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:	Cratloe Nursing Home
Name of provider:	Cosgrave Nursing Consultancy Limited
Address of centre:	Gallows Hill, Cratloe, Clare
Type of inspection:	Unannounced
Date of inspection:	15 September 2023
Centre ID:	OSV-0005393
Fieldwork ID:	MON-0041491

About the designated centre

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

Cratloe nursing home was originally built as a domestic dwelling which had been extended and adapted over the years to meet the needs of residents. It is located in a rural area on the outskirts of the village of Cratloe in Co. Clare. It is split level building and it accommodates up to 32 residents. Accommodation for residents is provided on both levels with a lift provided between floors. It provides 24-hour nursing care to both male and female over the age of 18 years. Care is provided for people with a range of needs: low, medium, high and maximum dependency. It provides short and long-term care primarily to older persons. There are nurses and care assistants on duty covering day and night shifts. Accommodation is provided in both single and shared bedrooms. There are separate dining, day and visitors rooms as well as an enclosed garden courtyard area available for residents use.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	29

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
Friday 15 September 2023	10:00hrs to 17:30hrs	Gordon Ellis	Lead

What residents told us and what inspectors observed

The inspector was met by the person in charge and the provider, who facilitated the inspection.

Following an introductory meeting, the provider accompanied the inspector on a tour of the designated centre. The Inspector saw that staff were being very attentive and respectful to residents who were mobilising around the centre and were using the communal areas as they wished. There was a busy but pleasant atmosphere during the inspection.

Cratloe Nursing Home is a split level building that has been added to incrementally over time and is located on the outskirts of the village of Cratloe. The centre is registered to provide care for 32 residents and there were 29 residents living in the centre on the day of the inspection. Communal spaces are available for residents which include a dayroom, a dining room, a lounge room and a visitor's room, all of which are located on the first floor. The building comprises of a mixture of single and twin bedrooms with a central enclosed courtyard. Ground and first floor are served by an internal staircase, lift and an external staircase to the front of the centre.

Residents moved around the centre freely, throughout the day. The residents were enjoying playing bingo on the day of the inspection. An enclosed garden on the top floor was maintained, adequate seating and tables were provided for residents to use. Residents who chose to smoke were observed to do so in this garden area. The inspector was informed that an internal smoking room was previously used by residents and a new designated smoking area was now relocated to the enclosed garden. However, the inspector noted discarded cigarette butts were being put into a plant pot and a call bell could not be found to enable them to call for assistance if required.

The inspector noted the centre was generally clean. However, the inspector observed come areas to be cluttered, chairs were found in a resident's en-suite and some areas of the centre required painting such as some resident's bedrooms, some door frames. A timber window board in a resident's bedroom required attention as it showed signs of swelling and paint was flaking off.

The provider was in the process of painter and decorator on the day of the inspection. The inspector noted a new window had been fitted in place of a fire exit and a new hand wash sink had been fitted in the laundry room but had not been connected as of yet.

Fire evacuation floor plans were displayed along the various corridors. The inspector noted they were not up-to-date as a floor plans indicated a designated fire evacuation route and fire exit that was no longer in use. Furthermore, the designated fire exit that had been replaced with a window had not been reflected in

the evacuation floor plans.

During the walk around, the inspector noted fire risks in regards to fire door, visual deficiencies in the building fabric, emergency lighting and emergency directional signage. These are outlined in detail under the quality and safety section of this report.

Staff spoken with demonstrated a good knowledge of the evacuation procedure in place. The fire alarm panel was located on the first floor and was noted to be free of faults. Fire extinguishers were present throughout the centre and were serviced.

The next two sections of this report presents 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

This unannounced risk inspection was to monitor the designated centre's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to follow up on the provider's progress with addressing actions from the previous inspection in March 2023.

The majority of commitments made by the provider from the previous inspection with regards to premises and fire precautions had been actioned. In regards to premises, the registered provider was issued with a restrictive condition to reconfigure, or reduce the occupancy of bedroom 12 to ensure that any resident residing in the room is afforded 7.4m2 floor space to include their bed, a chair and personal storage space by the 31 December 2023. The provider was working towards having this work completed by the prescribed date.

Notwithstanding this, some further improvements were required to achieve regulatory compliance in relation to premises and on fire precautions in the centre. These are discussed under the quality and safety section of this report.

