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:	Liffey 3
Name of provider:	St John of God Community Services CLG
Address of centre:	Dublin 24
Type of inspection:	Unannounced
Date of inspection:	22 June 2026
Centre ID:	OSV-0005785
Fieldwork ID:	MON-0050834

About the designated centre

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

Liffey 3 is a designated centre operated by St John of God Community Services CLG. The designated centre is comprised of two apartments and provides a residential service for up to five adults with a disability. The apartments are located in a South Dublin suburb. Each apartment has individual resident bedrooms, two bathrooms, and a shared living, kitchen and dining area. The centre is staffed by a team of social care workers and health care assistants. Staff are managed by a person in charge who is a social care leader.

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
Monday 22 June 2026	09:30hrs to 18:00hrs	Karen Leen	Lead

What residents told us and what inspectors observed

This report outlines the findings of an unannounced inspection of designated centre Liffey 3 and was completed as part of regulatory monitoring. It was evident that residents were content living in this designated centre and were engaging in activities of their choosing, with appropriate supports in place for residents to promote community engagement. However, improvements were required in relation to Regulation 28: Fire precautions and Regulation 17: Premises.

The inspection found that the fire precautions in the centre had not been subject to thorough review and inspection by the provider. The inspector identified a number of concerns in relation to the containment and evacuation of residents, leading to an urgent action being issued to the provider. This will be discussed further under Regulation 28: Fire precautions.

The designated centre comprised two apartments located in the same complex in South Dublin and was registered for five residents, at the time of the inspection there was one vacancy. The centre is located close to a number of local amenities and public transport. Residents informed the inspector that they have access to transport in the designated centre and also like to use the local transport systems located a short walk from their home. Residents attended local day service settings, drop in day service classes and one resident was in receipt of an individualised service from their home supported by centre staff.

The inspection was facilitated by the person in charge for the duration of the inspection. In addition, the inspector had the opportunity to meet with all four residents, three support staff, the person in a position of management and a member of the providers' senior management team. The inspector used observations and discussions with residents, in addition to a review of documentation and conversations with key staff, to form judgments on the residents' quality of life.

The inspection found that residents availed of a number of activities both in their home and local community. Residents discussed that they like their local area and that they would often go out for meals, attend local music shows or visit the city centre.

The inspector completed a walk-through of both apartments in the designated centre. The first premises visited by the inspector had a number of outstanding maintenance works which required attention. The inspector found that décor of the apartment to be outdated and requiring fresh interior paintwork. In addition, a vacant room in the apartment required flooring to be replaced due to a previous leak and in the main residents' bathroom the ventilation system was not working and there was a strong odour present. The inspector found that upkeep of this apartment a vast contrast to the second apartment visited during the course of the

inspection. The provider had identified the required works, however, there was not date for the works to commence on the day of the inspection.

The second premises in the centre, was decorated in bright and welcoming colours with pictures and achievements of residents presented in frames on communal walls. This premises was home to three residents, each of their bedrooms were personalised and decorated to their tastes. One resident told the inspector that when they moved into the apartment their support staff and family had helped them to pick the items that they would like to have in their bedroom.

On arrival to the first premises, the inspector had the opportunity to meet with one resident who was supported by staff to attend an appointment. The resident was seen to be smiling at staff as they spoke to the inspector and the person in charge. The inspector had the opportunity to meet with the resident on their return from their appointment. The inspector observed the resident enjoying a light snack and refreshment with staff in their dining room. The resident was being supported by two staff, who discussed that the resident was tired from their earlier appointment but that they had plans to rest and go for a drive in the evening if they wished.

Later in the inspection, the inspector spoke to one resident on return from a doctor's appointment. The resident was relaxing in the sitting room watching wrestling. They told the inspector that they love their home. They discussed that they have lived there for a long time and that they get on well with everyone. They said that they see themselves as someone who likes to look out for others. They like to check that everything is okay in their home before they go out and that everyone is happy.

The inspector asked the resident who they would go to if they were not happy or had an issue in their home. The resident responded to the inspector and asked "why would I not be happy? I love my home". The resident said they would talk to their keyworker or the person in charge if they really needed help. The resident told the inspector they have a new key worker but discussed the good relationship they had with their previous keyworkers. The resident spoke positively about the staff team and commented on how the keyworker system was a good way to set goals with a specific person.

The inspector briefly met one resident on return from their day service. The resident indicated to staff that they were very tired and would like to rest and not meet with the inspector.

The inspector had the opportunity to speak with staff throughout the inspection process. Staff spoken to were knowledgeable of residents' assessed needs and had identified required supports in the house that would further benefit the lived experience of each resident. The inspector found that the atmosphere in the centre was that of a light hearted nature with residents making jokes and laughing with staff. Residents spoke to the inspector about their planned holidays and how staff support them when they need some help to achieve certain goals.

