Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Fairview
Name of provider:	Gheel Autism Services CLG
Address of centre:	Dublin 3
Type of inspection:	Short Notice Announced
Date of inspection:	11 April 2024
Centre ID:	OSV-0005301
Fieldwork ID:	MON-0043068

About the designated centre

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

Fairview is a designated centre operated by Gheel Autism Services CLG. The designated centre is comprised of multiple housing units, most of which are located on the provider's campus. On campus, there are three group houses and five single occupancy apartments and an off-campus, one single-occupancy house. The centre has capacity to accommodate 18 service users in total. Fairview designated centre is situated in a suburban area of Dublin in close proximity to local amenities and good public transport links. In the designated centre, there is a focus on supporting individuals with autism through their life journey and enabling them to have fulfilling life experiences, while having autonomy and control over their choices and decisions. Within the model of support, the staff team actively contribute to the fostering of positive relations with the local community and in particular with those living in the immediate neighbourhood to build networks and connections with the people supported to enhance their community participation and quality of life. The centre is managed by a person in charge who is supported in their role by location managers and a staff team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	17

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 11 April 2024	10:30hrs to 17:30hrs	Gordon Ellis	Lead

What residents told us and what inspectors observed

This was a short notice announced risk inspection that focused on regulation 28: Fire Precautions and regulation 23: Governance and Management.

This centre is comprised of multiple housing units, most of which are located on the provider's campus. On campus, there are three group houses namely; The Villa, The Bungalow, Georges House and five single occupancy apartments together known as The Apartments. These areas are covered on this current inspection.

Each of the housing units had a designated location manager who reported to the person in charge. Location managers were present in each house and were available to discuss the fire safety aspects of their unit. Staff were being very attentive and respectful to residents who were mobilising around the centre, coming and going throughout the day.

The inspector had the opportunity to meet residents, some of whom spoke of their interests and their positive time in the designated centre. Some residents showed the inspector their pets and personal belongings. Residents moved freely around their home and appeared comfortable and relaxed.

Fire safety risks had been identified during a previous inspection in February 2024. During this inspection, a number of fire risks had been identified in regards to; deficiencies of fire doors, inadequate means of escape, a lack of emergency lighting to external areas, the management of keys to fire exit doors and day-to-day arrangements of fire precautions. An immediate action was issued to the provider in regards to inappropriate storage of flammable items and untidy housekeeping in a boiler room. This was addressed on the day of the inspection. This and additional fire safety risks will be discussed in detail in the next two sections of the report.

During the walk around examples were evident where the provider had carried out minor repairs to fire doors and was in the process of assessing fire precautions, procedures and documentation as an interim measure until fire safety works were completed. Furthermore, the provider was in the process of having a full fire safety risk assessment report carried out on the designated centre. The fire safety risk assessment report was not available on the day of the inspection but was submitted post the inspection. This will be discussed in detail in the next two sections of the report.

Fire evacuation floor plans were displayed in each unit. However, they were not up-to-date in some of the units and did not reflect the current layout.

The fire alarm panel was located in each unit and was noted to be free of faults. Fire extinguishers were present throughout and were serviced. Staff spoken with demonstrated a good knowledge of the evacuation procedure in place, however the emergency response plans and the fire action notices on display were found to not

be reflective of the localised fire action for staff.

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 short notice announced risk inspection of Fairview found that the governance and management of fire safety was not robust and did not adequately support effective fire safety arrangements to keep residents safe.The oversight of fire safety management and the processes to identify, and manage fire safety risks were not adequate 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.

The aim of the inspection was to monitor the designated centre's compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and to follow up on the provider's progress with addressing actions from a previous inspection.

The provider of the designated centre is Gheel Autism Services CLG. There were local managers in each location who reported to the person in charge.

