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:	Archview Lodge Nursing Home
Name of provider:	Archview Lodge Nursing Home Limited
Address of centre:	Drumany, Letterkenny, Donegal
Type of inspection:	Unannounced
Date of inspection:	12 February 2024
Centre ID:	OSV-0000314
Fieldwork ID:	MON-0041392

About the designated centre

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

Archview Lodge Nursing Home is committed to providing a pleasant, homely, safe environment for the 29 residents living in the home. Residents' individual nursing and personal needs are catered for and their privacy, dignity is upheld. We respect each resident's independence and recognise the importance of maintaining links with their families and friends in the resident's ongoing life in Archview Lodge Nursing Home. The centre provides accommodation for both female and male residents over the age of 18 yrs who may have the following care needs: General Care, Respite care, Physical Disabilities, Mental Disabilities, and the early stages of Alzheimers and Dementia. Terminal Care and other conditions such as Parkinson's disease are also catered for. Accommodation is provided in a range of single and twin rooms. Some rooms have en-suite facilities. There is a choice of communal bath or shower facilities. There are a variety of communal lounges and quiet seating areas provided for residents. All accommodation is at ground floor level.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	27

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
Monday 12 February 2024	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 person in charge 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 spending their time the communal rooms. The inspector observed that the atmosphere was relaxed and homely.

The centre had an enclosed rear garden and a large mural of the old Letterkenny town was painted on a wall that faced the garden for residents to enjoy.

Archview Lodge Nursing Home is a single storey building. Accommodation is provided in a range of single and twin rooms. There are a variety of communal lounges and quiet seating areas provided for residents. The designated centre can accommodate up to 29 residents. At the time of the inspection, there were 27 residents accommodated in the centre.

During the walk around, the inspector observed that there was a good standard of cleanliness in the centre and the corridors were free from clutter. The inspector observed a storage area located in a corridor was fitted with a metal shutter. This shutter was found to be half open which compromised the means of escape. Fire doors were fitted and maintained to a good standards. Notwithstanding this, minor issues were found to some of the fire doors to the bedroom areas and along a corridor.

In another area, a fire exit located in a sluice room was found to be locked and not in use. Furthermore, two fire exits were lacking emergency fire exit signage.

Fire evacuation floor plans were displayed along the various corridors. A fire alarm panel was noted to be healthy and free from faults. Fire extinguishers were present throughout the centre and were serviced. Staff spoken with demonstrated a good knowledge of the evacuation procedure in place.

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 previous inspection in regards to premises and fire safety.

The provider had carried out a significant amount of fire safety works in relation to compartmentation, widening and fitting new fire doors throughout the centre. The commitments made by the provider from the previous inspection with regards to premises and fire precautions had been actioned.

Further improvements were required to achieve regulatory compliance in relation to premises and the provider needed to take action to meet the regulatory requirements on fire precautions in the centre.

In regards to premises, the provider was issued with a restrictive condition to ensure no new resident is admitted to bedroom 3 or any resident within the centre transferred to room 3 until this bedroom is reconfigured to have an area of not less than 7.4m² of floor space to include a bed, a chair and personal storage space for each resident. The inspector found this room to be fully vacated at the time of the inspection.

The provider had mostly provided a premises which conformed to the matters set out in Schedule 6. However, a shared bedroom accommodation did not conform. This is outlined in detail under Regulation 17: Premises.

The provider of the designated centre is Archview Lodge Nursing Home Limited, and the person in charge of the centre was found to be supported by the representative of the registered provider, a clinical nurse manager and nursing and care staff. There was an established management team with clear roles and responsibilities,

This inspection found that some fire safety management systems in place were not robust. The oversight of fire safety management systems 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. These are outlined in detail in the quality and safety section of the report and under Regulation 28.

Further improvements that the provider needed to make in relation to day-to-day 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 oversight of fire safety in the centre required improvements. Management systems in some areas were not sufficiently robust and required action to ensure the centre delivered appropriate, safe and constant care to residents.For example:

- The provider had not recognised some of the fire risks found on the inspection and additional fire precautions were required to ensure that residents were protected from the risk of fire as detailed under regulation 28.
- The inspector was not assured by the evacuation strategy and staffing levels at night time hours.
- The provider has a history of non compliance with regulation 28 from previous inspections carried out on February 2022 and January 2023. On this current inspection, the provider was found to be non compliant with regulation 28.

