Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People

Name of designated centre:	St Ita's Community Hospital
Name of provider:	St Ita's Community Hospital
Address of centre:	Gortboy, Newcastlewest, Limerick
Type of inspection:	Unannounced
Date of inspection:	19 October 2018
Centre ID:	OSV-0000664
Fieldwork ID:	MON-0025126

About the designated centre

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

The following information has been submitted by the registered provider and reflects a description of the service as set out in the statement of purpose. The service at St Ita's Community Hospital is provided by the Health and Safety Executive (HSE) and the centre is located in Newcastle-West, Co. Limerick. The centre is registered for an operational capacity of 78 residents, providing respite and palliative care as well as continuing care for long-stay residents. At the time of inspection there were 76 residents registered in the designated centre. Nursing care is provided mainly for older people over 65 years of age with needs in relation to age related and degenerative neurological diseases. Care is provided across three residential units for residents with dependency levels ranging from low to maximum. Dementia-specific care is provided in a separate unit that accommodates up to 12 independently mobile residents. Care plans are developed in accordance with assessments and residents are provided with access to a range of allied healthcare services. Private accommodation is provided where possible within the constraints of the existing building which is over 100 years old in some parts. Residents are provided with opportunities for activation and social interaction including engagement with local community activity groups.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	70

How we inspect

To prepare for this inspection the inspector or 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
19 October 2018	10:10hrs to 17:00hrs	Niall Whelton	Lead
19 October 2018	10:10hrs to 17:00hrs	Noel Sheehan	Support

Capacity and capability

This was an unannounced inspection by the Health Information and Quality Authority (HIQA), which included assessment by a specialist inspector in fire safety. The purpose of this inspection was to assess fire safety in the centre, with a particular focus on the arrangements in place to evacuate residents.

Improvements were required to ensure that the systems of governance and management in relation to fire safety were effective to ensure the safety of residents living in the centre. Inspectors were not assured that the fire safety arrangements in place were adequate to ensure prompt, safe and effective evacuation of residents in the event of a fire.

Inspectors had concerns in that where fire risks were identified and documented; they were not acted upon to mitigate the risk. The registered provider had arranged for a fire safety risk assessment of the building by a fire safety engineering consultant, the report of which dated back to May 2011. There was a subsequent on-site review and update, inspection of which was carried by out the same firm in October 2014. Although some assessment findings and recommendations had been acted on, inspectors noted a number of items which were not yet addressed. Inspectors were concerned that this risk assessment had not been reviewed since October 2014.

One such recommendation included three bedrooms arranged such that they were required to escape through a corridor which was fully open to the day room of the unit. If a fire was to occur in the day room, the fifteen residents accommodated in these three bedrooms would be required to evacuate through this area and would not be afforded a protected means of escape.

Further to previous assurances requested by the office of the Chief Inspector in relation to these three bedrooms, there was a plan in place to separate the day room from the escape corridor. The registered provider had also arranged for simulated drills to take place, but from room seven only. Inspectors were told that a scenario simulating a fire in the day room, or the simulated evacuation of all fifteen residents had not been tried.

Due to the findings of inadequate fire doors and breaches in the fire rated enclosures, inspectors were concerned about fire containment measures throughout the building.

Fire safety training was provided to staff, but these arrangements were not adequate to ensure that all staff attended training as required. Training records showed a large cohort of staff who had not received training in the previous twelve months.

Regulation 23: Governance and management

Improvements were required to ensure that the systems of governance and management in relation to fire safety were effective to ensure the safety of residents living in the centre.

Where fire risks were identified and documented; they were not acted upon to mitigate the risk.

There were inadequate arrangements to ensure a suitable programme of simulated fire evacuation drills took place.

The arrangements for fire safety training were not adequate to ensure all staff attended training as required.

Judgment: Not compliant

Quality and safety

The registered provider was not taking adequate precautions against the risk of fire. Oxygen cylinders were observed in each unit to be stored with large quantities of combustibles and near potential ignition sources. For example oxygen cylinders were stored in very close proximity to multiple devices being left on charge unattended. Oxygen is a high risk material and where inappropriately stored poses a risk to residents and staff. When not in use, they should be appropriately stored in a well ventilated area remote from ignition sources. The arrangements for use and storage of oxygen required review by a competent person to ensure it is used and stored safely. This was immediately brought to the attention of the person in charge of the centre on the day of inspection.