Subsequent to the previous inspection on February 2024, the provider had made a commitment to engage a competent fire consultant to carry out a full audit and assessment of fire safety arrangements within the designated centre and to produce risk rated recommendations to the provider. This assessment was not available on the day of the inspection but was subsequently submitted to the Chief Inspector.

The assessment dated April 2024 identified a number of red rated and orange rated risks throughout the buildings on the campus in regards to; fire doors, service penetrations, recording of servicing and inspection of kitchen cooking, inappropriate storage practices of combustible materials, fire exit doors fitted with locking mechanisms, means of escape, fire training and in-house fire checks. The findings of this inspection aligned with the providers' assessment.

The provider had carried out minor repairs to fire doors, emergency lighting and was in the process of assessing fire precautions, procedures and documentation as an interim measure until fire safety works were completed. Notwithstanding this, repeated findings were identified from the previous inspection. A fire door was found to be wedged open and a fire door glass panel had been replaced with Perspex. Furthermore, an immediate action was issued to the provider in regards to inappropriate storage of flammable items and untidy housekeeping in a boiler room.

The findings relating to fire safety are set out in greater detail in the quality and safety section of the report.

Regulation 23: Governance and management

The management systems in place in the designated centre failed to ensure that the service provided was safe, appropriate to residents' needs, consistent and effectively monitored.

The oversight of fire safety in the centre was not fully robust and did not adequately support effective fire safety arrangements to keep residents safe. For example:

- An immediate action was issued to the provider on the day of the inspection in regards to inappropriate storage practices of flammable items in a high risk room.
- The day-to-day management of fire risk in the centre did not ensure that risks were identified and managed effectively. These findings are set out under Regulation 28.
- The inspector was not assured fire safety training being delivered was in compliance with respect to the content and application. For example, training content reviewed did not include fire prevention, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.
- A review of the emergency response plans and the fire action notices on display concluded they were not reflective of the localised fire action for staff.
- Subsequent to the inspection, the provider had submitted their own fire safety risk assessment carried out by their competent fire person dated April 2024. The report had identified a number of red and orange rated fire risks that required action.

Judgment: Not compliant

Quality and safety

This section of the report details the quality of the service and how safe it was for the residents who lived there. Overall, the oversight of fire safety management and prevention in the centre was not fully robust and did not adequately support effective fire safety arrangements.

Fire safety risks had been identified during a previous inspection in February 2024. A number of fire containment risks had been identified in regards to; fire doors missing closers, doors had signs of damage and doors were being wedged open. Risks in regards to fire prevention, records and policies had also been identified.

Following the findings of the previous inspection, the provider had arranged for a full fire safety risk assessment to be carried out and had submitted the same report some weeks after this inspection.

Significant fire safety risks were identified in the fire safety risk assessment and on this inspection, particularly in regards to inappropriate storage practices, means of escape, fire-containment, visual deficiencies to fire doors and a lack of emergency lighting. All of which could lead to serious consequences for residents in a fire emergency.

On this inspection, the provider had carried out minor repairs on some of the fire doors and emergency lighting. Fire procedures and records were under assessment. Notwithstanding this, a fire door was noted to be wedged open and a fire door glass panel had been replaced with Perspex. This was a similar finding from the previous inspection. Furthermore, an immediate action was issued to the provider in regards to inappropriate storage of flammable items and untidy housekeeping in a boiler room.

The findings relating to fire safety are set out in greater detail under Regulation 28: fire precautions.

The units were laid out with a sufficient number of escape routes and exits. The travel distances, corridors, stairwell, exit widths and low occupancy numbers to staff ratios were sufficient to allow efficient evacuation in the majority of locations. Notwithstanding this, a number of final exits from the group units had steps immediately down from final exits which would not be appropriate for residents in the event of an evacuation.

A number of final exits both internally and from enclosed external areas required keys. Staff did not carry a copy of these keys. This created a risk of a key being misplaced and could cause a delay in the event of an evacuation. Most exits had keys located at the final exits except for a garden gate that was locked on the day of the inspection.