In summary, the inspector found that improvements were required in relation to the upkeep of the premises in the designated centre in order to ensure all residents property and belongings were treated to the same standard. Enhancements were

required both locally and at provider level to ensure the appropriate review and assessment of fire precautions in the designated centre.

The next two sections of the report present the findings of the inspection in relation to the governance and management arrangements in the centre, and how these arrangements affected the quality and safety of residents' care and support.

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective the management systems were in ensuring that a good quality and safe service was being provided. Overall, the inspector found that there were effective leadership arrangements which were ensuring that residents were in receipt of good quality of care. However, improvement was required in relation to the providers' oversight and monitoring systems in place.

The provider had ensured that there was a clearly defined management structure which identified lines of authority and accountability. The staff team reported to a person in charge, who was employed in a full-time and supernumerary position. The person in charge was supported in their role by a residential co-ordinator and a programme manager.

There was a newly appointed person in charge for the designated centre who had implemented a suite of local audits and reviews in relation to residents supports and governance systems in the centre. The inspector found that this had increased the oversight of the centre since their appointment in April 2026.

Regulation 14: Persons in charge

The inspector reviewed the Schedule 2 information for the person in charge and found that they had the qualifications and experience to fulfill the requirements of the regulations.

The person in charge had been appointed to the centre in March 2026, the inspector found that during this time they had developed a number of systems for oversight and monitoring and found that they were effective in identifying areas of good practice and areas where improvements were required.

Residents spoken to discussed that the person in charge was very supportive and that they were regularly in the centre to discuss any concerns they might have.

Judgment: Compliant

Regulation 23: Governance and management

The inspection found that the provider while the provider had implemented systems to review the quality of care in the designated centre. These systems included provider led six-monthly unannounced visit and monthly governance and management meetings. The inspector found that a number of actions remained outstanding on the day of the inspection.

The inspector found that the provider had identified a number of actions required to one premises in the designated centre in April 2026 with the inspector finding that for a number of the actions no date for completion had been identified. In addition, the six-monthly audit found highlighted that concerns in relation to the refurbishment and premises had been addressed and completed. However, the inspector found that these actions had only been addressed in one premises in the centre.

Furthermore, the inspector found that the provider led six-monthly audits had failed to identify gaps in the provider's training records. The six-monthly audit completed in April 2026 did not identify a number of gaps in mandatory training for staff in the centre. For example, one staff working in the designated centre for a number of years had not completed training in positive behaviour supports. The training plan was updated by the end of the inspection by the person in charge and all training dates were scheduled for completion.

The inspector acknowledges that the provider is required to place refurbishment and premises concerns through a housing authority external to the provider. However, the inspection found that wear and tear to one premises were having a negative impact on the lived experience of one resident in the centre. This will be discussed further under Regulation 17: Premises.

The provider and person in charge had completed an annual review of care for 2025 for the designated centre. The inspector found that the review had taken into consideration the views of residents and their representatives. The feedback from residents was positive with residents highlighting that they had the opportunity to go on loads of different outings. Residents noted that they had great fun during the year. Residents informed the provider that they wanted to make plans for holidays in 2026. The inspector found that plans were in place for residents holidays, with one resident telling the inspector that they were going through the final bookings with staff using online booking systems.

In addition, the provider had completed an accessible easy-to-read version of the annual review. The easy-to-read annual review was presented to residents at a residents' meeting. The easy-to-read document included a number of pictures of residents participating in activities throughout the year.

The person in charge had been in post since March 2026 and the inspector found that they were implementing a suite of audits in order to enhance the quality of care in the centre and promote staff responsibilities within the centre.

Judgment: Substantially 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 in the designated centre. The inspector found that residents' wellbeing and welfare was maintained by a good standard of care and support. Residents had a good quality of life, and the residents spoken with told the inspector that they were happy living in the centre and with the services provided to them

Improvements were required in relation to the general upkeep of one of the premises in the designated centre and the length of time for identified works to commence. The inspection found that while the provider had identified a number of works to be completed in one premise there was no time line set for the commencement of a number of identified concerns.

Furthermore, improvements were required to the systems in place for the review of fire precautions in the designated centre. The inspection found that a number of daily and weekly checks required on fire containment measures in the centre had not been appropriately reviewed leading to a failure to repair identified issues as highlighted within Regulation 28: Fire precautions.

The inspection found that the person in charge and staff team had put supports in place in order to promote each residents input into the running of their home. Information was made available to residents in accessible and easy-to-read documents. Residents' meetings were occurring in the centre which promoted residents knowledge and further promoted residents ability to self-advocate.