There was a water leak noted in the corner of a corridor coming from the ceiling. While it was not clear where the source of the leak was, there may be electrical equipment behind this ceiling/partition causing a potential risk. Inspectors were told the leak was there for some time.

In another corridor, there were large panels of electrical equipment along an escape route which was not enclosed in fire rated construction.

In general, inspectors found that the building was laid out to provide residents and other occupants with an adequate number of escape routes and fire exits. The fire procedure for the centre identified that progressive horizontal evacuation was

adopted as the primary evacuation method for the centre. The compartment in Camellia with three, five-bedded rooms opening off the day room, was provided with three exits, one of which opens directly to open air adjacent to room seven. Inspectors had concerns that the doors were configured such that it would be difficult to evacuate a mattress on a ski sheet. To this end, during the inspection, staff trialled moving two separate mattresses using the evacuation sheets contained under the mattress through the exit directly to open air adjacent to Room seven. The foam type mattress did not fit through the exit. Although the preferred route of escape identified to inspectors was through to the corridor past the fire doors, inspectors were not assured that in the event of a fire in the dayroom, there were adequate measures in place to ensure the safe evacuation of residents through the external exit if required.

The registered provider did not have adequate arrangements for the maintenance of means of escape as evidenced by the deficiencies noted to some fire doors. When requested, there was no record of any regular checks of the condition and functionality of fire doors throughout the centre. The system of fire safety checks required review to ensure they were of adequate extent, frequency and detail.

There were a number of fire doors which were found to be not capable of restricting the spread of fire and smoke as required. Features such as smoke and heat seals were missing and some doors were not closing correctly. In particular the fire door to the large kitchen, an area of special fire risk, was found to be damaged with a significant gap to the top of the door and the closing device was not capable of closing the door. Furthermore, inspectors noted a small kitchen and hair salon which was not provided with a fire door. The provision and condition of fire doors in the centre required review from a competent person.

Locks to exits throughout the centre were identified which required the use of a key to open them. Although there was a break glass unit with a key adjacent to the door concerned, inspectors were told that each exit required a different key to open it and staff do not carry a master key or copy of the keys at all times. Inspectors were not assured that sufficient measures were in place to ensure exits could be readily openable in the event of a fire. The exit providing escape from the side of the chapel had two exit doors each with a different key required to unlock the exit. When requested during the inspection, a risk assessment for this was not available.

Inspectors observed good practices also in relation to fire safety. For example, one staff nurse told inspectors they had recently included in their daily checklist for the unit, that all evacuation sheets are appropriately fitted to the bed. Inspectors saw documentary evidence of this. Staff spoken to demonstrated good knowledge of the procedures to follow in the event of a fire and were able to explain the procedure to summon assistance from other units to assist evacuating residents.

Inspectors looked at the kitchen and laundry facilities in the centre. Inspectors spoke to a staff member in the laundry room and found them to be very knowledgeable about what to do in the event of a fire and they were able to identify emergency shut off facilities available. There were two multi-task attendants working in the kitchen, without a regular kitchen staff member present. While this

was only from 15.45 to 17.00 each day, those staff members were not confident in the procedures to follow should a fire start in the kitchen. Inspectors also noted that the nozzles of the fire suppression system were not in line with the deep fat frying equipment below. This was identified in the 2014 review by the fire safety engineering consultant.

Regulation 26: Risk management

Oxygen cylinders were inappropriately stored.

The key-operated doors on escape routes did not form part of the hazard identification and assessment of risks schedule.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors were not assured that adequate arrangements were in place to ensure residents could be safely evacuated.

The location of residents in the centre was not considered in line with their assessed needs and were not located to ensure the most effective evacuation.

There were a number of fire doors which were found to be not capable of restricting the spread of fire and smoke as required.

Inspectors were not assured that sufficient measures were in place to ensure exits could be readily openable in the event of a fire

The arrangements for the storage of oxygen required review

There were inadequate arrangements for the maintenance of means of escape

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
Capacity and capability	
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Not compliant

Compliance Plan for St Ita's Community Hospital OSV-0000664

Inspection ID: MON-0025126

Date of inspection: 19/10/2018

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:
Governance Structure:

The policy document, Fire Safety Policy and Procedures, for the Centre sets out the responsibilities for all members of staff in relation to fire safety.

