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:	Ennis Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Showgrounds Road, Drumbiggle, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	03 May 2023
Centre ID:	OSV-0000683
Fieldwork ID:	MON-0040037

About the designated centre

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

Ennis nursing home is located on the outskirts of the town of Ennis. It is purpose built, two storey in design and provides 24 hour nursing care. It can accommodate up to 60 residents over the age of 18 years. It is a mixed gender facility catering from low dependency to maximum dependency needs. It provides long-term residential, convalescence, respite, dementia and palliative care. There is a variety communal day spaces on both floors including day rooms, dining rooms, quiet room, oratory, smoking room, family room, hair dressing room, large reception area with seating and residents have access to landscaped secure garden areas. Bedroom accommodation is offered in single and twin rooms.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	56

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 May 2023	09:00hrs to 17:00hrs	Una Fitzgerald	Lead

What residents told us and what inspectors observed

During this one day of inspection, the inspector spent time speaking with residents, and observing those residents who could not voice their opinions of the service provided to them. In addition, the inspector observed the interactions between staff and residents. Overall, the feedback from residents was very mixed. Residents told the inspector that they were satisfied with the activities held and that there was choice on how to pass the day. One resident stated that the centre was a "magnificent" place to live. However, residents also told the inspector that there was not enough staff in the centre. While the inspector acknowledged that residents reported that staff, as individuals, were very kind, the residents were not happy with the length of time it took to have their call bells answered. The inspector observed a positive atmosphere in the centre. A lot of good practice was observed during this inspection, with good regulatory compliance in many areas. However, the availability of staff, and the cleanliness of the building observed was not in line with regulation requirements.

On entering the premises there was a large entrance foyer. There was a large "Cead mile Failte" sign hanging on the wall that had been made by the residents utilising coffee beans. The area was inviting, and residents were seen spending time in this area throughout the day. Visitors also congregated here, while waiting to visit their loved ones. Many residents sat here just observing the coming and goings of other residents and staff. In the evening time, the inspector observed a gathering of residents and visitors, and a spontaneous "sing song" session occurred. The residents were observed to enjoy the sing along, and the atmosphere was inviting with lots of conversation and laughing observed.

Activities were held throughout the day on both floors. In the morning, the inspector observed a group exercise class that was attended by eight residents. The staff member facilitating the session actively encouraged all residents to partake. The residents were addressed by their first name, and there was light hearted discussion ongoing. In the afternoon, the inspector observed multiple residents participating in a baking session. Fresh scones were made. Again, the inspector observed lots of free flowing conversation and laughter from the residents who attended.

Residents told the inspector that they sometimes hesitated in ringing the bell as they were conscious that there was daily staffing shortages. When asked about the call bell response times, and if they were satisfied with how quickly the bells were answered, one resident stated “you can't expect staff to answer quickly as they are very busy". The resident also told the inspector, by way of explanation, that staff do answer the bell but "not too quickly", meaning there was a waiting time. This sentiment was supported in the feedback given to the inspector from multiple residents. A second resident told the inspector that at night time, the bells kept them awake. Residents stated that they believed the reason for the delay was a result of the low number of staff on duty, and that it was not a reflection of the staff as individuals. The staff were observed chatting with residents while bringing them

from their bedrooms to the communal room. However, these interactions were sometimes rushed as the staff were observed to be under pressure to attend to the next resident that was waiting for assistance.

Following the introductory meeting, the inspector walked the premises with the person in charge. The observation by the inspector was that the premises was not kept in a good state of repair. Many resident bedrooms were personalised and residents had placed items of importance to them on display. The inspector visited a sample of bedrooms, and chatted with the residents. Multiple residents who had capacity to ring their call bells did not have their bells within reach, and had no other method of calling for assistance. In some double bedrooms, resident's had to share a call bell. This meant that one resident was reliant on the person sharing their bedroom to ring the bell on their behalf.

Staff engagements with residents were kind. The inspector observed that staff engaged respectfully with residents when attending to their needs and chatted with residents. Communal sitting rooms were supervised. However, in the afternoon, the inspector observed that the staff allocated to this task had not had sufficient orientation. The staff member had limited knowledge of the residents and was unable to engage in conversation with residents. In addition, the inspector observed that residents in the upstairs communal sitting room had no access to side tables. The inspector observed a resident who had spilt their cup of soup on their top and had nodded off to sleep. The was no place within the residents reach where they could have placed their drink.