Externally, a number of escape routes required maintenance from vegetation and to ensure they were free from obstacles. At the Villa, the ground conditions and levels required a review. Two external escape routes were over soft ground. The width of a path from a fire exit was narrow in places and changed in level, which would not be suitable for residents to use in the event of an evacuation.

Furthermore, insufficient external emergency lighting was observed along external pathways of three of the units. This created a risk during night time evacuations as residents and staff would not have the required illumination afforded to them in order to evacuate and reach the designated fire assembly points.

At the end of a corridor in the Villa, a designated means of escape was through a self-contained living accommodation. The inspector reviewed the external area around this accommodation and the floor plans that indicated the layout and configuration of this area.

It was evident the escape route from this area could not be maintained at all times to ensure it was free from obstruction and could not be relied upon in the event of a fire emergency. Based on this review, assurances were required if this was a suitable means of escape.

The records provided on the day of inspection showed that the fire detection alarm systems, emergency lighting and fire extinguishers were maintained and serviced. Maintenance records of daily and weekly inspections by staff were under assessment. These were recorded and up-to-date. However, fire risks had not been identified by the provider or staff in the in-house checks and additional checks were required to be added in regards to visual checks of fire doors and electrical fittings.

Additional concerns were identified in regards to the staff training, evacuation floor plans and giving warning in the event of a fire. These and other fire safety concerns are detailed further under Regulation 28: Fire Precautions.

Regulation 28: Fire precautions

The registered provider had failed to meet the regulatory requirements on fire precautions and improvements were required by the provider in other areas to ensure adequate precautions against the risk of fire in the centre.

Day-to-day arrangements in place in the centre did not provide adequate precautions against the risk of fire. For example:

- An immediate action was addressed on the day of the inspection in regards to inappropriate storage of flammable items and untidy housekeeping in a boiler room. This was highlighted to the person in charge and staff who arranged for the removal of these items on the day.
- Items were being stored under a stairwell on the day of inspection. While these were minor items, there was a risk that the quantity of items could increase over time which could potentially create a fire load and compromise this escape route.
- A fire door into a utility room was found to be wedged open. This interfered with the closing mechanism and created a risk of fire and smoke to spread with ease.

Arrangements for the means of escape, including emergency lighting were not adequate. For example:

A number of final exits at the Bungalow, Villa and Georges House had immediate steps down from the threshold of the final fire exits. This required a review as the change in levels were not suitable for a means of escape.

External escape routes from all units required a review to ensure the routes were not obstructed, were level, were free from vegetation and were provided with a hard surface suitable for safe egress. For example, at the Apartments an external

escape route was obstructed by a cleaners store and the path was over grown with vegetation. At the Villa, both escape routes were over soft ground with changes in gradients and the width of the path was narrow in places.

External areas of the units were noted to be lacking emergency lighting along external escape routes. This required a review in order to provide adequate illumination to all external evacuation routes in the event of a night time fire evacuation.

A number of final fire exits although openable, were fitted with locking mechanisms. Keys were located at most of the final exits except for a garden gate that was locked and located on an escape route. Furthermore, staff did not carry a copy of a key for these fire exits. All fire exit should be readily openable to ensure instant egress from a building in the event of a fire emergency.

In addition to this, a garden gate located on an escape route was in a bad state of repair and could not be fully opened. This created a risk to the safety of the residents from a delayed or obstructed access to a fire exit in a fire emergency.

In the Villa, a designated fire exit indicated a means of escape through a residents self-contained accommodation unit. Assurances were required if this was a suitable means of escape. The escape route could not be maintained at all times to ensure it was free from obstruction and could not be relied upon in the event of a fire emergency. This was identified in the providers' fire safety risk assessment.

Window restrictors in the majority of residents' bedrooms were fixed and did not allow for a window to be opened fully for escape purposes. This created a risk of a delayed or obstructed access to an alternative means of escape in a fire event.