The Centre is a smoke free campus.

In mid-2018, a meeting between Older Persons Residential Services and Estates Department was initiated. Meetings between Older Persons Residential Services and Estates will take place on a quarterly basis per annum. Fire Safety Projects regarding the physical environment of the Centre is part of the agenda at each quarterly meeting with Older Persons Residential Services Management and Estates Department. This will ensure that works identified through Fire Risk assessments are raised, monitored and closed out. Older Persons Residential Services Management will also monitor the status of these works.

In addition, all issues from the Fire Risk assessments will be discussed locally at the monthly Health & Safety Committee Meeting and at the monthly Hospital Management Meeting.

Local issues can be raised at the Quality Risk & Patient Safety (QRPS) monthly meeting. This also provides an opportunity for shared learning across other Centres within the scope of Older Persons Service in the Mid West. The QRPS meetings are attended by Directors of Nursing, Maintenance, Health & Safety Officer, Older Persons Management and Risk Advisors.

Any issues still outstanding at this stage can be progressed to the Mid West Community

Healthcare QRPS meeting and/or Head of Service.

Fire Safety is part of the induction process for all new staff.

A comprehensive Fire Safety checklist template has been completed for staff to record checks on a daily/weekly/monthly basis, held in each unit and in the Fire Register Folder and Fire Register Book for the Hospital.

Documentation:

Fire Procedure Documents, inclusive of Fire Safety Policy and handbooks for all wards, are in place. The Fire Safety Policy sets out the system of governance and management in relation to fire safety.

A Fire Safety Register is in place on site. The register is updated nightly by the Night Sister. It is also scheduled that the Fire Compliance levels according to the Fire Register book is completed on a daily basis by the CNM on each unit.

This includes a visual inspection of every fire panel in the hospital, that all fire exits are clear and a weekly check list of all fire fighting equipment. Copies of test certificates are also kept in this folder.

Risk assessments have been completed for O2 storage and key locks and added to the designated Centre's Risk Register. The Policy document for O2 has been reviewed and amended to include the safe storage of O2 cylinders.

Training:
Simulated evacuation exercises were carried out on the 14th September 2018. Simulated evacuation of the residents in the three bedrooms on the unit referred to in the Inspection Report took place on 14th September 2018. The trainer was requested to carry out simulated evacuation of Rooms 5 and 6 and the sitting area as part of the training schedule. This was completed on 24th November 2018. The trainer also carried out a simulated evacuation of the entire sub compartment on 24th November 2018.

Fire training inclusive of fire drill, firefighting equipment, simulation evacuation took place on 12th November 2018, 24th November 2018, 13th December 2018. All training is documented and filed in Training Records.

Further fire safety training for 2019 has been scheduled for February, April and September 2019 and will be carried out by a Fire Safety Consultant. Staff will also undertake their own Simulated Evacuation exercise (Fire Drill) per unit.

Fire Safety training is mandatory and attendance is tracked and monitored by management. Staff are notified 6 weeks in advance initially and further receive reminders to attend the required training date. Staff that are not rostered to work on the scheduled days of training are given the time back in lieu.
Any non-compliance will be managed under the HSE HR Policies and Procedure.

Schedule of Works:

A fire safety risk assessment of the building was carried out by a Fire Safety Engineering Consultant in 2011, there was a subsequent onsite review inspection carried out by the same Consultant in 2014. All high risks identified in red in the report were actioned and closed out. The remaining schedule of works will be addressed by the construction company who has been appointed to complete the schedule of works as identified in the Fire Safety Engineering Consultant's report, 2014.

Work started on the 17th January 2019. The first schedule is the replacement of the single door sets. The screen for G21 will be on site on the 21st January 2019 to be fitted. Maintenance and nursing management are currently planning the schedule of dates to progress the replacement of the main entrance door to ensure the least amount of disruption to the residents. This consultation has included the Infection Prevention Control Manager.

