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:	No.5 Stonecrop
Name of provider:	Corlann
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	19 May 2026
Centre ID:	OSV-0005144
Fieldwork ID:	MON-0042379

About the designated centre

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

No.5 Stonecrop consists of a semi-detached house located in a suburb on the outskirts of a city. The centres can provide full-time residential care for a maximum of four male residents, over the age of 18, with intellectual disabilities including those with autism who may have multiple/complex support needs that may require support with behaviours that challenge. Each resident has their own individual bedroom, one of which has an en suite bathroom, and other rooms in the centre including a kitchen, a dining room, a living room, a main bathroom and a staff office. Support to residents is provided by the person in charge, a social care leader, social care workers and relief care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Tuesday 19 May 2026	10:00hrs to 18:00hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

This inspection was conducted to assess compliance with regulations to inform an expected registration renewal application for the centre. During the course of this inspection, the inspector met all four residents living in the centre and also spoke with one staff member, a social care leader, the person in charge, an area manager and a sector manager of the provider. Overall, a good level of compliance was found during this inspection which indicated that residents were well supported. Some regulatory actions were identified though in areas such as fire doors, the directory of residents and a lone working risk assessment not being followed.

On arrival at the centre, three of the four residents living in the centre were initially elsewhere attending day services. The fourth resident was present and was introduced to the inspector by the staff member present. While this resident did not engage with the inspector, the staff member outlined how the resident had gone on tours of Thomond Park in Limerick and the Guinness Storehouse in Dublin. The same staff member also highlighted how residents did various activities such as horse riding and swimming with other activities planned such as going to the circus.

The resident that had initially been present left the centre shortly into the inspection. As no residents were then present, the inspector focused primarily on reviewing documentation having already spoken with a staff member and members of centre management. Amongst the documentation that was reviewed were surveys that staff working in the centre had supported each resident to complete. These surveys were noted to contain positive responses to all questions asked in the survey. This included questions such as "Do you feel safe?", "Do staff help you when you need it?" and "Is this a nice place to live?"

It was seen that the house provided for residents to live in was clean, homely and well-furnished on the day of inspection. Communal space was provided via a kitchen, a dining room and a living room with each resident having their own individual bedroom. Such bedrooms were seen to be personalised to residents. For example, one resident's bedroom had photographs of the resident and their family on display while another had a colourful mural of horses on one bedroom wall. The external areas to the house were seen to be reasonably maintained also. This included a small garden and patio area to the rear of the house.

During the afternoon of the inspection residents began to return to the centre. To support the needs of one of these residents, the inspector was requested to go the centre's staff office before residents returned with the inspector following this request. The inspector met the resident in question shortly after they returned to the centre in the staff office. This resident shook the hand of the inspector but otherwise did not engage with him. This resident was soon supported to leave the centre for an outing with a staff member and was not met again.

Two of the other residents were also met after their return but neither of these residents interacted with the inspector. Both were seen to move freely throughout the centre with one of these helping to set the table for a meal of fish and chips that was being prepared in the centre. These two residents appeared comfortable in their environments and around management of the centre who were present at the time. Such management and the staff member on duty were overheard to be pleasant in their general interactions with all residents during this inspection with the overall atmosphere on the day being quiet and relaxed.

While the inspector was in the staff office, another resident came there to meet the inspector in the presence of the social care leader. This resident seemed happy when they met the inspector and indicated that they liked living in the centre. They spoke of some of the things they did such as attending day services, going to choir, going swimming and getting coffee out. It was also mentioned by the resident that they had gone on a recent overnight stay in Killarney and they talked about some of the things they did there. This included going on a horse and cart.

The resident then showed the inspector their bedroom. While doing so the resident pointed out the colour of the walls which was painted yellow (the resident's favourite colour). The resident pointed out their bed spread and their CD player while also showing the inspector their en suite bathroom. It appeared that the resident was very proud of their bedroom and seemed happy to be showing it to the inspector. After this the resident spent some time using a treadmill in the living room before saying goodbye as the inspector was leaving the centre.

In summary, all four residents living in this centre were met during this inspection but three of these did not significantly interact with the inspector. The fourth resident did talk with the inspector and showed the inspector their bedroom. The resident appeared proud of this bedroom and the house where residents lived was seen to be well presented on the day of inspection. Residents attended day services during the inspection day and also did activities such as horse riding and swimming. Regulatory actions identified during this inspection will be discussed elsewhere in this report.

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

Capacity and capability

It was found that the management and monitoring systems in place for the centre had resulted in an overall good level of compliance. This indicated that residents were being well-supported in the centre.