Adequate arrangements were not in place for the maintenance of the means of escape and the building fabric. For example:

In the self-contained apartments, access and egress from the residents' bedroom to the fire exit was past their kitchen area. As a kitchen is a high risk area, this has potential to comprise a means of escape for residents in a fire event. Suitable mitigating measures should be put in place by staff to ensure all kitchen appliances are regularly serviced and checked that they are turned off during night time hours.

Areas in some of the units 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. These were evident in a laundry, hot press and electrical rooms.

Some fire doors had signs of damage and holes that compromised the fire rating. Fire seals were missing in places and some smoke seals had been painted over, which rendered them ineffective.

The provider needed to review fire precautions in the centre. For example, In-house checks were being carried out in regards to means of escape, fire hazards, emergency lighting and were documented. However, in the Bungalow an immediate

action was identified in regards to a fire hazard in a boiler room. Furthermore, an external means of escape was not adequate due to a garden gate being unable to be opened. These risks had not been identified by the provider or staff in the in-house checks. Furthermore, visual checks in regards to fire doors and electrical fittings did not form part of the in-house checks.

Arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures required improvement. For example:

While the majority of staff had completed fire safety training, four staff were overdue fire training. The inspector was informed a date in June was scheduled to for all staff to be up-to-date with fire training.

The content of fire training covered by staff was not clearly defined. Assurances were required in regards to fire safety training being delivered and if it was in compliance with respect to the content and application. For example, training content reviewed did not include fire prevention, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Furthermore, key operated break glass units to raise the fire alarm in the apartments were in operation. However, it was not clear if this procedure was part of the fire training to ensure staff were familiar.

Arrangements for containment of fire and detection in the event of a fire emergency in the centre required were not adequate. For example:

Assurances were required in regards to the ability of a selection of fire doors to prevent the spread of smoke and fire. Numerous fire doors had gaps, fire seals were either damaged or missing and some smoke seals had been painted over. Hinges and ironmongery in places did not appear to be fire rated.

Doors and glazing to areas appeared to not meet the required fire rating. A laundry fire door had been fitted with a perspex panel. Ceiling hatches, electrical rooms and store rooms did not appear to be fitted with a fire door. Furthermore, a number of bedrooms, offices and store room doors were not fitted with door closers. In addition to this, two store rooms along a corridor in the Villa unit were lacking fire detection.

These deficiencies posed a risk to residents in the event of a fire.

Arrangements for giving warning in the event of a fire required improvement. For example:

The fire detection alarm system was not fully interconnected for all of the units. This meant when a fire was detected in a specific unit it was not communicated between the remaining units. Staff had stated they would call each unit to inform them if a fire was detected in their unit. However from a review of the emergency response plans and the fire action notices on display, they were found to not be reflective of

the localised fire action for staff.

Arrangements in place for the person in charge to ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre required improvement. For example:

- The fire evacuation floor plans in most units did not accurately reflect the layout and required more detail. In the Bungalow, the location of an electrical store and a boiler room were not indicated on the floor plan. In the Villa, two store rooms along a corridor and the position of some fire doors were not indicated.
- Furthermore, fire action notices on display in the Villa were blank and were not filled out with information for staff to follow in the event of a fire.

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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

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

Compliance Plan for Fairview OSV-0005301

Inspection ID: MON-0043068

Date of inspection: 11/04/2024

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider has commissioned a competent fire safety professional who has commenced the review and update of the relevant policy in June 2024, namely PP1008 The management of internal emergencies and this policy will be updated by October 2024.

This review has commenced in tandem with the assessment of all of the other designated centers across the organisation. The provider is reviewing our internal emergencies policy and a standalone fire policy will be created by October 2024.

