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:	L'Arche Ireland - Dublin
Name of provider:	L'Arche Ireland
Address of centre:	Dublin 13
Type of inspection:	Unannounced
Date of inspection:	27 November 2025
Centre ID:	OSV-0003418
Fieldwork ID:	MON-0048487

About the designated centre

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

L'Arche Dublin is a community-based service in Co. Dublin providing care and support for nine residents over 18 with an intellectual disability. The centre is located close to the centre of a seaside town. The centre comprises of three houses in close proximity of each other. The first house consists of 10 bedrooms, two of which are en suite. It also contains two offices, a living room, sun room, kitchen come dining room, living room, pantry, laundry room, visitor's room, two bathrooms with bath and shower facilities. There is a large front and back garden with two wooden structures used as an office and an art room/training room. There is also an outdoor room used exclusively by one of the residents. The second house is close to the first and contains seven bedrooms, four bathrooms, a living room, kitchen/dining room, laundry and office. There is also a back garden with a building which is used for visitors and an our door room which is used as a recreational area by one of the residents living in that house. Both houses are close to a variety of local amenities such as shops, pubs and churches. The third house has three bedrooms, a bathroom, kitchen and sunroom. There are good local transport links close to the centre and residents have access to vehicles in the centre to support them to access activities and venues in line with their wishes. Residents are supported on a 24 hour basis by a staff team consisting of a person in charge, deputy team leaders, nursing staff, social care workers and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

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 27 November 2025	09:00hrs to 17:00hrs	Maureen Burns Rees	Lead

What residents told us and what inspectors observed

From what residents told the inspector and what the inspector observed, residents living in this designated centre were receiving person-centred care and support and were enabled to access activities of their choosing. However, on the day of inspection it was identified that the behaviours of a resident in one of the houses were difficult for staff to manage in a group living environment and were having a negative psychological impact on another resident living in that house. Other areas for improvement were identified in relation to the upkeep of the premises. In addition, an outdoor room had been installed to the rear of two of the houses. These rooms were used on a daily basis by identified residents as an activity and relaxation space. However, an application had not been made to the Chief Inspector of Social Services to include the rooms in the footprint of the centre.

This unannounced inspection was completed to assess the provider's regulatory compliance in relation to the care and welfare of residents who were living in the centre. The inspection was undertaken following receipt of solicited and unsolicited information. In October 2025, the provider was granted an application to change the footprint and layout of one of the three houses so as to facilitate a resident from one of the other houses to move and live in that house. This was undertaken to address identified compatibility issues and safeguarding concerns which had been reported to the Chief Inspector as solicited information. Soon after, the identified resident transitioned to live in the centre. The resident met with the inspector at the time of this inspection and appeared to have settled well in their new home.

L'Arche Dublin is made up of three houses located in a coastal area of Dublin, and provides care and support to nine adult residents. There were no vacancies at the time of this inspection. The three houses are located on the same road, with two being next door to each other, and the third house a short walk away. The houses are close to a local village which has a library, shops, a church, restaurants and good transport links. As outlined under Regulation 17 later in the report, maintenance and repair was required in a number of areas.

The first house is home to two residents. The house comprises a sitting room, an office, a kitchen and dining area, eight bedrooms, three bathrooms and an outdoor cabin used by one resident. Both of the residents had their own bedroom which they had personalised according to their own taste. One of these rooms was noted to include memorabilia which reflected the individual resident's life history and their interests. The other resident's bedroom was found to be sparse which was reported to be in line with their preferences. Both residents had access to a sitting room although staff reported that it was mainly used by only one of the residents with the other resident preferring to use an outdoor room which was identified for their sole use. One of the residents was noted to enjoy sitting out at the front of the house directing traffic. Staff reported that the resident was well known and respected in their local community. The inspector met with both of the residents who lived in this

house in the company of staff. One of these residents was reluctant to engage with or to indicate to the inspector their views of the service. The resident appeared comfortable in the company of a staff member and was observed being supported by staff to go on an outing which included a trip to the barbers. The other resident met with and showed the inspector their outdoor room which contained the resident's vast music and digital video disc collection. The resident told the inspector how they enjoyed spending time each day in this room listening to their music and watching movies.

The second house was next door to the first, and was accessed through a back garden. This house was home to one resident. The inspector met briefly with the resident in the company of their support staff. This resident was unable to tell the inspector their views of the service but could be heard vocalising with staff who were supporting their personal care needs. This house had a small size kitchen leading to a living room and sun room, a bathroom and three bedrooms, one of which was a staff office.

The third house is a large bungalow located within walking distance of the other houses. It was home to six residents with a variety of support needs. The house comprises ten bedrooms, one of which was en-suite. The house has a medication room, an office, a large living room, kitchen come dining room, a laundry room and an number of toilets. One resident had a self-contained area within the house which comprises a sitting room which included a wheelchair accessible kitchenette, a bedroom and a bathroom. There was a fire exit from this area which was accessible. The inspector met with each of the six residents living in this house over the course of the day, including in the afternoon on their return from day services. A number of residents were observed being supported with their morning routines. Two residents departed for a trip to the airport to plane watch, which was one of their passions. A resident in this house had an outdoor room which they regularly used and was observed to contain their collection of magnets, digital video disc collection, a desk and art supplies.