This centre was registered until December 2026 without any restrictive conditions and had been previously inspected on behalf of the Chief Inspector of Social Services in January 2025. That inspection was focused on the area of safeguarding and, although no significant safeguarding concerns were raised then, some areas for improvement were identified. These included copies of relevant standards not being in place and some identified actions not being followed up on. A satisfactory compliance plan was submitted in response to the January 2025 inspection which outlined the measures the provider was going to take to come back into compliance.

With the provider expected to submit an application to renew the registration of the centre, the current inspection was conducted to assess compliance in more recent times. Overall, this inspection found good compliance in key regulations. For example, it was found that the provider was meeting regulatory requirements under Regulation 23 Governance and management such as conducting provider unannounced visits to the centre every six months. Appropriate staffing was also generally being provided in the centre with such findings contributing to residents being well-supported while living in this centre. Some regulatory actions were identified though in areas such as the directory of residents and the centre's statement of purpose.

Regulation 15: Staffing

Staffing in a designated centre must be in keeping with the needs of residents and the centre's statement of purpose. The centre's statement of purpose, as reviewed during this inspection, outlined specific staffing levels that were to be provided by the centre to meet the needs of residents. Staff rotas reviewed from March 2026 on indicated that such staffing levels were being provided. These rotas, which were maintained in a planned and actual format, also indicated that there was a good consistency of staff working in the centre. Having such a consistency is important in promoting consistent care and professional relationships. However, when reviewing staff rotas, the inspector noted an occasion in April 2026 where a staff member without required training had lone worked in the centre. This will be addressed under Regulation 26 Risk management procedures.

Aside from this, Regulation 15 Staffing requires specific documentation relating to staff working in a centre to be obtained. This documentation includes written references, full employment histories and evidence of Garda Síochána (police) vetting. Documentation for six staff members were reviewed with the majority of the required documentation found to be in place and in order. However, it was identified that a copy of a photo identification one staff member had expired while it needed to be confirmed if relevant qualifications that one staff member had referenced in their documents had been completed or not.

Judgment: Substantially compliant

Regulation 16: Training and staff development

During this inspection copies of relevant standards, guidance documents and the regulations were seen to be present in the centre. Ensuring that copies of such matters are available to staff is required by this regulation and this was an improvement from the previous inspection. This regulation also requires that staff are appropriately supervised. A supervision log for 2025 along with supervision records for 2024 and discussions with one staff member confirmed that core staff were in receipt of formal supervision. Some relief staff also worked in the centre but the inspector was informed that such staff received formal supervision in other designated centres where they ordinarily worked. A training matrix provided indicated that most staff working in the centre had completed relevant training to support residents. However, it was identified that some relief staff had not completed some training but the training matrix indicated that these staff were booked in to receive this training in the coming months.

Judgment: Compliant

Regulation 19: Directory of residents

A directory of residents was in place for this centre which contained most of the required information such as residents' names and their dates of birth. However, it was noted that one resident's date of admission to the centre was inaccurate while the address of the authority, organisation or body that arranged residents' admission to the centre was not included as required. Similar findings had also been highlighted during the June 2023 and January 2025 inspections of the centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

This inspection found an overall good level of compliance which indicated that residents were well supported and that management and monitoring systems were operating effectively. Such systems included:

- An annual review for the centre being completed in December 2025 which assessed the centre against some relevant national standards. This annual review was reflected in a written report which also included feedback from residents and their representatives.
- Three provider unannounced visits to the centre by representatives of the provider had been conducted in April 2026, October 2025 and April 2025. These visits were reflected in written reports and assessed areas relevant to

the quality of safety of care and support provided to residents. This included areas such as staffing, safeguarding and complaints.
- An audit schedule was being followed in the centre which resulted in specific audits in areas such as medicines management being conducted during 2026.
- Weekly reports on events in the centre had completed throughout 2026. These reports were sent to management of the centre for review.

Judgment: Compliant

Regulation 3: Statement of purpose

The centre had a statement of purpose in place that had been reviewed in May 2026. This found to contain required information such as the information set out in the centre's certificate of registration and the specific care and support needs that the centre was intended to meet. It also contained details of the staffing and management details for the centre. However, the following points were noted regarding these:

- The whole-time equivalent for the person in charge that was specific to No.5 Stonecrop was not expressly set out.
- An organisational structure was outlined in the statement of purpose which indicated that the social care leader reported to the person in charge. However, from discussions during the inspection, the social care leader reported to the person in charge for some matters and an area manager for other matters. This was not set out in the statement of purpose.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Information about how to complain was seen to be in display in the centre and was also contained within the centre's residents' guide. Resident meetings notes reviewed for 2026 indicated that complaints was being discussed with residents. Based on documentation reviewed and discussion with centre management, there had only been one complaint made concerning the centre since the January 2025 inspection. Records provided about this complaint indicated that it had been appropriately recorded with follow up action taken in response. This was in keeping with the requirements of this regulation.