The management structure was clearly defined, it identified lines of authority and accountability. The registered provider of the centre is Cosgrave Nursing Consultancy Limited, which comprises of two directors. Both directors are directly involved in the operational management of the centre, one being the named person in charge. They are supported in their role by a clinical nurse manager and a team of nurses, health care assistants, domestic, activities and administrative staff.

This inspection found that the governance and management of fire safety in Cratloe Nursing Home was of a good standard and systems in place were effective in the maintenance of fire safety systems. However, the oversight of fire safety management and the processes to identify, and manage fire safety risks required improvement to ensure the safety of residents living in the centre. This was

evidenced by the fire risks identified on the day of the inspection, one of which resulted in an immediate action having to be issued to the provider. These are outlined in detail in the quality and safety section of the report and under Regulation 28.

Regulation 23: Governance and management

While effective governance and management systems supported a good standard of maintenance of effective fire safety systems and a number of good fire safety management system were in place some management systems were not sufficiently robust and required action. The provider had not recognised some of the risks found on inspection. For example:

- Additional fire precautions were required to ensure that residents were protected from the risk of fire as detailed under regulation 28.
- The inappropriate storage practices of flammable liquids resulted in an immediate action on the day of the inspection.
- In regard to some areas, a documented procedure or policy was not in place for staff to follow to ensure the means of escape is kept accessible, clutter free and not found in a wet state.
- Some fire doors were found to be propped open in a way that interfered with the fire door closing mechanism.

Judgment: Substantially compliant

Quality and safety

Fire safety systems and the fire safety aspects of the physical premises were maintained to a good standard. It is acknowledged the provider did complete most of the commitments made after the previous inspection in March 2023. Notwithstanding this, due to the findings of this inspection the registered provider was required to make improvements in order to meet the regulatory requirements on fire precautions in the centre.

The inspector found uncertainty over fire-containment in regards to deficiencies with fire doors, visual deficiencies in the building fabric, inappropriate storage of flammable liquid, the provision of emergency lighting to external escape routes and the provision of emergency directional signage to internal corridors which could lead to potential consequences for residents in an emergency. The provider must make improvements in order to comply with the regulations.

The inspector identified numerous deficiencies in regard to fire doors which would compromise containment measures in place to prevent the spread of fire and

smoke. The provider needs to have a full assessment of fire doors in the centre carried out by a competent fire safety expert and appropriate actions are to be taken in order to address these deficiencies. This is outlined in more detail under Regulation 28.

While emergency directional signage was provided for in most areas of the centre, the inspector noted some internal corridors were missing emergency directional signage to indicate the route to take in the event of an emergency in order to reach a fire exit. In addition to this, the inspector was not assured there was adequate emergency lighting provided to some external areas in order to provide illumination in the event of a night time evacuation.

The centre was laid out with a sufficient number of escape routes and fire exits to aid in the safe evacuation of residents in a fire emergency. However, the inspector observed some corridors were found to be cluttered and an external fire exit was impeded by a parked car. Furthermore, while risk assessments were in place for evacuating through wet rooms as a means of escape, the inspector observed one wet room to be cluttered with a commode and a bin that would potentially delay an evacuation.

In addition to this, a procedure or a policy for staff to follow in order to ensure that this type of means of escape was kept accessible, clutter free and not found in a wet state at all times was not documented.

The inspector reviewed the fire safety register and noted that it was well organised and comprehensive. The in-house periodic fire safety checks were being completed and logged in the register as required. However, the inspector noted deficiencies identified in regard to fire doors on this inspection had not been recorded or identified in the in-house routine checks of fire doors.

Service records were available for the various fire safety and building services and these were all up to date. There was a fire safety management plan and emergency fire action plan in place. These were found to be comprehensive and informed good fire safety management of the centre. Detailed evacuation procedures were present for each compartment for day and night time evacuations.

Staff were familiar and confident on evacuation procedures and all staff were up-to-date with fire training. The residents' personal emergency evacuation plans (peeps) were found to be clear and detailed. A colour coding system was used to identify the level of dependency for each residents. A copy of each residents peeps were kept on the back of each resident's bedroom door for staff to reference

Regulation 17: Premises

Actions were required by the registered provider having regard to the need of the residents to provide premises which conformed to the matters set out in Schedule 6.