Regulation 10: Communication

The inspection found that residents had access to a number of easy read documents to support them in areas of their care and support. For example, residents meetings were set in an accessible template which residents could access in the centre or through an online QR code system.

The person in charge and support staff promoted each residents chosen form of communication and this was evident throughout interactions on the day of the inspection and the accessible information available to residents.

The inspector reviewed four residents' files and found that each resident had a clear communication support plan in place which identified if the residents required any additional supports in order to enhance their communication with staff and peers in the centre. These supports were found to be in place for residents through a number of different formats such as accessible information, Lámh and easy read documents. In addition, the inspector found that resident were supported by suitably trained staff who were aware of each residents communication support needs. The inspector observed support staff demonstrating clear communication with residents and responding appropriately to residents' requests.

Residents had access to communication systems such as mobile phones, electronic tablets and smart televisions. One resident told the inspector that they like to watch a number of television shows that require WiFi. The resident discussed that the WiFi in their home is always very strong.

Judgment: Compliant

Regulation 17: Premises

The inspector did a walk-through of both apartments that made up the designated centre. The provider had identified a number of refurbishment works required in one premises in the designated centre some of which had been outstanding for over a one year period. The inspector acknowledged that some of the large-scale projects required the assistance of the housing association, and this was causing a delay in the completion of the works. On the day of inspection, the following works remained outstanding:

- Internal paint work required to one premises
- Bathroom repainting and identified mould
- Vacant bedroom flooring requires replacement due to evidence of mould on floor due to previous leak
- Bedroom refurbishment for one resident
- Hanging of personal photographs and pictures

The inspector found that while the provider had identified the premises concerns in the designated centre, on the day of the inspection there was no timeline in place for completion.

The inspector found that for there was a notable contrast between the upkeep and personalised homely atmosphere of both apartments. One apartment reflected a welcoming and warm atmosphere, while the second apartment required visual repairs and decoration. The inspector acknowledges that for one resident the

decoration required was minimal, however, the inspector observed that due to the required internal paint work and general wear and tear the apartment appeared dark and lacked personal representation for the resident.

In addition, during a walk-through of the centre the inspector found the vents in two shower rooms and one staff room in both premises had dust particles in the vent and as a result one was not working.

One shower room was also found to have a strong odour. The inspector found that the poor ventilation in this room was increasing the damp odour. This shower room was the main shower room for one resident in the designated centre.

The second premises in the designated centre was found to be bright and welcoming. Residents' bedrooms were decorated in line with their personal tastes and preferences, with pictures of family and friends decorating the communal areas of the centre.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspector found that one apartment in the designated centre did not have adequate protection and containment measures in place in the event of a fire. This included one fire door that had a large gap from the floor underneath to the bottom of the fire door. The inspector found that the gap to the door frame had not been identified during centre or provider led audits of fire precautions.

Another fire door leading to a staff office was found to have damage to one side of the door due to the use of a plastic door wedge to keep the fire door open in one apartment.

The inspector completed a walk-through of the second apartment in the designated centre and found a second fire door was held open by a small table. The person in charge noted that a magnetic fire door hold which would keep the office door open had been identified as required. This was to keep the door open so residents could freely access the office, however, on the day of the inspection the magnetic holder had not been put in place by the provider and remained outstanding.

During the course of the inspection, the person in charge updated the fire risk assessment to highlight the containment issues identified during the course of the inspection. The fire risk assessment was updated to ensure that fire doors remained closed and that objects used to wedge doors were removed. Residents had appropriate support from staff in order to evacuate in the event of a fire and there was three night staff in place in the designated centre. Residents spoken to in one premises in the centre, could fully explain the fire evacuation process to the inspector and what they would do in the event of a fire.

The inspector completed a review of the designated centres daily and weekly fire checks and found gaps in the recording of weekly checks on fire doors in the designated centre. The documentation demonstrated that from 13 April 2026 to the 11 May 2026, fire doors in one apartment in the designated centre had not been manually checked. During the course of the inspection, the inspector found that in addition to the previously discussed fire door concerns, three doors in the centre did not close when activated. Once brought to the attention of the person in charge, a qualified technician attended the designated centre and fixed the three doors identified by the inspector.

The inspector found a plug socket had not been fixed appropriately to the wall, this plug socket was placed in a utility room, the fire door to this utility room was one of the fire doors found by the inspector to not close.

On review of residents personal emergency evacuation plans (PEEPs) the inspector found that additional information was required in order to support staff practice in the event of a fire evacuation. For example, for one resident the PEEP noted that the resident may refuse to evacuate. On review of the PEEP and fire evacuation drills there was no guidance to support staff in how they may engage with the resident to evacuate. The person in charge and support team discussed the PEEP with the resident during the course of the inspection and updated the PEEP in order to provide greater support.