Judgment: Compliant

Quality and safety

No restrictive practice nor safeguarding concerns were identified during this inspection with residents supported to pursue activities away from the centre. This indicated that residents were being supported to enjoy a good quality of life. Some issues were noted with fire doors and night-time evacuation in the centre.

The premises which made up this centre was seen to be well-presented on the day of inspection although some consideration was being given to sourcing an alternative premises for residents with a view to meeting future needs. The needs of residents were set out in their personal plans which indicated that the existing premises was suitable for their current needs. Two residents' personal plans were reviewed which had been recently reviewed and contain guidance in areas such as residents' household skills and their health needs. Residents were supported to avail of appointments with various health and social care professionals.

Support was also given to residents with their medicines with the centre equipped with storage for medicines and fire safety systems such as a fire alarm and fire doors. However, issues were observed with some fire doors in the centre while night-time fire drills indicated evacuation times of over three minutes. It was also identified that a staff member had lone worked in the centre without having fire training completed. This was not consistent with a lone working risk assessment that was in place for the centre. While this needed review, no safeguarding concerns nor restrictive practices were identified during the course of this inspection. There was also evidence that residents were supported to take part in activities and outings away from the centre.

Regulation 13: General welfare and development

From discussions with a resident, a staff member and centre management during this inspection, along with the contents of two residents' personal plans reviewed, residents were being supported to pursue activities in the community and to maintain contact with their families. For example:

- Some residents were supported to visit their families away from the centre at weekends.
- All residents attended day services but two residents were also supported to avail of a semi-retirement initiative on certain days of the week.
- Residents were supported to do activities such as swimming and horse riding.
- Support was given to residents to help them achieve priority outcomes identified through the personal planning process followed in the centre. Such outcomes included going on overnight stays away and going to see shows.

- One resident had been supported to purchase a particular drink independently when on certain outings away from the centre.

Judgment: Compliant

Regulation 17: Premises

During the January 2025 inspection, the inspector was informed that the provider was in the initial stages of seeking an alternative premises for residents with a view to better supporting the needs of these residents in the future. On the current inspection, it was indicated that the provider was currently considering an alternative premises for these residents for the same reason. However, management also indicated that the current premises provided for No.5 Stonecrop was meeting residents' current needs. This was also indicated in the personal plans reviewed for two residents.

On the day of inspection, the existing premises was seen to be clean, well-furnished and well-maintained. Some mould had been observed in two residents' bedrooms during the previous inspection but no such matters were seen during the current inspection. The resident bedrooms seen were noted to be personalised and provided with storage facilities. Sufficient communal space was also seen to be provided for.

Judgment: Compliant

Regulation 20: Information for residents

This centre had a residents guide in place which was marked as having been reviewed during April 2026. When reading this guide it was noted that it contained all of the required information including arrangements for resident involvement in the running of the centre. The guide was also presented in an easy-to-read format.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place that had been reviewed in July 2025. This provided guidance for the identification, assessment and management of risk in the centre. Control measures for specific risks including self-harm and unexpected absence were also outlined in this policy. Identified risks in the centre were contained within the centre's risk register. This risk register had been reviewed

in May 2026 with a corresponding risk assessment in place for each risk. Such risk assessments described the individual risks and outlined controlled measures to mitigate these risks. One of these risk assessments covered lone working in the centre and was initially dated 1 April 2026. To mitigate the risks of lone working in the centre, it was indicated that staff lone working in the centre were have training in medicines management, epilepsy, first aid and fire safety. It was identified from staff rotas reviewed that one particular staff member had lone worked in the centre later in April 2026. Based on training records provided for this staff member, they had not completed any training in medicines management, epilepsy, first aid and fire safety. This was not in keeping with the contents of the lone working risk assessment for the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The centre had fire safety systems in place including a fire alarm, emergency lighting, fire extinguishers and a fire blanket. Records provided indicated that such systems were serviced by external contractors to ensure that they were in proper working order. For example, the fire alarm and emergency lighting had received a quarterly maintenance check in April 2026. The centre was also provided with fire doors which are important in preventing the spread of fire and smoke in the event of a fire occurring. However, issues were observed with some of the fire doors in the centre. For example, for one fire door part of a seal in a door frame had come loose while another fire door did not close fully under its own weight.

