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:	Donegal Community Hospital
Name of provider:	Health Service Executive
Address of centre:	Drumlonagher, Donegal Town, Donegal
Type of inspection:	Unannounced
Date of inspection:	20 July 2023
Centre ID:	OSV-0000617
Fieldwork ID:	MON-0040921

About the designated centre

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

Donegal Community Hospital is a purpose built two storey building located in the town of Donegal, within walking distance of all local amenities. The residential part of the hospital is a 29 bed unit located on the ground floor, which provides palliative care, respite care, convalescence, rehabilitation and continuing care. Accommodation comprises seven single bedrooms (six en suite), one en suite twin bedroom and five multiple-occupancy bedrooms, each accommodating four residents. There are two sitting rooms, a dining room and an oratory for communal use. The designated centre includes a treatment room, staff facilities, a small laundry and a main kitchen.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	24

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 20 July 2023	09:30hrs to 17:10hrs	Gordon Ellis	Lead

What residents told us and what inspectors observed

The inspector was met by the person in charge, on behalf of the registered provider, who facilitated the inspection.

Following an introductory meeting, the person in charge accompanied the inspector on a walk around the designated centre.

This area of the building is single storey throughout and is interlinked with a Day Hospital, which is outside the registered designated centre. The centre is registered for 29 residential beds with a dining room, sitting room, and an oratory along with ancillary spaces. The building comprises of seven single bedrooms, six of which had en-suite facilities, one en-suite twin-bedded room and five four-bedded rooms.

During the walk around, the inspector observed a number of fire risks that required immediate action to be taken to address the immediate risks. A fire door into a linen room was tied in such a way as to keep the door open and a fire door into a cleaners store was found to be wedged open. In an ESB room, the inspector observed shoes, coats, luggage bags and furniture and a plastic glove had been placed over a fire detector.

The storage in two rooms of the centre was found to be disorganised and untidy. The inspector observed the inappropriate storage of flammable and combustible items stored in various locations. This is outlined in detail in the subsequent section of this report.

The inspector saw residents in their bedrooms and in the sitting room. Staff were being very attentive and respectful to residents, and were encouraging residents to participate in viewing Ireland's women's world cup game.

There was a sufficient number of escape routes and exits from of the building. The inspector noted a final fire exit door used in the event of a fire evacuation was through a smoking area for residents and the fire exit door opened in to the internal side of the centre instead of in the direction of escape. In addition to this, there was a lack of emergency exit signage in some internal corridors to indicate the route to access a fire exit in both directions. Furthermore, some corridors were observed to be cluttered with trolleys and bed mattresses were being stored in these areas.

The inspector saw a number of areas where utility services penetrated fire rated walls and ceilings; these required sealing up. External routes were mostly kept clear and provided escape away from the building. The inspector noted large bins were being stored on an external means of escape and directly up against an external wall with a series of windows.

Staff spoken with demonstrated a good knowledge of the evacuation procedure in place. The fire alarm panel was located in the main reception and at the nurses'

station, both of which were 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 was an unannounced risk inspection carried out over one day by an inspector of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The Health Service Executive (HSE) is the registered provider for the designated centre. The designated centre benefits from access to and support from centralised HSE departments, such as the fire and estates. The inspector had been informed by the person in charge that a fire safety risk assessment had been carried out by the provider in April 2023 but had not been made available to the person in charge.

The centre was found to be not compliant in regard to regulation 28 and regulation 23 on a previous inspection in March 2023. On this current inspection, while some of the commitments made by the provider to come into compliance with these regulations were carried out, outstanding actions still existed. Additionally, a repeated finding in regard to regulation 28 in relation to the storing of oxygen cylinders.

Furthermore, on this inspection, the oversight of fire safety management systems and the processes to identify, and manage fire safety risks were ineffective to ensure the safety of residents living in the centre. This was evidenced by the level of immediate actions and significant fire safety risks identified on this current inspection, which are outlined in the quality and safety section of this report.

