the time of the inspection. Prior to this inspection, the provider submitted an application to vary conditions 1 and 3 on the designated centre's registration. This application was to change the purpose of a number of areas and to register a part of the premises not currently registered for residents' use, to facilitate the next phase of a new centre premises on the campus. Any feedback regarding parts of the centre that are not registered is provided separately.

Building and fire safety works had been progressed at the time of this inspection, and this application was fully assessed by the inspector as part of this inspection. Whilst the provider had made improvements to fire safety and premises issues since the last inspection, the inspector found that further actions were required in relation to fire safety and some aspects of the premises.

The inspector was met by the person in charge, who facilitated the inspection. Following an introductory meeting, the inspector completed a walk around of the centre. This gave the inspector an opportunity to meet with staff and residents and observe life in the centre.

Residents appeared to be relaxed and comfortable in the company of staff. All observed interactions were respectful towards residents. The layout of the centre was generally suitable for its stated purpose and met residents' individual and collective needs. The centre is located in Longford town. Residents' bedroom accommodation was arranged on the ground floor level throughout in four separate units. Sunset and Autumn Lodge units are located in a separate building on an elevated site at the back of the main building. Padre Pio and Our Lady's Unit 1 are located in the main building.

The provider had proposed to repurpose a Physiotherapy area as a Multi-Denominational Prayer room not previously registered. Furthermore, the provider proposed to register a Therapy area along with a series of connected rooms not previously registered and to de-register a resident's chapel so it could be used as a Community Physiotherapy Room.

Access controls had been put in place by the provider to ensure security and safeguarding measures were in place in adjoining parts of the building that were proposed to be de-registered to not form part of the centre. However, the same corridor and fire exit was also designated as an evacuation route for residents located in the Lodge during an evacuation. The provider was proposing to de-register this corridor along with ancillary rooms and the chapel. In addition to this, there was a lack of fire doors along this corridor, which resulted in residents being evacuated along a route that was not a protected means of escape. The inspector raised concerns with staff in regards to this arrangement; if this route was to be de-

registered the provider would not have oversight of this route to ensure it was kept clear and managed from a fire safety perspective to continue to be used for residents in the Lodge in a fire evacuation.

During a walk around the centre, the inspector noted fire evacuation floor plans were out-of-date due to the number of changes and demolition of units to make way for the new extension currently being built. Fire evacuation floor plans were missing from repeater panels. Emergency directional signage (running man signs) along a corridor were not adequately illuminated. Cross corridor doors into Our Lady's Unit 1 failed to close when tested, and double doors into an assembly hall had gaps between doors.

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 affect the quality and safety of the service being delivered.

Capacity and capability

This inspection found that the management and oversight of the service had improved since the last inspection. Notwithstanding these improvements, action and resources were necessary to ensure that residents were adequately protected from the risk of fire.

A review of the fire safety systems found that the provider had failed to ensure adequate arrangements for containment, maintenance of building systems, a review of fire prevention due to the repurposing of rooms, to provide adequate emergency lighting and a failure to fully complete fire risks identified on a previous inspection.

This was an unannounced inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended) and to follow up on the actions the provider committed to in their compliance plan to address significant non-compliance with the regulations as identified during the last inspection carried out in November 2025.

The registered provider of St Joseph's Care Centre is the Health Service Executive (HSE). The provider is represented by a general service manager. The local management team consisted of a person in charge who was appointed by the provider in May 2025. An assistant director of nursing (ADON) position was vacant since October 2025, and had not been replaced at the time of this inspection. Therefore, this inspection again found that the management structure in place did not reflect the centre's statement of purpose.

The provider had submitted an application to vary conditions 1 and 3 on the designated centre's registration. This application was to change the purpose of a number of areas and to register a part of the premises not currently registered for

residents' use. These proposed changes were to facilitate the next phase of building new centre premises on the campus. This application was assessed by the inspector as part of this inspection in relation to Regulation 28: Fire Precautions and Regulation 17: Premises. The findings are outlined in detail under the relevant regulations.

Weekly audits and fire safety checks on the means of escape, appropriate storage, containment and fire prevention were being completed. Fire safety training was provided for staff and staff were up to date with this training.