Upon completion of the new fire policy, training will be provided to all staff, accompanied by a video available on our internal training system for all staff. This training will be part of our mandatory training program and will complement our existing fire safety training. The PIC fire safety orientation training will be enhanced following the publication of the new fire policy by October 2024. Governance on training compliance will continue to be monitored by the PIC and location managers to ensure that all staff have completed this training. Fire safety will continue to feature as a standing item on agendas at team meetings in the designated centre.

Additionally, We have enhanced and improved our bi-annual audits which will provide greater oversight of our new and informed fire and health and safety registers. This includes detailed review of all inspections of all fire safety equipment, evacuation routes, and emergency procedures. This proactive approach not only captures immediate safety concerns but also tracks follow up to previous action items to ensure they are closed out on. The bi-annual audit, fire and health and safety registers and quality and safety walkaround template enhancement was completed in June 2024. These internal checks and audits will commence in July 2024 across the designated centre by staff team, location manager, PIC and the quality and safety team. Our audit process will review

floor plans to ensure they are reflective of the blue print of the homes and any adaptations to the homes have been incorporated following the Architects review and update of floor plans which is due to be completed by the 9th July 2024.

The PIC has developed a new Staff Fire Safety Orientation – Specific to Fairview OSV-0005301 to enhance risk management to address risks identified in the inspection report and subsequent risk assessment from fire safety specialists. The Fire Safety Orientation will be delivered to all current staff in the designated centre and as of 02/07/2024;

• Villa staff - 88% complete (One staff long term sick leave and one staff on annual leave).
• Bungalow staff - 76% complete (two staff on maternity leave and one staff on long term sick leave)
• Apartments staff – 69% complete – (four staff have not completed training, two of these staff are relief and have not been on shift, one staff is on annual leave and the other staff is a new member of staff that will cover this in their induction).
• Georges House staff – 66% complete (one staff is on maternity leave, one staff is on long term sick leave and the third staff is a new staff member which will cover this in their structured induction).

The Fire Safety Orientation will be delivered to all staff that have not completed their training when they return from leave and going forward, training will be delivered to all new staff as part of their induction to the designated centre as they onboard. The PIC fire safety orientation training will be enhanced following the publication of the new fire policy by October 2024.

In line with the fire safety risk assessment the orientation will cover the following areas;

• Staff training and management of internal emergencies policy (will include new standalone fire policy).
• Panel and break glass usage
• Escape routes and local action
• Panel reading
• Assembly points and fire equipment
• Evacuation aids and emergency packs
• Building layout and call points
• First aid supplies
• Smoking and vaping guidelines
• Fire drills and fire door checks procedures
• Identifying fire safety risks and risk escalation
• Storage of flammable items
• Emergency response plans (ERP)
• Personal emergency evacuation plans (PEEPS)
• Location registers and responsibilities
• Local information
• Floor Plans

This orientation will be completed by all current staff by 31st July 2024. The overall fire safety induction, training and experience has been enhanced through the Fire Safety

Orientation specific to Fairview which will be completed by all staff in addition to the completion of the general Fire Awareness Training already in place which meets the recommendations from the fire risk assessment report. The PIC has designed a new specific induction for FV designated centre to include the fire safety orientation and will be further informed by the completion of our new fire policy by November 2024.

In addition to our fire safety training we are developing and updating a standalone fire safety policy. We are creating a mandatory training video to deliver to all staff to accompany the new fire policy. Local training will be delivered by location managers to staff teams in the policy and the local Emergency Response Plans which includes fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid firefighting equipment, fire control techniques and arrangements for the evacuation of residents. Compliance of this training will be captured in the health and safety and fire resisters, quality and safety walk around and bi-annual audits.

Immediate action regarding the inappropriate storage practices of flammable items in a high risk room were actioned on the day of the inspection and made safe. Furthermore, newly informed fire and health and safety registers accompanied with the new Staff Fire Safety Orientation specific to Fairview are in place to ensure these practices do not reoccur. The PIC following the immediate action issued during inspection in regards to inappropriate storage practices of flammable items in a high risk room. Cleaning schedules are now in place to prevent schedules in place now across the designated centre to ensure there is no storage of flammable items in high risk rooms.