At the centre's last registration in 2021, the Chief Inspector applied a restrictive condition to the provider's certificate of registration, which stated that no further long-term residents could be admitted to the centre. As such, the centre is currently registered for short-term placements up to a maximum of 60 days. The inspector found that five residents accommodated in short-stay beds had been accommodated for more than 60 days. This is a repeated non-compliance from the inspection in 2021 and the previous inspection in March 2023.

Significant fire risks and actions that the provider needs to take in relation to fire safety in the centre are set out in the next section of this report and are reflected in the opening section.

Regulation 23: Governance and management

The provider failed to meet the requirements of the regulation on governance and management. Oversight of fire safety in the centre were not fully effective and did not adequately support fire safety in the centre. Additionally, the provider was not operating the designated centre in line with its current conditions of registration.

The provider's governance and management systems had failed to ensure that the service provided is safe, appropriate, consistent and effectively monitored. For example:

- The provider had not recognised some of the fire risks found on the inspection.
- The management of fire safety risks did not ensure that residents were adequately protected in the event of a fire emergency.
- Immediate actions in regard to fire risks had to be issued to the provider on the day of the inspection as outlined under regulation 28.
- Deficiencies identified in regard to mean of escape, good house-keeping, storage of flammable and ignition sources had not been identified on the in-house routine checks by the provider.

Judgment: Not compliant

Quality and safety

In view of the fire safety concerns identified during this inspection, the inspector was not assured that the provider's fire safety arrangements adequately protected residents from the risk of fire in the centre nor ensured their safe and effective evacuation in the event of a fire.

While it is acknowledged the provider did complete some of the commitments made after the previous inspection in March 2023, more focus and effort was now required to ensure that fire safety risks currently in the centre were promptly addressed.

The registered provider was failing to meet the regulatory requirements on fire precautions in the centre and had not ensured that residents were protected from the risk of fire. The provider must make significant improvements in order to comply with the regulations. The inspector found uncertainty over means of escape, fire-containment, visual deficiencies in the building fabric, fire doors, inappropriate storage of flammable and combustible material, and emergency lighting which could lead to serious consequences for residents in an emergency.

The inspector found additional fire safety issues on the day of the inspection that had not been identified by the provider and required immediate action. For example, a fire door into a linen room was tied in such a way as to keep the door open and a fire door into a cleaners store was found to be wedged open. In an ESB room, the inspector observed shoes, coats, luggage bags and furniture and a plastic glove had been placed over a fire detector. These events presented potential fire risks in that if a fire did develop, it would be accelerated and could spread with ease. This was brought to the attention of the person in charge and arrangements were made to address these risks before the end of the inspection. On the day of the inspection, the person in charge submitted correspondence to the providers' fire and estates department to highlight these areas of risk.

While there were sufficient fire exits and escape routes provided, the means of escape and emergency lighting required a review by the provider. Some corridors were observed to be cluttered with trolleys and bed mattresses were being stored in these areas. There was a lack of emergency exit signage in some internal corridors to indicate the route to access a fire exit in both directions

The inspector observed an area under a staircase was being used as a Communications Store. A nest of untidy wires were found along with various services penetrations through a wall from this store room that required fire sealing. Additionally, the inspector was not assured the fire door to this store room would contain the spread of fire and smoke as a ventilation grill had been fitted to the door. Should a fire develop in this area, it could potentially compromise the vertical means of escape that serves the upper floor and would spread with ease into the adjoining corridor. This required a review from a competent person in regard to fire containment and the suitability of using this area under the staircase as a storage area.

Inappropriate storage practices were observed in two areas of the centre. An equipment store room was un-tidy and disorganised. There was no space or clear path to access items such as wheel chairs that may be required for residents in a fire emergency. In the general operations office, the inspector noted that large quantities of chemicals, paint and alcohol gels were being stored. This presented a potential fire risk - if a fire did develop, it would be accelerated by the presence of these items. Both areas required a review by the provider.