Issues relating to the management of fire safety are detailed under Regulation 23: Governance and Management. Further fire safety issues are detailed under the quality and safety section and Regulation 28: Fire precautions of the report.

Regulation 23: Governance and management

The management structure in place was not clearly defined, with clear lines of accountability and responsibility. An assistant director of nursing position had been vacant since October 2025. This impacted on effective governance and oversight of the service, and suitable deputising arrangements were not available in the event of an absence by the person in charge. This was a repeated finding from a previous inspection in November 2025.

The provider's management of risk in the centre was not effective, and as a result, the systems in place to identify, manage and respond to risk and ensure residents' safety were not adequate. This was evidenced by the following:

- The provider had not recognised some of the fire risks found on the inspection, and additional fire precautions were required to ensure that residents were protected from the risk of fire as detailed under regulation 28: Fire Precautions.
- Several repeated fire risks identified on this current inspection had not been completed within the timelines of the provider compliance plan. These are outlined in detail under Regulation 28: Fire Precautions.
- Fire prevention, management policies and evacuation policies were noted to be outdated due to the changes and demolition of units.

Judgment: Not compliant

Quality and safety

This inspection found that the management of fire safety, as described in Regulation 23: Governance and management section of this report, did not fully ensure the safety of residents, staff and visitors.

The inspector found that action was required in regard to some visual deficiencies in the building fabric, building systems and fire doors. Furthermore, the provider had failed to fully complete fire risks identified on a previous inspection. Repeated fire risks were identified on this current inspection and remained unresolved. These are outlined in detail under Regulation 28: Fire precautions.

Furthermore, external emergency lighting was missing along fire exit routes to illuminate the route of escape in the event of a fire evacuation. Some areas were noted to have holes, utility pipes or ducting that penetrated through the fire-rated walls and ceilings that required appropriate fire sealing measures.

Other concerns were identified in regards to the proposed re-purposing of rooms and de-registering of areas that required a review by the provider's competent fire person. These concerns are outlined in detail under regulation 28: Fire precautions.

The inspector reviewed the fire safety register and noted that parts of it were well organised. Notwithstanding this, fire management policies, evacuation policies and floor plans were noted to be outdated due to the changes across the centre. Fire evacuation floor plans were missing from repeater panels.

In-house periodic fire safety checks were being completed and logged in the register as required. However, there were gaps identified such as deficiencies in the building fabric, emergency lighting or containment had not been identified in the in-house routine checks.

Residents' living environment was generally well maintained and was decorated in a traditional style that was familiar to them. Since the previous inspection, the provider had completed actions and had reviewed the design and layout of twin-occupancy bedrooms in Sunset Lodge Unit. This improved the layout to facilitate residents with assistive equipment to manoeuvre around their beds safely.

A storeroom off the main reception area of the centre had been redecorated, and the ceiling had been replaced. Furthermore, some areas where walls and ceiling surfaces were visibly damaged or had holes had been repaired.

Notwithstanding the works carried out by the provider, further improvements were required to conform to the matters set out in Schedule 6 of the regulation as outline under Regulation 17: Premises.

Regulation 17: Premises

The provider had carried out improvements to the centre's premises and had completed most of the actions committed to in their previous compliance plan.

Notwithstanding this, the centre's premises required improvements in order to conform to the matters set out in Schedule 6 of the regulation. For example:

- There were some areas where walls and ceiling surfaces were visibly damaged or had holes that required sealing and redecoration to address gaps in these surfaces.
- Some doors sampled required repair due to damage, wear and tear.
- Several casings for emergency lighting were missing.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Day-to-day arrangements in place in the centre required improvement to provide adequate precautions against the risk of fire. For example:

- A store room that was restricted to be used as a storage room due to a large electrical mains panel fitted in the room and the risk of a fire developing did not have signage displayed to notify staff not to use this room for storage purposes.

Arrangements for means of escape and emergency lighting in the event of a fire emergency in the centre required improvement. For example:

- Externally, emergency lighting was missing along some fire exit routes to illuminate the route of escape in the event of a fire evacuation at night-time and ultimately to a fire assembly point. In particular, external emergency lighting, a designated fire assembly point and directional signage were missing from a waiting area and from a newly re-purposed multi-denominational room fire exits along the external evacuation routes
- Internally, some emergency directional signage along escape corridors were not illuminated. Furthermore, some emergency light fittings were missing their casings.