Judgment: Substantially compliant

Quality and safety

Overall, fire safety systems and the fire safety aspects of the physical premises were not robust and required improvements. It is acknowledged the provider completed the commitments made after the previous inspection in January 2023. Notwithstanding this, due to the findings of this inspection the registered provider was failing to meet the regulatory requirements on fire precautions in the centre in the following areas:

- Sealing up of service penetrations in fire resisting construction.
- Arrangements for evacuating all persons in the designated centre
- Arrangements for maintaining the means of escape..
- Day-to-day arrangements in place in the centre to ensure adequate precautions against the risk of fire

Of the fire doors reviewed, the inspector noted most were well fitted and appeared to be effective to contain the spread of fire and smoke. Minor deficiencies such as gaps to the underside of fire doors to some residents' bedrooms and a smoke seal to a cross corridor door had been painted over.

While emergency directional signage was provided for in most areas of the centre, the inspector noted some fire exits were lacking fire exit signage and required a key to unlock the final fire exit. A copy of the key was located adjacent to each door in a break-glass unit. Notwithstanding this, all fire exits should be readily openable without the use of keys. Key-operated or staff-controlled fire exit doors on escape routes are sometimes provided in limited situations. It is recommended that there is one master key that operates all doors concerned and all staff members should have this key on their person.

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. The inspector noted a fire exit located in a sluice room was indicated on the evacuation floor plans as a designated fire exit. However, the inspector found this to be locked. In addition to this, two fire exits were lacking emergency fire exit signage.

The inspector reviewed the fire safety register and noted that it was 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. Notwithstanding this, an extractor unit over a cooking area had signs of significant grease or material build up and this created a potential fire risk.

There was a fire safety management plan and emergency fire action plan in place. These were found to be comprehensive. Notwithstanding this,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.Furthermore, additional fire risks found on the day of the inspection had not been identified in the providers fire safety routine checks. These are outline din detail under regulation 28: Fire Precautions.

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. However, the inspector reviewed fire drill records for the largest compartment based on night time staffing levels and found it demonstrated an extended evacuation time. As the evacuation time was excessive, this implied a deficit in the evacuation strategy.

In addition to this, the Inspector was not assured that the current staffing levels during night time hours were adequate to safely evacuate all residents from the largest compartment in a safe and timely manner. The largest compartment accommodated nine residents. The inspector noted a number of residents required two staff members to aid in their evacuation as some residents were bed bound, had cognitive, hearing and mobility impairments and some required supervision.

Furthermore, the inspector was not assured that a staff member would be available to adequately supervise the remaining residents in the centre during an evacuation, to meet the fire brigade and to manage residents once outside if an external evacuation was required.

The provider had an updated fire safety risk assessment recently carried out with some medium fire rated risks identified that required action. At the time of the inspection not all identified risks had been completed within the time frame as set out in the providers fire safety risk assessment. This is outlined under regulation 28: fire precautions.

Regulation 17: Premises

The centre was found to be clean, clutter free and maintained to a good standard.

The registered provider having regard to the needs of the residents had mostly provided premises which conformed to the matters set out in Schedule 6. However, some shared bedroom accommodation did not conform. For example:

The layout of a twin room led to the only window in the room being located within a resident's bed space. As a result, when this resident had their privacy curtain pulled, the other resident in the bedroom did not have access to natural light. Therefore, access to natural light was only afforded to one resident.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had completed their previous compliance plan commitments. Notwithstanding this, the registered provider had failed to meet the regulatory requirements on fire precautions in the centre. The provider 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. For example:

- Oxygen cylinders were noted to be stored outside. However, an oxygen cylinders was not secured from falling over.
- A refuse bin was observed to be placed up against a generator and created a potential fire risk. Refuse bins should be adequately separated from heating sources and maintained in their own separate refuse area.
- Signage was noted to be lacking in the kitchen area to indicate the location of the gas shut off valve and the electrical power shut off switch to staff in the event of a fire.
- An extractor unit over a cooking area had signs of significant grease or material build up and created a potential fire risk.

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 fire exit located in a sluice room was indicated on the evacuation floor plans as a designated fire exit however, the inspector found this to be locked and not in use. Furthermore, two fire exits were lacking emergency fire exit signage. A fire exit sign in a dining room was not illuminated and the fire exit door was fitted with full length curtains that could impede instant egress in the event of an evacuation.

The provider did not have adequate arrangements in place for the maintenance of fire equipment, the means of escape and the building fabric. For example, some of the internal fire exits and external exits from the enclosed garden areas were fitted with key operated locks. While a break glass unit contained a key was located adjacent to these doors, staff members did not have a copy of this key on their person. Further improvements are required by the provider to ensure these fire exits are at all times readily openable to provide instant egress.