On foot of the previous inspection, the registered provider was issued with a restrictive condition to reconfigure, or reduce the occupancy of bedroom 12 to ensure that any resident residing in the room is afforded 7.4m2 floor space to include their bed, a chair and personal storage space by the 31 December 2023. On the current inspection the provider was working towards having this work completed by the prescribed date.

The provider had progressed a programme of painting and decorating and had fitted a wash hand basin in a laundry room. Notwithstanding this, the following areas identified on this inspection that required improvements in regards to Schedule 6 were as follows:

- The inspector noted several chairs were being stored in a resident's en-suite. The provider is required to review storage arrangements.
- On the previous inspection, it was identified that a required wash hand basin was not installed in a laundry room. On this inspection the wash hand basin had been fitted by the provider, however plumbing was due to be connected before it could be put into use.
- While the provider was carrying out painting and decorating on during this inspection, some areas of the centre required painting such as resident's bedrooms and door frames.
- A timber window board in a resident's bedroom required attention as it showed signs of swelling and paint was flaking off.
- Some doors did not close fully when released and some holes were found in ceilings that required attention.

Judgment: Not compliant

Regulation 28: Fire precautions

Improvements were required by the provider to ensure adequate precautions against the risk of fire. Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire and some fire risks identified required immediate action by the provider. This was evidenced by the following fire risks:

- The inspector observed a number of plastic containers that contained flammable liquid being stored next to an external generator. This was brought to the attention of the provider who addressed the immediate risk on the day of the inspection.
- The inspector noted a chair in one location and a health hazard bin in another area obstructed a fire door from closing when released. This would allow fire and smoke to easily spread in the event of a fire emergency.
- At the main entrance door, the inspector identified a gas line and shut-off lever without signage, a protected cage around the lever and paint or a labelling to indicate that the pipeline was supplying gas. The lack of a cage

created a risk of the lever being tampered and the lack of signage, labelling or paint created a risk for the public to not be aware this was a gas pipeline.
- A metal ashtray was lacking in a residents external smoking area, the inspector noted discarded cigarette butts were being put into a plant pot and a call bell was not provided.
- At a nurse's station door, the inspector noted a slide bolt was fitted on the outside of the door. This requires a review by the provider as it creates a risk of staff becoming trapped inside the office in the event of a fire.

The provider needed to improve the means of escape for residents including emergency lighting in the event of an emergency in the centre. For example, a car was parked directly outside an external fire exit and caused an obstruction, which could have impeded and delayed an evacuation.

The inspector was not assured that adequate levels of emergency directional signage were provided for in some internal corridors on the ground and first floor. For example, there was a lack of emergency directional signage along the corridors on the first floor to indicate the route to take in the event of an emergency in order to reach a fire exit. This requires a review by the provider throughout the centre.

Externally, the inspector was not assured there was adequate emergency lighting provided to some external areas in order to provide illumination in the event of a night time evacuation and ultimately the safe placement of residents at the designated fire assembly point. This requires a review by the provider.

The provider needs to review the maintenance of the means of escape and of the building fabric. For example, some corridors were found to be cluttered. In one area a means of escape was found with a bin and a commode. In another corridor the inspector found an ironing board and a cleaning trolley. This has the potential to impede and delay an evacuation in the event of a fire emergency.

Furthermore, a means of escape with the potential to be locked or in a wet state did not have a documented procedure or policy for staff to follow in order to ensure the means of escape is kept accessible, clutter free and not found in a wet state. This is to ensure the means of escape is maintained in a good state at all times to ensure it can be used as a protected means of escape in the event of an evacuation.

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, the inspector noted some large holes in the ceiling of a store room that required sealing. In addition to this, the inspector was not assured the spray foam that had been used to seal around pipework in a hot press and an electrical room were an appropriate fire sealing product carried out be a competent person.

The provider needs to improve the review fire precautions throughout the centre. While in house fire safety checks were being carried out and recorded were, further fire safety training is required, in order to further support staff to identify fire safety risks and protect residents from the risk of fire. For example, deficiencies identified

in regard to fire doors had not been recorded or identified in the in-house routine checks of fire doors.