The next two sections of the report present the findings of this inspection in relation to the capacity and capability in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

The inspector found that the provider had systems in place to oversee the quality and safety of care in the centre. While these systems generally worked well, action was required, specifically in relation to the staffing strategy, and the overall maintenance and upkeep of parts of the premises. The totality of the findings evidenced that the provider had not sufficiently resourced the centre to ensure adequate daily staffing numbers, and that appropriate action were allocated to bring the premises into compliance with the requirements of the regulations. The inspector found that the provider had failed to implement the compliance plan submitted to the Chief Inspector following the last inspection of the centre in June 2022. The impact of these findings are discussed throughout the report.

This was a risk inspection carried out by an inspector of social services to monitor compliance with the Heath Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). This unannounced risk inspection took place over one day. The inspector followed up on the action taken

by the provider to address the areas of non-compliance found on the last inspection. The inspector also followed up on unsolicited information of concern submitted to the Chief Inspector. The findings of the inspection partially substantiated the concerns in the area of staffing, and the cleanliness of the building.

Mowlam Healthcare Services Unlimited Company is the registered provider of this centre. There was a clearly defined management structure in place with identified lines of authority and accountability. The director of nursing, who was the person in charge, facilitated this inspection. The person in charge is supported in the role by a full time supervisory assistant director of nursing. Senior management support was also provided by a regional manager from the Mowlam Health care group. There were 56 residents accommodated in the centre on the day of the inspection and four vacancies. There were 25 residents assessed with maximum care needs, 20 residents with high dependency care needs, nine residents with medium dependency care needs and two residents with low dependency care needs.

On the day of the inspection, there were sufficient numbers of suitably qualified staff available to support residents' assessed needs. The team providing direct care to residents consisted of two registered nurse on duty at all times, and a team of health care assistants. As a result of the negative feedback from the residents, the inspector reviewed the actual staffing numbers on duty, over a period of short weeks, and found that the centre was not sufficiently staffed on a continuous basis. Worked rosters evidenced a shortfall of up to 24 hours of health care staff availability on the day duty. It was primarily the responsibility of the health care staff to answer the resident call bells when they rang for assistance. Planned rosters could not be fully completed due to the lack of availability of health care staff. While the inspector acknowledged that newly appointed staff were expected to commence working in the centre in the near future, at the time of inspection, this start date for new staff was not confirmed. The staffing system in place was not effective in maintaining appropriate staffing levels to cover periods of planned and unplanned leave. This meant that if current staff did not fill the vacant shift, the staffing numbers on these days were not adequate to deliver care, in accordance with the needs of the residents. There was appropriate levels of registered nurses on duty, and this was evident in the positive findings under Regulation 5: Individual assessment and care plans and Regulation 6: Health care.

The governance and management of the designated centre was organised. Information requested was provided in a timely manner. A provider-specific auditing management system was in place. The person in charge was completing monthly audits, and escalated operational and clinical risk to the provider. The person in charge submitted notifications, as required by the regulations, and the directory of residents was kept updated.

There was a system in place to manage risk in the centre. This system was underpinned by the risk management policy, which was observed to be followed in practice. There was a risk register in place where risks were identified. Risks were clearly documented, with the level of risk, the controls in place and the person responsible documented and regularly updated. However, a review of the register found that the provider failed to take adequate action when risk was escalated. For

example, the risk associated with the state of repair of the kitchenette on the first floor from which food is prepared and served from had been identified and escalated to the provider, but action had yet to be taken to address this issue. In addition, a number of known risks, specific to this centre, had not been identified on the risk register. For example, the risk associated with call bell access for some residents in double bedrooms. This was a repeated finding from the last inspection in June 2022. This was a risk to the safety of residents as they had no alternative method of calling for assistance.

Staff files contained all of the information required under Schedule 2 of the regulations. All new staff go through a process of induction into the centre. The inspector was told that the induction process was completed over one week. The documentation to support this induction process was completed on all files reviewed. The person in charge had completed annual performance appraisals with all clinical staff as part of the supervision system in place. Staff had access to education appropriate to their role. This included infection prevention and control training, fire safety, manual handling and safeguarding training. Staff responses to questions asked displayed a good level of knowledge. Notwithstanding this positive finding, on the day of inspection, the inspector observed that not all staff had appropriate knowledge of the systems in place and were allocated tasks without appropriate training.

Regulation 15: Staffing

On the day of inspection, the number and skill mix of staff was appropriate with regard to the needs of the current residents, and the size and layout of the designated centre.