A storage area located in a corridor was fitted with a metal shutter. The inspector found this shutter to be left half open. This presented a risk of a fire spreading from the storage area and moving into the corridor which would compromise the means of escape. Furthermore, the inspector was not assured the metal shutter would meet the criteria for a fire rated shutter to contain the spread of smoke and fire.

The majority of fire doors in the centre were fitted and maintained to a good standard. However the inspector did note some of the bedroom fire doors had a gap underneath the door over the allowable tolerance and a cross corridor fire door smoke seal had been painted over, which rendered it ineffective to contain smoke.

The inspector noted some ceiling areas in the centre were noted to have utility pipes or ducting that penetrated through the fire-rated ceilings (ceilings built in a way to provide a certain amount of fire resistance time), and these required appropriate fire sealing measures.

Arrangements for containment of fire and detection in the event of a fire emergency in the centre required improvement by the provider. For example:

A section of a wall that separated the reception office from the main entrance corridor was noted to have a soft spot in the wall. The inspector observed metal storage cabinets traversed the corridor and the reception office. The inspector was not assured the required level of fire rated was afforded to the existing wall construction.

While there was gas detection provided in the kitchen, it was not linked to the fire detection alarm system. This had been identified in the providers' fire safety risk assessment to be completed within one month. The providers fire safety risk assessment report was dated 24 October 2023 and this risk remained unresolved.

Arrangements for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency in the centre were not adequate and required further review to ensure full compliance with the regulation and to ensure residents were safe. From a review of the simulated evacuation drills for the largest compartment, which were based on night time staffing levels, demonstrated an extended evacuation time. As the evacuation time was excessive, this implied a deficit in the evacuation strategy.

In addition to this, assurance was required that the current staffing levels during night time hours were; adequate to safely evacuate all residents from the largest compartment in a safe and timely manner, adequate supervision of the remaining

residents in the centre during an evacuation, to meet the fire brigade and to manage residents, if an external evacuation was required.
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	Substantially compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for Archview Lodge Nursing Home OSV-0000314

Inspection ID: MON-0041392

Date of inspection: 12/02/2024

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:

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.

The Provider has arranged to put in place new management systems effective 1 May 2024 to ensure: (i) the robust recognition of fire risks so that all identified risks are addressed effectively by 30 May 2024 (to include all fire risks concerns identified during the Inspection); and (ii) that evacuation strategies with appropriate staffing levels at night-time hours are in place no later than 30 May 2024.

The Provider, as part of its Compliance Plan under Regulation 23, relies on the compliance actions taken and outlined below under Regulations 17 & 28 of the Care & Welfare Regulations.

To ensure effective compliance with Regulation 23 of the Care & Welfare Regulations and the Centre's Certificate of Registration, the Provider has made arranged to submit applications to the Chief Inspector, on 29 April 2024 to vary Condition 1 and remove Condition 4 of the Centre's Certificate of Registration supported by floor plans dated 29/4/24 and a new Statement of Purpose dated 29/4/24 reflecting, inter alia the increased floor area of Bedroom No. 3 of the Centre following its reconfiguration after the Inspection.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

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.

The Provider has taken the following actions to ensure compliance under Regulation 17 by reference to each of Bedrooms 3 & 17.

Bedroom 3

Following the Inspection, the Provider reviewed its compliance with Condition No. 4 of the Centre's Certificate of Registration which prohibits the admission of two residents to Bedroom 3, until the floor area available in the Bedroom 3 room is 7.4m² for each of two residents, and is assured that no residents were admitted, post-registration, to Bedroom 3 in full compliance with the registration condition, to include the day of the Inspection and this Compliance Plan.

The Provider assures that, following the Inspection, the Provider arranged to reconfigure the floor space of Bedroom 3 so that it has a floor space of 7.4m² for each of two residents in compliance with Paragraph 1B of Schedule 6 of the Care & Welfare Regulations.

The Provider has arranged to submit applications to the Chief Inspector on 29 April 2024 for registration decisions to (i) remove Registration Condition No. 4 and (ii) vary Registration Condition No. 1 to reflect the slight increase in floor area for Bedroom 3 supported by (a) the required regulatory application fees; (b) a Statement of Purpose dated 29/4/2024; and (c) new floor plans (dated 29/4/2024) to reflect, for good order, the increase in floor area within Bedroom No 3 and the overall floor plan of the Centre.

Bedroom 17

Following the Inspection, the Provider reconfigured Bedroom 17. The Provider assures the Chief Inspector that it installed a fire-proofed Velux window and tunnel so that additional natural light now enters Bedroom 17. The position of the additional light source for Bedroom 17 is identified within maps attaching to the Statement of Purpose dated 29/4/2024 submitted to the Chief Inspector on that day.