While fire evacuation drills were taking place and contained good levels of detail, clarity and learning outcomes, further fire drill practice was required in order to further support staff to protect residents from the risk of fire. For example, fire drills were being carried out for the largest compartments which included different scenarios and staffing levels, however the inspector noted not all fire evacuation routes had been tested to ensure staff were adequately familiar with all available routes of evacuation, in particular evacuating through secondary evacuation routes to the outside via wet rooms.

Arrangements for containment of fire and detection in the event of a fire emergency in the centre required improvement by the provider. For example, the inspector was not assured of the ability of a selection of fire doors to prevent the spread of smoke and fire. The provider needs to have a full assessment of fire doors in the centre carried out by a competent fire safety expert. A number of fire doors observed by the inspector had door-closer mechanisms, hinge screws and fire door seals partially or completely missing in some cases. Gaps were noted at the bottom and between some doors. Furthermore, a number of fire doors had signs of damage, fire smoke seals were painted over, some doors had non fire-rated brass ironmongery and did not close fully when released. These containment deficiencies posed a risk of fire and smoke to spread in event of a fire.

In addition to this, the inspector noted while the fire detection alarm system was confirmed to be an L1 category system, a number of locations were lacking fire detection. For example detection was missing in a laundry room and in some areas used to facilitate protected means of escape. The provider stated planned works to upgrade the fire detection system were on-going.

The displayed procedures to be followed in the event of a fire lacked detail and clarity for people working in the centre to be able to easily follow in the event of a fire. For example, floor plans on display did not indicate the location of compartment areas on the floor in question (compartment and sub-compartment boundaries) suitable for phased evacuation of residents from a high-risk area to a low-risk area on the same floor (horizontal phased evacuation).

Furthermore, while fire evacuation floor plans were on display which indicated evacuation routes, these were outdated. The inspector noted a fire exit door had been removed, however the floor plans had not been updated to reflect this change and still indicated this as a fire exit. Furthermore, on the first floor the same risk was observed, the floor plan indicated a route to a fire exit that was no longer in use.

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	Substantially compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Cratloe Nursing Home OSV-0005393

Inspection ID: MON-0041491

Date of inspection: 15/09/2023

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The additional fire precautions as documented by the HIQA Fire Officer and as detailed under regulation 28 have been discussed by the Registered Provider and a competent Fire Consultant since inspection and detailed in Section 2's Action Plan. 2. Flammable liquids were removed immediately after been identified by HIQA Fire Officer and are now stored in a locked shed for future use and in the event of power outage. 3. A documented procedure has been implemented into each (x 3) wet rooms which are also used as an emergency escape ensuring these rooms a kept clutter free and not found in a wet state. 4. Doorstops were removed immediately from the premises, ensuring that no fire door closing mechanism are interfered with in the event of a fire.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: 1. Resident ensuite bathrooms all have been assessed and inappropriate seating has been removed and stored accordingly elsewhere, or within storage sheds provided within Nursing Home. 2. Handwash basin in new wet laundry are to be fully functional by 30/11/2023, awaiting Plumbing Contractor to complete. 3. Our Clinical Governance Plan is reviewed and updated every quarter, and which includes continuous environmental upgrades. This also includes the maintenance and upgrading of the Nursing Home on a continuous basis, which bedrooms and door frames	