The inspector acknowledged that there was ongoing recruitment in progress. However, there was no clear staffing strategy in place to provide assurance that the centre could be adequately staffed on an on-going basis. The failure of the provider to ensure that the staffing levels were adequate is addressed under Regulation 23: Governance and Management.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were not always appropriately trained. For example; on the day of inspection staff with limited knowledge of the systems in place were allocated the task of supervising residents.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The directory of residents included all of the information specified in paragraph (3) of Schedule 3.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider had failed to ensure that the centre had sufficient resources to ensure the effective delivery of care. This was evidenced by;

- the staffing resource was not in line with the staffing levels committed to in the centres' statement of purpose. The centre was registered to have 24.8 full-time healthcare assistants. At the time of inspection, there was three full-time vacancies. There was no system in place to ensure adequate staffing levels could be maintained particularly with regard to planned and unplanned leave. If current staff were not available, the daily hours of health care staff who deliver the direct care would be left unfilled.
- The inspector reviewed the staff rosters and found that over a period of two weeks there were staffing shortages of up to 24 hours, per day, in the health care staff on day duty. Despite these inadequate staffing levels, the centre continued to admit residents. For example, three new residents were admitted into the centre on a day when staffing levels were inadequate. This was a risk to the overall safety of residents living in the centre.

The management systems in the centre were not effective;

- The systems in place to ensure that cleaning in the centre was maintained to a high standard was poor. The provider had failed to take adequate action when areas of risk were identified and escalated. For example, an internal audit had identified that the kitchenette on the first floor was a risk to resident safety. The person in charge had escalated this known risk to the provider, however no action had been taken.
- The premises were not maintained in a good state. The provider had failed to implement their own compliance plan submitted following the last inspection in June 2022. There was clear evidence from the minutes of meetings, and completed audits that the provider had full knowledge of the overall state of the premises and had not taken action. For example, following the last inspection, the provider had committed to ensure that all residents have

equal access to call bells. This was not completed.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge notified the Chief Inspector of all incidents, as required by the regulations.

Judgment: Compliant

Quality and safety

Overall, residents in Ennis Nursing Home were supported and encouraged to enjoy a satisfactory quality of life. Residents indicated that they felt safe living in the centre and knew the staff well. Residents were encouraged and supported by staff to maintain their personal relationships with family and friends. Visitors were welcomed in the centre. As previously stated, the allocation of resources and the arrangements in place for the upkeep of the premises was inadequate. This detail is outlined under Regulation 17: Premises.

Residents' medical and health care needs were met. Staff spoken with were knowledgeable on the individual care needs of the residents. The inspector reviewed resident files. Care plans were found to be individualised and person-centered. An electronic documentation system was in place and the care information in relation to each resident was easily retrieved. Residents had access to medical and allied health care supports. A review of the residents' care records found that recommendations made by health and social care professionals were implemented and updated into the resident's plan of care. For example, the implementation of advice received from a tissue viability nurse specialist had ensured the healing of wounds.

The provider had systems in place to monitor environmental restrictive practices, and the inspector found that a restrictive-free environment was actively promoted.

The laundry facilities and procedure were managed appropriately to ensure residents clothing was managed with care and minimised the risk of clothing becoming misplaced. Residents' laundry was managed onsite and each item of clothing was marked for identification.

Resident meetings were held. The inspector reviewed the minutes of the last meeting. The meeting was chaired by the activities team, and items discussed were then brought to the person in charge if action was required. The minutes

summarised that residents were satisfied with the food and activities.

The inspector reviewed the documentation that supported the monitoring of fire safety in the centre. Daily checks were completed. Fire equipment, such as fire extinguishers had been inspected by a competent person. Frequent fire drills had been completed. The records of drills that were completed were detailed and learning had been identified. Residents had taken part in the drills. Staff spoken with were clear on what action to take in the event of the fire alarm being activated. However, multiple fire doors released on the day had significant gaps which may effect the effectiveness of the doors to contain smoke, in the event of a fire emergency

Regulation 11: Visits

The registered provider had ensured that visiting arrangements were in place and were not restricted. Visits were encouraged and residents could meet their relatives or friends in the privacy of their bedroom or in one of the communal day rooms.

Judgment: Compliant

Regulation 17: Premises

While there was an ongoing maintenance programme described, there were areas of the premises that were not maintained in a satisfactory state of repair as required by Schedule 6 of the regulations. For example;

- the upstairs kitchenette was visibly unclean. The serving trolleys were layered with encrusted dirt. The kitchen appliances that were in use were visibly unclean. The cupboards and work top were in a very poor state, and due to the level of damage were not amenable to cleaning. This kitchenette and current state of repair, and the unhygienic condition had been an ongoing risk that had been escalated and brought to the providers attention.
- multiple bedrooms were in a poor state. Wardrobes, lockers and drawers were damaged. Some resident bedroom walls were chipped and unsightly.
- flooring along the main corridor on the first floor was observed to be damaged, leaving uneven flooring that could be a falls risk to residents.
- residents in double bedrooms continued to share a call bell. This was a repeated non-compliance from the June 2022 inspection.