The procedures to follow in the event of a fire evacuation being required were on display in the centre. Residents also had personal emergency evacuation plans (PEEPs) in place which outlined the supports they needed to evacuate the centre if required. These PEEPs had been reviewed during May 2026. Fire drills were conducted regularly in the centre during 2026 with low evacuation times recorded for day evacuations. However, while two fire drills had been conducted since September 2025 to reflect a night-time situation it was noted that both of the indicated evacuation times were over a three minute evacuation time which the provider was aiming for. It was also noted when reviewing the centre's fire register that a protocol for night-time evacuation of the centre had not been completed in full.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

Appropriate storage facilities were seen to be present in the centre for medicines to be stored securely in. This included storage of controlled medicines with such medicines requiring greater security and oversight given their nature. Daily checks of such controlled medicines were being carried out based on records reviewed for April and May 2026. Medicines records were also reviewed for one resident. These were found to contain all of the required information with such records indicating that the resident received their medicines as prescribed in the week leading up to this inspection. The same resident had also been assessed in August 2025 to determine if they could self-administer their own medicines.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

To comply with this regulation, all residents should have an individualised personal plan in place. Such personal plans are intended to provide guidance for staff on how to support the health, personal and social needs of residents. Two residents' personal plans were reviewed during this inspection. The contents of these residents' personal plans had been reviewed within the previous 12 months and provided guidance on how to support the needs of residents in areas such as their household skills, communications and feeding. These personal plans were also subject to an annual multidisciplinary review during April 2026.

Judgment: Compliant

Regulation 6: Health care

The two residents' personal plans reviewed were found to contain guidance on how to support the health needs of residents in areas such as low blood pressure, epilepsy and diabetes. This was achieved through specific healthcare plans for such needs. These healthcare plans had been reviewed during May 2026 and described the signs and symptoms of each health need while also outlining preventative and management measures for them. Based on further documentation reviewed within residents' personal plans they had undergone an annual health check by a general practitioner in November 2025. Such documentation also confirmed that residents had been supported to avail of appointments with other health and social are professionals including a dietitian, a dentist and speech and language therapist within the past 12 months.

Judgment: Compliant

Regulation 7: Positive behavioural support

This regulation requires that where any restrictive practices are used, including physical, chemical or environmental restraint, that such practices are applied in accordance with national policy and evidence based practice. Based on discussions during this inspection, documentation reviewed and observations on the day of inspection, no physical, chemical or environmental restrictive practices were identified. This indicated that the centre was promoting a restraint free environment.

Judgment: Compliant

Regulation 8: Protection

Since the January 2025 inspection of the centre, the Chief Inspector had been notified of one safeguarding matter from the centre. Documentation provided during this inspection confirmed that this matter had been subject to a preliminary screening with a safeguarding plan put in place. This was in keeping with relevant national safeguarding policy. Aside from this, it was noted that there was a low level of incidents recorded in the centre. This contributed to no safeguarding concerns being identified during this inspection based on documentation reviewed, observations during the inspection and discussions with one resident, centre management and a staff member. This staff member demonstrated a good knowledge of how to respond in the event that a safeguarding concern did arise. Records provided indicated that all staff working in the centre had completed safeguarding training.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and 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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Substantially compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for No.5 Stonecrop OSV-0005144

Inspection ID: MON-0042379

Date of inspection: 19/05/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The person in charge will ensure that all documentation required under Schedule 2 of the Regulations to be kept on file for staff are kept update and has updated the photographic identification for staff member and the qualification of another staff. [22/06/2026]	
Regulation 19: Directory of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 19: Directory of residents: The Provider will work with the Person in Charge to update details on who organised the admission of the resident on the Directory of Residents [19/06/2026]. The Person in Charge has updates one Resident's date of admission to the centre. [12/06/2026]	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The registered provider will ensure that • The SOP clarifies the whole time equivalent (WTE) time of the person in charge specific to this Centre [19/06/2026] • The roster setting out the working hours of the Person in Charge will be available in the centre. [26/05/2026] • All staff are clear that all matters to do with the designated centre should be reported to the person in charge. [26/05/2026]	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures:	

The registered provider will ensure the risk assessment for lone working is reviewed and that all staff have the training identified in the risk assessment when working alone. [22/06/2026]	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The registered provider will ensure; • The issues identified with two fire doors in the report are resolved [22/05/2026]. • That a night time fire drill is re-scheduled [25/05/2026] and the exit time recorded and reviewed to ensure it meets safe egress time. [08/06/2026] • The protocol for night-time evacuation of the centre will be completed in full [10/06/2026].	

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 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	22/06/2026
Regulation 19(3)	The directory shall include the information specified in paragraph (3) of Schedule 3.	Substantially Compliant	Yellow	19/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	22/06/2026
Regulation 28(3)(a)	The registered provider shall	Substantially Compliant	Yellow	22/05/2026

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	10/06/2026
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Substantially Compliant	Yellow	19/06/2026