All works carried out will be done in accordance with Part B of the Construction Regulations 2006. To ensure compliance from a client perspective, all works carried out will be snagged fully and a schedule of work drawn up for further actions. This will be known as “walkdowns” and will be carried out by local Maintenance. Any outstanding issues will be brought to the attention of Older Persons Services management and placed on agenda for quarterly meetings with Estates Department.

Servicing of equipment:
Fire alarm system, emergency lighting system and hand held fire fighting equipment are under contract for inspection and servicing. These are certified to IS291 and to IS3217. The last service carried out on the Fire Alarm and Emergency Lighting was on the 6th December 2018. Documentation certs are held in Fire Register Folder. Weekly tests of fire alarms in different zones of the designated Centre are completed by Maintenance. In relation to Fire Fighting Equipment, the fire extinguishers were serviced/ replaced in July 2018 and fire hydrants were pressure tested in September 2018. Fire Fighting Equipment is checked by the night sister weekly and recorded in the Fire Register book.

The Fire and Safety Officer had arranged for a risk assessment of all fire doors which was completed on 21st November 2018 by a Fire Safety Engineering Consultant. Remedial works to address fire doors will be undertaken by the construction company as part of the schedule of works. It is estimated that works will continue until the end of March at the earliest.

Regulation 26: Risk management	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management:	

Fire Safety Risk Assessment:
It is proposed that Fire Safety Risk Assessments will be reviewed on an annual basis. This will include a Site inspection by a Fire Consultant to identify any potential fire risks and report on same. The Fire & Safety Officer in consultation with local maintenance and management will ensure all actions are closed out. All items identified including breaches in compartmentation will be rectified. Furthermore, Maintenance will monitor the work of tradesman coming on site to ensure that any breaches made to compartment lines are rectified immediately.

Items arising from the Fire Risk assessment will be placed on the agenda at quarterly meetings with Estates and Older Persons Service Management meetings.

Storage of O2 Cylinders:
All oxygen cylinders have been removed from the units and are stored in outside storage unit according to the Oxygen provider's storage guidelines.

The site specific policy document on Administration and Management of Adult Oxygen Therapy has been amended to reflect the storage of O2 cylinders in a locked, external compound. This document has been communicated to staff and implemented. Risk assessments for portable O2 cylinders and O2 concentrators were completed and risk for portable O2 cylinders mitigated by removal to outdoor storage.

Water leak:
This will be reviewed and addressed through the schedule of works been carried out by the current construction company.

Distribution Board:
The panel referred to, along an escape route on a corridor, in the Inspection Report is a Redundant electrical distribution board. Specification for the fire proofing of this board has been sourced from the Fire Safety Consultants. The contractor will use this specification to carry out the required works. This will be inspected by the Fire Safety Engineering Consultant on completion.
Personal Evacuation Egress Plan (PEEP):

Each resident has a Personal Evacuation Egress Plan (PEEP) which is customised for each individual, depending on their abilities and needs. The method by which each resident is evacuated from the three bedded rooms on the unit referred to in the Inspection Report is dependent on the mobility status of the resident.

Each PEEP on the unit referred to on the report has been reviewed. Those residents who are sleeping on foam mattresses are mobile and can evacuate by themselves or with assistance.

PEEPS are reviewed and updated on a quarterly basis or when required if changes occur for example, changes in the resident mobility/dependency status.

For those residents who are dependent on the unit referred to in the Report, their mattresses have been replaced with Aircare 8 mattresses which will allow evacuation through the external exit. The exception to this will be the evacuation of a bariatric

resident on a mattress. As a result, admission to this Unit has been restricted to non-bariatric residents. The admission policy has been amended to reflect this and has been communicated to nursing staff on the unit for implementation.

Widening of the external exit door referred to in this Unit will be included in the schedule of works to be completed.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Evacuation process:
Each resident has a Personal Evacuation Egress Plan (PEEP) which is customized for each individual depending on their abilities and needs. Audit of evacuation sheets is carried out daily to ensure that they are in position in the beds. Assessment of the resident's individual needs will be assessed prior to admission to ensure that reasonable structures are in place in the case of fire evacuation.

Evacuation process for residents in the unit referred to in the Report:
Each resident on the unit has a Personal Evacuation Egress Plan (PEEP) which is customised for each individual depending on their abilities and needs. The method by which each resident is evacuated from the three five-bedded rooms on the unit referred to in the Inspection Report is dependent on the mobility status of the resident.