Arrangements for the maintenance of the means of escape, building fabric and building services were not fully implemented:

- Georgian glazing was identified in residents' bedrooms along a means of escape, a linen room and a store room that overlooked a corridor. A sliding vision panel was also noted in a linen room adjacent to a bathroom. The provider failed to resolve this issue identified on a previous inspection. This created a risk of the non-fire rated glazing failing in a fire situation, allowing fire and smoke to travel and to compromise the protected means of escape.

- From a review of electrical reports and maintenance reports, extensive works to the electrical system had been identified throughout the designated centre in July 2025. Most risks identified were required to be rectified within 30 to 90 days. The provider had started to address this issue but could not provide a completion date and had not completed these works in line with the dates committed to in a previous compliance plan. As such, the provider failed to resolve this issue, and the inspector could not be assured that the electrical system was being appropriately maintained and risks were being addressed in a timely fashion.
- Some areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated walls and ceilings (walls and ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures. For example, this was noted above two sets of cross corridors, in a DSR room, through a ceiling in a prayer room and in a therapy room.

Arrangements for the containing of fires were not fully implemented. For example:

- Several ceiling access hatches appeared not to provide the required fire resistance. The provider failed to resolve this issue identified on a previous inspection.
- The majority of fire doors were in good condition; however, the ability of a selection of fire doors to prevent the spread of smoke and fire was compromised. For example, some doors had gaps between double doors and failed to close past the latch when tested. A number of fire doors were not fitted with fire-rated tags to indicate the fire doors' resistance.

The displayed procedures to be followed in the event of a fire required improvement. For example:

- Fire evacuation floor plans were noted to be outdated due to the number of changes and demolition of units to make way for a new extension currently being built. Furthermore, fire evacuation floor plans were missing from repeater panels.

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 St Joseph's Care Centre OSV-0000466

Inspection ID: MON-0050604

Date of inspection: 21/05/2026

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:
A permanent ADON will be in position from 11th November 2026 in line with the Centres Statement of purpose.

In the interim period, governance and oversight will be enhanced by the introduction of an increased presence of the PPIM onsite bi-weekly to support and monitor regulatory non-compliances, risk management and fire safety, improving direct oversight of compliance with regulations and resident welfare. The PPIM will attend onsite governance meetings, which will include a walk around of the Centre to review the premises and meet with staff when onsite.

In addition to the implementation of a revised fire checks process in line with fire policy in the Centre, Environmental Audits of the Centre will be carried out. The findings will inform the development of a structured Quality Improvement Plan with clearly identifiable actions and associated completion dates.

An oversight group is being established to meet fortnightly to monitor regulatory compliance and the progress of QIPs to ensure identified non-compliances are addressed, improvements are sustained and appropriate management accountability is maintained. The membership of this group has been agreed and includes the CHA Lead, PPIM, DON/PIC, DON Band 2 for Older Persons Services, Quality and Patient Safety adviser, Compliance Officer and HR Specialist. Other relevant personnel will be invited as required.

Quarterly governance meetings chaired by the DON/PIC with attendance by a representative from all departments across the Designated Center are in place including membership from the maintenance team. The agenda for the governance meeting includes risk management and open risks on the risk register, fire safety, IPC and health and safety. Minutes of the meetings are recorded and shared by the CNM IIs and

department heads to their respective teams in order to share learning including any agreed changes regarding any revision in policy or procedures.

The repeated fire risks identified on inspection have been addressed. A process is now in place to identify and address any on-going risks as they arise, i.e. weekly fire safety checks and environmental audits. Oversight is maintained by the DON/PIC through a new procedure developed to report and follow up on fire issues identified with maintenance and HSE Fire Officer.

To further enhance and improve governance and oversight of fire safety within the Designated Centre from an infrastructural and operational fire management practice and systems perspective, the HSE Fire Officer will complete a quarterly Fire Safety Audit of the Designated Centre over the next 12-month period to proactively support the DON/PIC.