complete part of the ongoing planning and actions.
4. The Timber Window Board in Room 13 has been replaced with new window board, undercoated and painted maintaining a clean and safe environment for Residents and Staff.
5. (a). Our internal Maintenance Team have carried out a full maintenance of all doors to ensure they are working and closing correctly and the registered provider is in liaison with the Fire Safety Consultant and Building Engineer to assess what Fire Doors and Frames require upgrade to assist in meeting Regulation 28. It is expected that this report will be available from Monday 4th Dec 2023 and assessed safety measures implemented thereafter and according to the plan from the Fire Safety Consultant and Fire Safety Engineer.
(b). Holes in the ceiling that require attention have now been closed using (either) double fire slabbing board technique or with the required Fire closing foams, completed by our internal maintenance team.
The external Fire Consultant who has advised on the upgrade of the Fire Safety Doors in Nov 23, also reviewed the work of the Maintenance Team re the holes in the ceiling and around pipes in store cupboards, and assessed the product used to complete this work to seal these holes and gaps as appropriate. He has also quality assured this work that was completed and is assured that the product used is fit for purpose.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. As in Regulation 23 above, Flammable liquids were removed immediately after been identified by HIQA Fire Officer and are now stored in a locked shed for future use and in the event of power outage.
2. The Hairdressing Chair in the Yellow Corridor (by Room 7), has now been removed when not in use, allowing the Fire Door (adjacent to Room 4) to close seamlessly. And Staff have been informed that Household/Waste Hazard Bins are not to be used to hold doors open, but to be place appropriately within the Room they are meant to be in and not blocking or impeding emergency fire exits.
3. Signage and yellow tape have been implemented at the Front door donating that Gas is in use and the Gas Engineer who implemented the Gas Line has been asked to implement a cage around the Gas shut off valve. He has agreed to complete same by 30/11/2023.
3 (b). – No Parking Signs have been implemented (externally) on all Emergency Escape Doors, thus these doors are now free from obstructions and Car Parking about the Nursing Home is managed by designated parking – completed on 24th Nov 2023
4. The visiting area at the front of the Nursing Home has been made a "No Smoking Zone" due to its close proximity to the Gas Shut Off Valve, the required signage to inform individuals that this is a no smoking area has now been implemented and Residents have been informed to only smoke in the safe designated area (with Fire Extinguisher & Fire Blanket) in the back garden.
5. The slide bolt on nurses station door has now been removed reducing the risk of the

Nurses/Staff being trapped inside.
6. An Emergency Lighting Contractor/Fire Alarm Contractor has been commissioned to assess, plan and implement additional emergency lighting on the external building highlighting safe routes of escape to the external muster stations (x 2). This is due for completion by 30/11/2023.
6 (b). Emergency Lighting (internally and externally) have been upgraded by contracted Electrical Team ensuring safe access to Muster Stations in the event of an External Evacuation – completed by 24th Nov 2023.

7. The Emergency Lighting Contractor has been commissioned to implement additional Emergency Fire Escape Signage in the internal corridors (as highlighted by the HIQA Fire Officer). Completed by 30/11/23.
As per regulation 23 (point 3 above), A documented procedure has been implemented into each (x 3) wet rooms which are also used as an emergency escape ensuring these rooms a kept clutter free and not found in a wet state.
8. As per regulation 17 (point 5 B above), Holes in the ceiling that require attention have now been closed using (either) double fire slabbing board technique or with the required Fire closing foams, completed by our internal maintenance team.
9. An internal Fire Safety Door checklist is to be implemented into our Fire Safety Log Book and internal Fire Safety Doors will be checked weekly, with any problems being identified to management and the internal maintenance team for further assessment and potential repair action plan being implemented. Implemented as of Nov 2023.
10. X 8 Fire Safety Evacuation Drills have been completed and documented thus far in 2023, with all compartment evacuations practiced by all staff. Evacuation through the secondary evacuation routes to the outside via wet rooms were practiced via simulation exercises in April & May 2023 (following HIQA Inspector Audit in April 2023) and x 2 further training drills has been planned to be completed once again in Nov and Dec 23, totaling x 10 in 2023.
11. A Fire Safety Consultant has been commissioned to work/consult with our commissioned Building Engineer to assess all our Fire Doors to ensure that they are fully functional, fit for purpose and meet Regulations 28 as documented. The building engineer is to complete his assessment on Monday 27th Nov 23, with his report due by Monday 4th Dec 2023 and actions will be addressed accordingly thereafter.
12. As per point 6 above, an Emergency Lighting Contractor/Fire Alarm Contractor has been commissioned to assess, plan and implement additional fire detection points into the bathrooms/wet rooms (x 3) which are also used as emergency escape routes in the event of an emergency evacuation. These have been implemented on Wednesday 22nd Nov 23 and are due to be commissioned by 30/11/2023.
13. The Fire Evacuation Floor Plan were recently upgraded in May 2023 by our Fire Safety Consultant, who will now upgrade the same floor plans to incorporate the Compartment and Sub-compartment boundaries as requested by the HIQA Fire Officer on his Audit review. Due for completion by 30/11/2023.

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	30/11/2023
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	30/11/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment,	Not Compliant	Orange	30/11/2023

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	30/11/2023
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.	Substantially Compliant	Yellow	30/11/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	30/11/2023
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	30/11/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting,	Not Compliant	Orange	04/12/2023

	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	30/11/2023