Judgment: Not compliant

Regulation 28: Fire precautions

The fire safety systems in place to contain fire and smoke in the event of an emergency were not effective. A review of the fire doors in the centre found there were significant gaps between some fire doors and floor when they were closed. This was a potential risk to the effectiveness of the fire doors to contain smoke and fire in the event of an emergency.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents care plans were developed upon admission and formally reviewed at intervals not exceeding four months.

Care plans were informed through assessment using validated assessment tools that assessed, for example, residents dependency, risk of falls, risk of malnutrition, and skin integrity. A social assessment that gathered information on the residents hobbies, likes and dislikes was used to develop a social care plan. Where a resident had been reviewed by an allied health care professional, updates to the care plan were evident.

Judgment: Compliant

Regulation 6: Health care

Residents had timely access to medical assessments and treatment by their General Practitioners (GP), and the person in charge confirmed that GPs were visiting the centre, as required. Residents also had access to a range of allied health care professionals. The centre had weekly access to a physiotherapist, and occupation therapy was available monthly.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The provider promoted a restraint-free environment in the centre, in line with local and national policy.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector saw that residents' privacy was respected. Residents told the inspector that they had a choice about how they spent their day.

Residents had access to advocacy services.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ennis Nursing Home OSV-0000683

Inspection ID: MON-0040037

Date of inspection: 03/05/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The PIC will ensure that all staff are suitably trained to carry out the duties assigned to them and will provide them with a comprehensive induction programme commensurate with their roles. • As part of this induction programme, newly appointed staff will be assigned to the roster in a supernumerary capacity when they first commence in post. They will work alongside an assigned mentor who will facilitate them in acclimatizing to the working environment and systems, their colleagues, the residents and their relatives. • The PIC will ensure that residents are supervised by experienced staff who are familiar with the nursing home.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The PIC will ensure that staffing levels are always sufficient to meet the assessed care needs of all residents in the home, including anticipated admissions. • Since the inspection, we have appointed full-time Healthcare Assistants to the three vacant positions. • The PIC will ensure that there is always appropriate cover for staff who are taking planned leave. The PIC will cover unscheduled leave by consulting with staff to adjust their roster, if possible, to provide cover for staff who are unavailable at short notice. If this is not possible, the PIC will book agency staff to cover for staff who are unavailable	

to work their rostered hours.
• The PIC will ensure the policy on staff attendance and management of absence is effectively implemented.
• The Facilities team have undertaken a comprehensive review of the kitchenette and have scheduled a programme of works to replace all cabinetry with stainless steel shelves and cabinets.
• The PIC will ensure that all residents have access to their own individual call bell. In the twin room that only has one call bell socket the PIC has provided a handheld bell for the other resident. The Facilities team will review the call bell system to ascertain whether additional call bells can be added to the current system where required.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• There is a plan and timeline in place to replace all cabinetry in the kitchenette with stainless steel shelves and cupboards.
• Following a review of the overall cleaning schedules in the nursing home, a comprehensive cleaning schedule for housekeeping and kitchen-based staff has been introduced to ensure that all areas of the nursing home (including the kitchen and kitchenette) are thoroughly and effectively cleaned to an appropriate standard. This schedule includes equipment such as cleaning trolleys. The Catering Manager and Housekeeping Supervisor will monitor standards in their respective areas, and the Assistant Director of Nursing will conduct daily rounds of the nursing home to monitor overall compliance.
• We will replace bedroom furniture on a phased basis. There is a scheduled timeline for the replacement of wardrobes, bedside lockers and drawer units.
• The Maintenance Person in the nursing home will complete minor repairs and decorative 'touch-ups' as required.
• The Facilities Manager has completed a review of flooring and repairs/replacement will be scheduled where required. There is a plan in place to replace areas of flooring on the first-floor corridor.
• On behalf of the PIC, the Facilities team will arrange for the call bell provider to review the call bell system to ascertain whether additional call bells can be installed, including in the twin rooms.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• The PIC will ensure that all fire doors are checked as part of the daily walkabout and

any deficiencies will be notified to the Facilities Team.
• The Facilities team will arrange for gaps between/under fire doors identified and any other issues noted to be repaired.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/07/2023
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	31/10/2023
Regulation 23(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/08/2023
Regulation 23(c)	The registered provider shall ensure that	Not Compliant	Orange	31/08/2023

	management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/07/2023