The fire safety checks on each Unit, service area and communal areas have been reviewed by the CNM II and department heads respectively and once satisfied, will be signed off as part of the oversight arrangements.

Regular routine fire evacuation drills are carried out in all units, service areas and communal areas. Learning identified from routine fire checks and fire drills is documented and is disseminated by the CNM II to the relevant teams and shared and reviewed at the quarterly governance meeting.

Governance and oversight of the risk register has been strengthened. The CNM II in the nursing administration office has been assigned responsibility to review and keep the fire register updated and report to the DON/PIC on controls and timelines in relation to risk management.

A tracking system is now in place to monitor the progress of the implementation of agreed actions in the compliance plan and corrective actions identified from audits to ensure they can be fully addressed. These actions form part of the Quality Improvement plan for the Designated Centre and are reviewed by the oversight group on a fortnightly basis.

The centre acknowledges that elements of the fire prevention, management and evacuation policies require updating following the demolition of units and the associated changes to the layout. These policies are continuously being reviewed and revised to reflect the current building configuration, resident profile and operational arrangements.

The risk management policy and the risk register in the Designated Centre is being updated to further ensure adequate controls are in place for all aspects of fire safety and environmental works on going in the Designated Centre to mitigate any risk and ensure residents' safety and will be continually reviewed by the DON/PIC and the oversight group.

Both the fire prevention and evacuation procedures have been updated in line with the most recent changes and the Designated Centre’s overarching fire safety management strategy. The DON/PIC maintains full oversight of fire safety arrangements and ensures

that policies remain aligned with any structural or operational changes. Updated copies of all fire safety policies can be provided on request.

A programme of localised fire drill exercises has been initiated to ensure staff are fully familiar with the revised layout, evacuation routes and the operational use of the re purposed spaces. These fire drills are now incorporated into the Designated Centre's established fire safety training schedule to maintain competency. The fire drill records are maintained in the fire register.

The DON/PIC continues to carry out compartmental evacuation drills in line with regulatory requirements, and the re purposed areas now form part of those exercises. Records of completed drills and staff attendance are maintained in the fire register.

As the resident evacuation from The Lodge has been rerouted to exclude access via this corridor, the application to vary requesting that the area currently accommodating the physiotherapy service and ancillary rooms along the physiotherapy service access corridor to be deregistered remains. The corridor continues to be inspected, maintained and managed as part of the Designated Centre's established fire safety programme, including routine checks, compartmentation integrity, and evacuation planning. Designated assembly point signage has been relocated to an alternative evacuation route as part of the escape strategy from the Lodge.

A Fire Safety Consultant was appointed previously to carry out a Fire Risk Assessment of the therapy area. The store room and hairdresser room off the OT room in the therapy area will be provided with fire doors achieving 30-minute fire resistance (i.e. FD30s).

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises: Damaged areas to walls and ceiling surfaces have been repaired and painted. Holes identified have been repaired, sealed and decorated since the inspection.

All doors have been reviewed, and repair works are being carried out accordingly. A clear scope of works has been defined to identify the need and frequency for ongoing maintenance and a painting schedule is now in place to ensure a rolling programme of maintenance and painting, so surfaces are well maintained and clean. The progress on these works is being monitored at the maintenance management meetings that are scheduled monthly.

Environmental audits are being implemented to proactively identify any emerging maintenance issues and parts of the Designated Centre which require decorative maintenance and painting. Issues requiring maintenance are reported as they are

identified. An in-house maintenance reporting book system is in place in each Unit in the Designated Centre. The in-house maintenance reporting book system is reviewed weekly by the CNM II in each unit and by nursing administration for the communal areas of the Designated Centre to ensure issues identified are completed in a timely manner. A quality improvement plan will be implemented and updated as required from the findings of the environmental audits. These will be discussed at maintenance management meetings and reported on at the local governance meetings that is chaired by the DON/PIC and includes membership from the maintenance team, to review recommendations and progress agreed actions.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: A Fire Safety Consultant was appointed previously to carry out a Fire Risk Assessment of the therapy area pertaining to relocation of services. All items identified on the risk assessment have been actioned including replacement of fire doors as deemed necessary by the Fire Consultant and sign off for these works was received by the Fire Consultant also.