The inspector found that fire drills were occurring in the designated centre in line with the provider's fire policy and fire plan. The provider had ensured that fire fighting equipment and emergency lighting systems were subject to review in line with the regulations by an appropriated qualified person.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The provider had ensured that where residents required behavioural support, suitable arrangements were in place to provide them with this. The inspector reviewed one positive behaviour support plan in place for residents and one support plan that promoted residents well being. The inspector found that each plan incorporated the residents lived environment and included their likes and dislikes. The inspector found that the plan was detailed in a manner that could guide staff practices and support new staff in the centre who were being introduced to residents and their supports.

Clearly documented de-escalation strategies were incorporated as part of residents' behaviour support planning with accompanying well-being and mental health support plans.

Staff had up-to-date knowledge and skills to respond to behaviour that is challenging and to support residents to manage their behaviour.

Restrictive practices were regularly reviewed with clinical guidance and risk assessed to use the least restrictive option possible.

Judgment: Compliant

Regulation 8: Protection

At the time of the inspection, there was two open safeguarding plans in place for residents in the centre. The inspector reviewed the safeguarding plans and found that there was appropriate support measures in place in order to protect residents.

The inspector found that the provider had developed easy-to-read communication document for residents in order to explain safeguarding plans and the systems and reviews the provider had put in place in order to support the reduction of possible safeguarding concerns.

In addition, staff working in the centre completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with were knowledgeable about their safeguarding remit. The inspector reviewed staff meetings held from March to June 2026 and found that the person in charge was presenting staff with different scenario in relation to possible allegations of abuse or forms of abuse. The inspector found that the topics were discussed in detail and demonstrated staffs awareness of safeguarding procedures.

Judgment: Compliant

Regulation 9: Residents' rights

Through speaking with and observing residents and staff, and reviewing evidence related to care plans and personal objectives, the inspector found good examples of how the rights and choices of residents were being protected and respected. Staff demonstrated a good knowledge of residents' preferences in their routine, activities, and living spaces.

The inspector spoke to two residents during the course of the inspection and they informed the inspector that staff support them in their home and update them in relation to changes that are occurring both in the centre and at provider level. One resident told the inspector that support staff have helped them to understand more about their rights in relation to how they handle their finances and how they like to

spend their money. They told the inspector that they like who they live with and enjoy sitting with peers at residents' meetings to talk about their home.

The inspector reviewed residents' meetings occurring in the centre from April to June 2026. The person in charge had implemented an on line service that residents could access minutes of meetings and agendas. Residents could use the online link to add their say to meetings or add to the agenda and discussion topics. Residents' meetings were used to promote residents independence and their say in their home or community.

Residents meetings' were also used as a tool to promote each individuals communication style. For example, each month there was a chosen Lámh (sign language) sign that residents and staff had chosen as the sign for that meeting.

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 14: Persons in charge	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Liffey 3 OSV-0005785

Inspection ID: MON-0050834

Date of inspection: 22/Jun/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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: All staff are now in line with their training requirements. The staff team have all mandatory training completed. One staff member who had not completed Positive Behaviour Support training is booked to complete this training on 06/08/2026. All staff are booked on training for remainder of this year.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: Apt 26- All four issues listed below completed by 03 07 26 • All internal paint work completed. • Bathroom repainted and mould addressed. • Ventilation in bathroom has been repaired Bedroom refurbishment for one resident is underway and is in line with the residents will and preference and support needs. Works include: • Painting bedroom (completed) • New bedroom furniture • New sensory items, which will include soft sensory items, personal pictures and photos, and safety padding mats, wall decals and soft lighting.	

Outstanding work issue listed below is due for completion by 29/07/2026 • Apartment 26: Second Bedroom flooring will be replaced due to water damage resulting in mould.-

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Kitchen fire door that had a gap from the floor underneath to the bottom of the fire door.- work completed 25 06 2026

Both office doors have been fit with acoustic holders any damage to doors repaired- completed 26 06 26

Plug socket had not been fixed appropriately to the wall- work completed 26 06 26

All fire doors reviewed by contractor and gaps were repaired week ending 26 06 26

Weekly checklist for fire door and equipment checks have been updated for all staff week ending 23 06 26.

All PEEPS were reviewed and reflect the support needs of each individual in the apartments when engaging in a fire drill or an evacuation in the Designated Centre 23 06 26

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/Jul/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/Aug/2026
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.	Substantially Compliant	Yellow	6/Aug/2026
Regulation 28(1)	The registered provider shall	Not Compliant	Orange	23/Jun/2026

	ensure that effective fire safety management systems are in place.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	23/Jun/2026
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Not Compliant	Orange	23/Jun/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	30/Jun/2026