The inspector noted new fire doors and door closer mechanisms had been fitted in line with the commitments made by the provider following an inspection in March 2023. Notwithstanding this, the inspector observed a number of fire doors had door-closer mechanisms, hinge screws and fire door seals missing. Gaps were noted and a number of fire doors did not meet the criteria of a fire door. This was particularity evident in the shared en-suits between resident's bedrooms. Staff had informed the inspector that these doors were very difficult for residents to open on a daily basis and impacted on their independent lifestyle.

The centre is divided into five main fire compartments with eight registered beds accommodated in each of the two largest compartments. The inspector was not assured by the containment measures in some areas of the centre. For example, the

suspended ceiling tiles above some compartment cross-corridor fire doors continued passed the top of the fire doors. As the separation above the door was not of the same thickness or materiality, the inspector was not assured that adequate fire rating construction was provided for above the suspended ceiling line or that it finished to the underside of the roof and was adequately fire stopped. Further examples of deficiencies in regard to containment of fire are detailed under regulation 28.

The provider's competent person is required to review compartmentation arrangement throughout the centre and provide assurances that adequate compartmentation is provided for based on the current extent and location of compartment walls/floors/ceilings/fire doors/glazing in the centre.

The inspector spoke with various staff members on duty in regard to fire safety and evacuation procedures. Staff were confident and very familiar with the practiced evacuation procedures. Staff were up-to-date with fire safety training. However, a fire evacuation drill for the largest compartment based on the lowest staffing levels was not available for the period of 2023 on the day of the inspection.

The inspector reviewed the fire safety register and noted that parts of it were well organised, in-house periodic fire safety checks were being completed and logged in the register as required. However, deficiencies identified in regard to mean of escape, storage of flammable and ignition sources had not been identified in the in-house routine checks.

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 the fire safety management of the centre.

Regulation 28: Fire precautions

At the time of inspection, the registered provider had not taken adequate precautions to ensure that residents were protected from the risk of fire. The service was non-compliant with the regulations in the following areas:

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:

- An oxygen cylinder was found on an internal corridor. Outside, the inspector observed oxygen cylinders not stored upright or secured and a number of cylinders left unsecured outside the oxygen cylinder cage.
- In an ESB room, the inspector observed shoes, coats, luggage bags and furniture. This presented a potential fire risk- - if a fire did develop, it would be accelerated by the presence of these items.

- A fire door into a linen room was tied in such a way as to keep the door open and a fire door into a cleaners store was found to be wedged open. In both examples, the fire door mechanisms were interfered with, which would certainly result in the easy spread of fire and smoke - if a fire did start in these areas.
- An equipment store room was un-tidy and disorganised. There was no space or clear path to access items such as wheel chairs that may be required for residents in a fire emergency.
- In the general operations office, the inspector noted that large quantities of chemicals, paint and alcohol gels were being stored. This presented a potential fire risk if a fire did develop, it would be accelerated by the presence of these items.
- The inspector noted a plastic glove had been placed over a fire detector which interfered with the detection of fire.

The provider needed to improve the means of escape for residents and emergency lighting in the event of an emergency in the centre. For example, a final fire exit door used in the event of a fire evacuation was through a smoking area for residents and a final fire exit door opened in to the internal side of the centre instead of in the direction of escape.

In addition to this, there was a lack of emergency exit signage in some internal corridors to indicate the route to access a fire exit in both directions. In the event of an emergency, this lack of signage could cause confusion and could delay an evacuation.

The provider needs to review the maintenance of the means of escape and of the building fabric. For example, a large nurse's station was located along a means of escape. The inspector was not assured that adequate fire separation was provided around the nurses' station and this potentially compromised an evacuation route in the event of an emergency. In another area, the inspector noted a tea station which contained a toaster, a kettle, a microwave, a fridge and various blankets were being stored along a means of escape. As the tea station was not enclosed in fire rated construction. The evacuation route was compromised and this required a review.