The provider has commissioned an architect to design updated floor plans for the designated center following the architects review which will be rolled out across the DC and relating documents. The new floor plans are scheduled for completion on July 9, 2024.

The provider has designed a revised organisational chart that reflects Fairview Designated Centre's enhanced governance and reporting structures which will support staff to report and escalate risk appropriately. The organisational chart is included in the Fairview OSV-0005301 Staff Fire Safety Orientation, displayed in all locations and discussed during team meetings to enhance fire safety awareness and risk escalation and management of risk. This revised organisational chart will be integrated into the upcoming Risk Awareness Program training, currently being developed by the Quality and Safety Team and scheduled for completion by October 2024. This new training initiative will be implemented across all Fairview designated centre staff by December 2024. It aims to strengthen fire safety awareness among staff, facilitating the identification and management of fire risks. It ensures that all staff and residents have a clear understanding of the lines of authority and accountability at all levels concerning fire safety.

Fire safety is now included as a standard agenda item at management meetings and designated centre level since May 2024.

The Person in Charge (PIC) has implemented a system to maintain continuous oversight of training. Since April 2024, this now includes fire safety training and all mandatory

training to include HSeLand. This system is managed and discussed at monthly meetings (PIC and location managers) and driven locally by location managers.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC ensures all staff complete Gheels' online fire safety training, integrated into monthly meetings and new staff inductions since June 2024. Compliance is monitored by location managers using new software, reviewed with the PIC monthly since April 2024.

The PIC developed Fairview OSV-0005301 Staff Interim Fire Safety Orientation addressing inspection risks. This, in addition to the training outlined under Regulation 23 of the compliance plan, includes:
• Proper storage of flammable items.
• No door stops unless integrated with fire safety systems.

All Fairview staff to complete fire safety orientation training by July 31, 2024, including those on leave. Staff returning from long-term sick leave will complete required training before shifts. The PIC oversees training progress, collaborating weekly with location managers for full compliance.

Immediate post-inspection actions addressed risks like removing items under stairwells and keeping utility fire doors closed. The PIC communicated these practices to location managers. Weekly fire containment checks ensure effectiveness, reported promptly to PIC and location managers. Immediate post-inspection actions included removing items from under stairs and ensuring utility fire doors remain closed. Practices communicated via meetings, emails, and online postings since April 2024. Fire Safety Orientation training integrated for ongoing compliance and awareness. Fire safety is a regular agenda item.
Escape Route and Safety Enhancements: Following a specific fire safety engineer review in June 2024:
• Residents' room proximity to exits confirmed compliant under 10 metres.
• Scheduled installation of new Villa windows will begin by July 31, 2024, aligning with fire safety standards.
• All residents capable of recognising and escaping fire events through room windows if corridors obstructed.
• Daily checks of secondary evacuation pathways enacted post-inspection, overseen by Villa's location manager and PIC. Communication via meetings, emails, and online posts since April 2024. Staff sleeping quarters relocated, apartment door keypad replaced for immediate access, enhancing safety protocols.

The fire engineer confirmed the Villa's escape routes, indicating the apartment door is unlikely to be intentionally obstructed. Daily checks and increased staffing levels ensure readiness. An additional rear exit/entrance door guarantees external access if blocked.

Daily pathway inspections were implemented after the inspection. All residents are capable of responding to alarms or receiving evacuation support, and bedroom travel distances comply with regulations

Provider commissioned a fire door specialist in April 2024. Remediation work in progress and on schedule to be completed within the three month timeline outlined in fire safety risk assessment. All works will be completed by 31st of July 2024. The provider and PIC continue to monitor weekly.