Each PEEP on the unit has been reviewed. Those residents who are sleeping on foam mattresses are mobile and can evacuate by themselves or with assistance.

For those residents who are dependent on the unit, their mattresses have been replaced with Aircare 8 mattresses which will allow evacuation through the external exit. The exception to this will be the evacuation of a bariatric resident on a mattress. As a result, admission to this unit has been restricted to non-bariatric residents. The admission policy has been amended to reflect this and has been communicated to nursing staff on the unit for implementation.

A review will be completed of all Emergency Exit doors in the event of fire evacuation in the Hospital to ensure that all residents can be evacuated within the time constraints, safely, with ease and any follow up actions will be raised at local and Mid-West management meetings to progress required actions.

Fire Doors:
Fire door to large kitchen was repaired on 24th October 2018.

The Fire and Safety Officer arranged for a risk assessment of all fire doors. This took place on 21st November 2018. Remedial works will be undertaken by the construction

company. It is estimated that works will continue until the end of March at the earliest.

Fire Doors will be checked by local maintenance monthly to ensure that they are in good working order, any faults identified and recorded in the Fire Safety Register and Maintenance Log book for the Unit.
Any actions/tasks will be discussed at the monthly local Hospital Management Meeting where maintenance management are present and also the Health & Safety Officer and senior management.

Locks:
Risk assessment on locks was completed and additional controls identified. The additional controls were reviewed by the Fire and Safety Officer. The outcome of the review was that the existing system of break glass was adequate. One of the two break glass units has been removed from the Church area. The lock for the inner door for the Church has been dismantled. Keys to exits have been reviewed and keys have been clearly labelled.

Keys are provided in break glass units adjacent to each door in the Hospital that is key locked. A register of all these exit doors has been developed and filed in the Fire Register Folder. As part of the ongoing compliance a staff member will carry out daily checks of the exit fire doors to ensure each break glass unit has key present and will document same in the Fire Register Book. In addition, these checks are recorded daily on the Fire Safety Checklist and filed in the Fire Register folder.

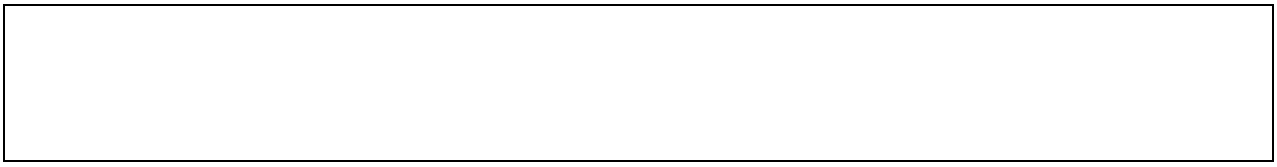
Fire Suppression System:
The fire suppression system has been realigned with the deep fat frying system below it. This was completed on the 13th December 2018.

O2 cylinder storage:
All oxygen cylinders have been removed from the units and are stored in outside storage unit according to the oxygen provider's storage guidelines.

The site specific policy document on Administration and Management of Adult Oxygen Therapy has been amended to reflect the storage of O2 cylinders in a locked, external compound. This document has been communicated to staff and implemented. Risk assessments for portable O2 cylinders were completed and risk for portable O2 cylinders mitigated by removal to outdoor storage.

Schedule of Works:
A construction company has been appointed to complete the identified schedule of works and have commenced work on the 17th January 2019.

The Fire and Safety Officer arranged for a risk assessment of all fire doors which was completed on 21st November 2018. Remedial works to address fire doors will be undertaken by the construction company. It is estimated that works will continue until the end of March at the earliest.



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(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	11/12/2018
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	11/12/2018
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the	Not Compliant	Orange	11/12/2018

	measures and actions in place to control the risks identified.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Not Compliant	Orange	11/12/2018
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	11/12/2018
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	11/12/2018
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	11/12/2018
Regulation 28(1)(c)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	11/12/2018
Regulation 28(1)(d)	The registered provider shall make arrangements for	Not Compliant	Orange	13/12/2018

	staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	13/12/2018
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/03/2019
Regulation	The registered	Not Compliant	Orange	13/12/2018

28(2)(iv)	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.			