Furthermore, some corridors were observed to be cluttered with trolleys and bed mattresses. This compromised a means of escape in the event of a fire emergency. Externally, the inspector noted large bins were being stored on an external means of escape and directly up against an external wall with a series of windows. This obstructed the means of escape and created a fire risk as if a fire did develop, it would easily spread into the designed centre.

The inspector was not assured of the ability of a selection of fire doors to prevent the spread of smoke and fire. While new fire doors had been fitted in some areas, a number of fire doors observed by the inspector had door-closer mechanisms, hinge screws and fire door seals missing. Gaps were noted at the bottom and between doors, some of which were compartment doors. Furthermore, a number of fire doors did not meet the criteria of a fire door, had non-fire rated ironmongery fitted and

some did not close fully when released. These deficiencies posed a significant risk to residents in the event of a fire.

Several 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.

The provider needs to review fire precautions throughout the centre. Deficiencies identified in regard to mean of escape, day to day management, storage of flammable and ignition sources had not been identified on the in-house routine checks. The fire safety risk assessment report carried out in April 2023 had not been made available to the person in charge nor to the inspector on the day of the inspection.

Arrangements for containment of fire in the event of a fire emergency in the centre required a review by the provider. For example, the inspector observed an untidy Communications Store under a staircase that was the only vertical means of escape serving the upper level of the building. The upper level is not part of the designated centre. The inspector was not assured by a ventilation grill on a fire door to the store would contain the spread of smoke and fire. Furthermore, the inspector observed services and cables that penetrated through a wall from this store into the adjoining corridor that required fire sealing.

The inspector noted that the suspended ceiling tiles above some compartment cross-corridor fire doors continued passed the top of the fire doors and was not assured that adequate fire rating construction was provided for above the suspended ceiling line.

The inspector was not assured by the fire rating of the dividing timber, door and glass wall section that separated the oratory room from the staff dining area. This was evidenced by the lack of a fire door, there was no evidence of fire rated glazing and a lower section of timber panelling existed. Furthermore, both fire doors used to access the kitchen area appeared to not be of the required fire resistance to contain a fire in a high risk room.

In a corridor, the inspector was not assured that the georgian type glazing and timber screen system provided the required fire rating to match the fire rating criteria of the compartment door it surrounded.

Personal emergency evacuation plans (PEEPS) were in place but required more detail. For example, it was not clear how many staff were required to evacuate each resident and it did not include a section for residents who were on sleeping meds, had hearing difficulty or required supervision post an evacuation due to dementia.

While fire evacuation drills were taking place, there was no drill available for 2023 for the largest compartment when staffing levels are at their lowest. Furthermore, the statement of purpose stated evacuation drills were to be performed on a

monthly basis, no evidence of consistent monthly drills were available to demonstrate this. The displayed procedures to be followed in the event of a fire required a review by the provider. For example, fire evacuation plans were not up-to-date as the location of a recently constructed compartment was not indicated on the floor plans, the location of the smoking shelter and the tea/coffee facilities were not indicated on the floor plan and the ESB room was labelled as a store. This could cause confusion and loss of valuable time in the event of a fire emergency.
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 28: Fire precautions	Not compliant

Compliance Plan for Donegal Community Hospital OSV-0000617

Inspection ID: MON-0040921

Date of inspection: 20/07/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider and PIC remain committed to complying with their legal obligations to develop, implement and sustain a fire safety programme, developing a strong fire safety culture in the centre and driving quality improvement where required. The Provider and PIC have reviewed the Fire safety strategy for the centre, including the site specific Fire Safety risk Assessment to address the unrecognised risks identified by the inspector. The robust controls in place will ensure that the fire precautions taken will at all times minimise the risk of fire in the centre. Actions to mitigate the unidentified fire risks identified by the inspector are detailed under Regulation 28 below. The PIC and clinical managers have put a system in place to communicate the contents of this compliance plan to all staff so as to ensure the center's fire safety arrangements adequately protect the residents from the risk of fire and their safe and effective evacuation in the event of a fire.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The following day to day actions are in operation: 1. Oxygen cylinders are no longer stored on internal corridors. One Oxygen cylinder is now stored in a keypad controlled room with signage on the door and this is checked 4 times daily at the Safety Pauses to ensure compliance. 2. Outside all Oxygen Cylinders are stored securely in the Oxygen cylinder cage which is	