Emergency Response Plans (ERPs) have been detailed and communicated through fire action notices. The PIC will oversee ERP updates pending new floor plans from the architect by July 9, 2024, with final updates due by July 31, 2024. Bi-annual audits will ensure floor plan accuracy and verify staff ERP knowledge and will be further informed with publication of our new fire policy.
All ERPs now include procedures for notifying units of detected fires. Updated ERPs, prominently displayed in each location, cover building layouts, escape routes, fire alarm call points, first aid and firefighting equipment, and resident evacuation arrangements in personal evacuation plans.

Location managers will train staff on the local ERP and policy PP1008 'Management of Internal Emergencies' during team meetings. Fire prevention and control techniques are included in the PP1008 policy and online fire safety training. Fire safety and health and safety registers have been enhanced to identify risks, with PIC and location managers reinforcing risk escalation processes through team meetings.

Quality and Safety team is developing a standalone Fire Policy, for completion by October 31, 2024. Staff training, including a video accessible via our internal system, will integrate this policy into our mandatory training program, enhancing existing fire safety protocols. PIC fire safety orientation will be updated following the policy's release, scheduled for November 2024.
Training compliance will continue to be monitored by management to ensure that all staff have completed necessary training. Fire safety will continue to feature as a standing item on agendas at team meetings in the designated centre.

The quality and safety team have enhanced and improved our audits in June 2024 which will provide greater oversight of our new and informed fire and health and safety registers. This includes detailed review of all inspections of all fire safety equipment, evacuation routes, and emergency procedures.

Fire door specialist commissioned, compliance target by July 31, 2024. All door glazing that did not meet fire rating was replaced in May 2024. Door closers have been fitted to final exit doors across the designated centre in May 2024. Fire safety signage has been reviewed and across the designated centre and will be completed by 31st July 2024.

The PIC has ensured all gates across the DC were repaired, keys removed for improved access and egress since May 2024.
Window restrictors removed across the DC, in May 2024. Villa windows upgraded by the 31st July 2024.
Additional Fairview Villa fire detectors installed in June 2024. Additional lighting installed

in the Bungalow, self-contained Apartments and will be completed along Villa evacuation routes by August 2024.
Vegetation cleared, pathways widened at Villa, solid escape path creation underway by July 2024.
Final exits clearance ramps commissioned by the provider and scheduled for completion by 31st July 2024.
Self-contained apartments access and egress from residents bedroom was assessed by fire engineer and the PIC and LM have incorporated daily evening checks to ensure all kitchen appliances are turned off during night time hours.
Kitchen fire checks and boiler rooms are now checked and monitored daily, integrated into health and safety and fire registers, included in fire training and orientation for new staff.

The provider commissioned and completed the sealing of all recommended service penetrations across the designated centre in June 2024 and thumb locks were installed on all final exit doors in May 2024.
The provider has substantially addressed risks identified in the April 2024 fire safety assessment, completing 74% of identified items. Mitigating measures include relocating staff sleeping quarters in the Villa, daily risk checks for obstructions behind the apartment door, and additional staff support for Villa residents. Installation of new windows in the Villa, expected by August 2024. Provider will assess alternative escape routes via windows in accordance with a specific fire engineer review. Attached letter from the interim CEO for time bound action plan that aligns with the level of risk for each item on the risk assessment.

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(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/11/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/10/2024
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of fire in the designated centre, and, in that regard, provide suitable fire fighting	Not Compliant	Orange	31/10/2024

	equipment, building services, bedding and furnishings.			
Regulation 28(2)(b)(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	31/10/2024
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/10/2024
Regulation 28(2)(c)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	31/10/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	31/10/2024
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for giving warning of fires.	Not Compliant	Orange	31/10/2024
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and	Not Compliant	Orange	31/10/2024

	escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 28(5)	The person in charge shall ensure that the procedures to be followed in the event of fire are displayed in a prominent place and/or are readily available as appropriate in the designated centre.	Not Compliant	Orange	31/10/2024