Regulation 28: Fire precautions	Not Compliant

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

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.

The Provider assures that it has taken the following actions to ensure full compliance with Regulation 28 of the Care & Welfare Regulations:
• All refuse bins previously placed against a generator are now stored in a separate refuse area away from all heating sources.
• Additional fire safety signage has been put up in the kitchen area to indicate to staff the location of the newly installed gas shut off valve and the electrical power shut off switch in the event of a fire.
• The Provider has attended to a deep cleaning of the extractor unit over the cooking area and removed grease or material build up – cleaned to TR.19 Regulation
• Evacuation floor plans have been amended to remove the door at sluice room as a designated fire exit as this would not be an appropriate place for staff to exit the building, residents do not at any time have access to the sluice room. All fire exits now have emergency fire exit signage.
• The fire exit sign in the Centre's dining room has been illuminated and the curtains have been removed-
• The Provider has put in place systems to ensure that all designated fire exits are in use and not obstructed in any way including those which had full length curtains on the day of the Inspection.
• New management systems introduced after the Inspection ensure that fire doors n the Centre are at all times readily openable to provide instant egress. The door to the courtyard has been fitted with a Maglock system which is connected to the fire alarm.
• The Provider, following the Inspector, introduced a management system which ensures that (a) all bedroom fire doors do not have a gap underneath the door above the allowable tolerance; and (b) all cross corridor fire door smoke seal are made effective to contain smoke.
• The Provider has attended to fire sealing and introduced retardant measures to address any risk where utility pipes and/or ducting have penetrated through fire-rated ceilings (ceilings built in a way to provide a certain amount of fire resistance time). Drop seal bars have been installed on bedroom doors 17, 18 and 21 the defective smoke seal has been replaced.
• All fire rated sealing has been completed by competant fire expert
• Since the Inspection, works have been completed to remediate the "soft spot" in that section of in the wall withn the Centre that separates the reception office from the main entrance corridor.
• The Provider has eliminated the risk identified by the Inspector with regard to the metal storage cabinets which traverse the corridor and the reception. The filing cabinet is removed and the wall reconstructed to ensure that it is now fire proof.
• A new fire rated shutter has been installed in the corridor and will be kept shut when

not in use.
• The Provider has ensured that gas detection systems in the Centre's kitchen are now linked to the Centre's fire detection alarm system.
• The Registered Provider has engaged with its external fire safety advisers with a view to ensuring that adequate arrangements are in place, on an ongoing basis within the Centre for evacuating all persons in the designated centre and safe placement of residents in the event of a fire emergency. The Provider assures the Chief Inspector that it has reviewed the simulated evacuation drills for the largest compartment in the Centre, including based on night time staffing levels, to ensure evacuation times.
• Oxygen cylinders stored outside the Centre have been properly secured so that they do not fall over.

By way of further assurance to assuage concerns raised on records reviewed during the Inspection, the Provider assures that these were records of a training day evacuation when the instructor paused the exercises on several occasions to enable enhanced training to staff participating in the training event. The evacuation times recorded for the training session reviewed did not present an accurate reflection of the actual evacuation time engaged. The Provider assures that this will not happen going forward.
Following the Inspection, the Provider arranged a planned evacuation drill of the largest compartment within the Centre on 21 March 2024 which had acceptable times. The recorded time for the drill was not excessive thus ensuring safe and effective evacuation strategy. The Provider has forwarded evidence of this drill separately to the Inspector.
Separately, with effect from 30 April 2024, the Provider shall ensure that enhanced steps are taken to ensure the rostering of appropriate levels of staff, including during night shift, within the Centre and to ensure, by reference to the residents' PEEPs, that two staff members are available to aid the evacuation of those residents who are bed bound, have cognitive, hearing and mobility impairments, mindful that some residents require supervision and fifty percent of residents in the Centre currently have dementia. The Provider's approach will be ensure that a staff member will be available at all times to supervise adequately all remaining residents in the Centre during an evacuation, to meet the fire brigade and to manage residents once outside if an external evacuation if required at night time.
The Provider assures the Chief Inspector that our Centre has a robust fire detection system with an addressable fire detection and alarm system panel. All residents have comprehensive PEEPs and we assure the Inspector that there are no bedbound residents admitted to the largest compartment of our Centre.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	29/04/2024
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	30/05/2024
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	29/04/2024

	suitable building services, and suitable bedding and furnishings.			
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	29/04/2024
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	29/04/2024
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	29/04/2024
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.	Not Compliant	Orange	29/04/2024