secured by a lock and chain. A system is in place for the external Oxygen supply company to collect empty cylinders in a timely manner – monitored by the PIC.
3. As part of the center's 4 times daily safety pauses:
• The ESB room is checked to ensure no inappropriate items are being stored there and signage stating same has been put in place.
• All fire doors are checked to ensure they are kept closed and that the door mechanisms have not been interfered with.
4. The equipment store has been decluttered and a system has been put in place to ensure there is a clear path maintained at all times.
5. The general operative's office has been cleared of all chemicals and potential fire accelerants. Alternative dedicated fire protected storage has been located and quantities stored will be kept to the minimum amount needed.
6. All smoke detectors are free from coverings and the PIC met with the foreman of the external workmen to instruct them to stop this practice.
7. The tea station items and bed linen found to be obstructing a fire escape pathway have been removed.
8. Corridors have been decluttered and staff reminded that all fire exits/pathways are to be kept clear at all times.
9. Large external bins have been removed to the rear of the building where they no longer obstruct fire exit pathways.

The PIC has engaged with HSE Estates/Fire department and HSE local Maintenance department to:
1. Issue a tender to external contractors to replace the final fire exit door, which opens to the internal side of the center, with one that opens in the direction of the escape – to be completed by 31/10/23.
2. The smoking area has been removed and plans to demolish it are in progress to be completed by 31/10/23.
3. Masterfire are in the process of reviewing and installing additional signage and emergency lighting – to be completed by 31/10/23.
4. Estates have requested Masterfire to complete an audit of all fire doors and produce a risk assessment report which will detail the red and amber risks to be addressed as a program of works – to be completed by 31/11/23.
5. HSE fire officer has requested Fire Risk Assessment report from Maurice Johnston company who completed their site inspection during April/May 2023 – report pending. A program of works will then be tendered by the HSE Fire Officer to address the red and amber risks detailed in the report and identified by the HIQA inspector on the day of their inspection. The Maurice Johnston report will be submitted to HIQA by the provider once it's available.

Personal Emergency Evacuation Plans:
PEEP's have been reviewed and updated to include – the number of staff required to evacuate each resident, information on those residents who are prescribed night sedation, information on those residents who have hearing, sight or cognitive impairment.

Fire Evacuation Drills & Fire Floor plans:
The provider and PIC have reviewed the fire evacuation drill procedure to ensure that monthly scenarios include a drill for the largest compartment by the lowest level of staff available (night duty compliment). One such drill has taken place – 8 patients with high dependency needs were evacuated in 3 minutes and 40 seconds. Monthly fire drill records are being completed.
98% of staff have received Fire training and the remaining 2% of staff will complete their training in November 2023.
The PIC has requested updated Fire Floor Plans and updated fire procedure/action signs for staff and visitors from HSE Estates department. The sign on the ESB room has been changed to reflect its use.

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

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2023
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.	Not Compliant	Orange	31/10/2023
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting	Not Compliant	Orange	31/08/2023

	equipment, 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	31/10/2023
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.	Not Compliant	Orange	30/11/2023
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	30/07/2023
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	30/07/2023
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	30/07/2023
Regulation 28(3)	The person in charge shall ensure that the	Substantially Compliant	Yellow	30/07/2023

	procedures to be followed in the event of fire are displayed in a prominent place in the designated centre.			