Both the fire prevention and evacuation procedures have been updated in line with the most recent changes and the Designated Centre's overarching fire safety management strategy.

The DON/PIC maintains full oversight of fire safety arrangements and ensures that policies remain aligned with any structural or operational changes. Updated copies of all fire safety policies can now be provided on request.

The DON/PIC continues to carry out compartmental evacuation drills in line with regulatory requirements, and the re purposed areas now form part of those exercises. Records of completed drills and staff attendance are maintained in the fire register.

To proactively support the DON/PIC to improve governance and oversight of fire safety within the Designated Centre from an infrastructural and operational fire management practice and systems perspective, the HSE Fire Officer will complete a quarterly Fire Safety Audit of the Designated Centre over the next 12-month period.

The Store room has signage added to inform staff the room is no longer to be used for storage purposes.

External emergency lighting has been installed on fire exit routes. Additional directional signage has been installed from the waiting and multi denominational room fire exits, along the external evacuation routes to a fire assembly point.

All emergency directional signage along escape corridors are illuminated. An independent specialist contractor is engaged in a schedule of works to review and replace casings for emergency lighting. To date 10 emergency lights remain outstanding.

The Georgian glazing identified in OLU1 in residents' bedrooms along a means of escape, a linen room and a store room has been replaced with fire rated glazing. Photographic evidence can be provided on request.

The Maintenance Department has engaged an external electrical contractor to address the works identified in the electrical system condition report for St Josephs. All identified works has now been completed and signed off. All openings for pipes and ducting penetrating fire rated walls and ceilings have been appropriately fire stopped.

Existing ceiling hatches in ceilings have been replaced with fire rated ceiling hatches since the last inspection. Photographic evidence can be provided on request.

The doors identified on inspection have been reviewed and repaired to ensure there are no gaps in fire doors. Latches on all doors have been examined by maintenance and are now in full working order.

Fire doors throughout St Joseph's Care Centre undergo regular inspection, maintenance, upgrade and replacement works when and where defects are identified and arise. Weekly visual inspections take place on each unit and all communal areas as part of the weekly fire safety checklist which are maintained in the fire register. Any defects are reported to maintenance for immediate remediation. Fire rated tags on fire doors have been relocated and are visible on the doors.

The OT room has been reviewed. The door to the store room and hairdresser room will be replaced with new 30 min fire doors (FD30s). We note there are other rooms off the OT room i.e. offices, however these do not require fire resisting construction in accordance with the fire regulations. These areas have been inspected by the HSE Fire Officer and risk assessed by the previously appointed independent fire safety consultant.

The results, defects and work orders is now reviewed at the monthly maintenance meetings and the quarterly governance meeting chaired by the DON/PIC to guarantee ongoing compliance with fire doors. A folder has been created by the Maintenance Department to record the biannual fire door checks, including any actions required, comments and sign-offs.
The records are now reviewed by Maintenance Management to ensure that all fire doors remain compliant and that any identified issues are appropriately addressed and closed out and monitored through the monthly maintenance meeting with DON/PIC. Furthermore, all doors have been checked since the inspection to ensure they are closing effectively.

The fire evacuation floor plans have been updated to reflect any alteration works, the demolition of units and the ongoing construction of the new extension. The changes to circulation routes and compartmentation now reflect the current building layout.

Updated evacuation floor plans have been prepared to reflect the present configuration of the centre, including revised escape routes and staff assembly points. Fire evacuation floor maps have now been installed at repeater panels throughout the centre to ensure staff have immediate access to accurate information during an emergency.

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.	Substantially Compliant	Yellow	15/11/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	11/11/2026
Regulation 23(1)(c)	The registered provider shall ensure that there are deputising arrangements for key management roles in place.	Substantially Compliant	Yellow	11/11/2026

Regulation 23(1)(d)	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	30/10/2026
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.	Substantially Compliant	Yellow	30/11/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	31/08/2026
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	30/10/2026
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/08/2026
Regulation 28(2)(i)	The registered provider shall	Not Compliant	Orange	30/11/2026

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 28(3)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.	Substantially Compliant	Yellow	31/08/2026