Each of the houses had a relaxed and friendly atmosphere, and residents appeared to be content and comfortable. Staff volunteers and residents were noted to congregate at various times of the day in the kitchen-dining area in each of the houses which was considered the heart of each house. Staff were observed chatting and joking with residents in a kind and respectful manner. The inspector observed a resident being supported to have a drink by staff, who was seated beside them at eye-level and supported in a calm and unhurried manner. Meetings with residents in each of the houses occurred on a weekly basis. Records maintained of these meetings showed discussions regarding meal choices, activities, holidays and trips out.

Residents living in the centre were supported to lead active lives of their choosing and in line with their interests. Three of the residents were engaged in a formal day service programme with an individualised service for the remaining residents provided from the centre. Other activities that residents engaged with included, travel within Ireland and abroad, bowling, library visits, swimming, concerts, gym sessions, shopping trips and meals out. It was noted that a small number of the

residents accessed the community independently. Suitable risk assessments and controls were in place to support positive risk taking. A number of the residents had electronic devices which supported them to access information. The centre had two mini-buses and a car for use by staff to support residents to access activities in the community.

Residents were supported to maintain relationships with family members and those important in their life. There was evidence of regular engagement with family members with the service. There were no restrictions on visiting in the centre.

The next two sections of the report present the findings of this 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

Overall, there were suitable governance and management arrangements in place to promote the service provided to be safe, consistent and appropriate to residents' needs. However, the floor plans submitted and linked to a condition of the centre's registration were not fully reflective of layout of the centre and they did not include outdoor rooms which had been installed to the rear of two of the houses and were accessed daily by identified residents. The provider had adequately resourced and staffed the service, and collected information in order to improve the quality of life of residents.

The provider had completed an annual review of the quality and safety of the service and unannounced visits, to review the safety of care, on a six-monthly basis as required by the regulations. A number of other audits and checks had been completed. Examples of these included infection prevention and control, finance, incident reports, hygiene, care plans and medication management. There was evidence that actions were taken to address issues identified in these audits and checks. There were regular staff meetings and separate management meetings with evidence of communication of shared learning at these meetings.

The person in charge had a background as a registered staff nurse in elderly care and held a certificate in management. She had taken up the position in January 2023 and had more than 10 years' management experience. She was in a full-time position and was not responsible for any other service. She was found to have a good knowledge of the requirements of the regulations and of the assessed needs for each of the residents. The person in charge reported that she felt supported in her role and had regular formal and informal contact with her manager.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. The person in charge was

supported by two team leaders and a deputy team leader. The person in charge reported to the community leader/ service manager, who in turn reported to the chief executive officer. There was an on-call roster in place to ensure that support was available for staff out of hours. Residents were found to be supported by a team of staff members with the help of live-in volunteers in each of the houses. There was an adequate number of staff who had the required skills and qualifications for their roles.

Regulation 14: Persons in charge

The inspector reviewed the Schedule 2 information which was submitted in relation to the person in charge. This demonstrated that the person in charge had the required knowledge and experience to fulfil the duties of their role, as required by the regulations. The person in charge was on site five days a week, and demonstrated good knowledge of the residents' care needs and of the requirements of the regulations.

Judgment: Compliant

Regulation 15: Staffing

The full complement of staff were in place at the time of inspection. This promoted consistency of care for the residents. The inspector viewed the staff rosters for the four weeks prior to this inspection. These were well maintained and demonstrated that residents were enjoying good continuity of care. The inspector noted that there was an appropriate number of staff who had the required skills and qualifications to support residents. The team comprised of staff nurses, health-care workers and live-in volunteers who were rostered for 30 hours each week.

A sample of three staff files and three volunteer files were reviewed by the inspector. These contained all of the information required under this regulation. Volunteer roles had been set out in writing. Volunteers in the centre had all information required under Schedule 2 such as Garda vetting and a copy of their qualifications. The actual and planned duty rosters were found to be maintained to a satisfactory level.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had measures in place to ensure that both staff and volunteers received training and supervision to equip them to deliver safe, person-centred care and support to residents. From a review of the staff training matrix, the inspector found that staff had completed training in areas such as fire safety, safeguarding, food safety, manual handling and a range of modules relating to infection prevention and control. Volunteers were also recorded on this matrix and had completed the same courses as staff members. The provider had a system to identify staff members who required refresher training. In general, live-in volunteers stayed for a minimum of a 12 month period. Records showed that they received both formal induction and support.

The inspector viewed a sample of supervision records for three staff members and three volunteers which had been carried out in line with the provider's policy. These records showed that items such as training and development, roles and responsibilities and support were covered.

Staff meetings occurred regularly. The inspector viewed minutes from a sample of staff meetings and found that these covered updates relating to residents, ensuring that information and learning was shared across the team to enable safe and consistent practices. The inspector noted that the provider's annual review included staff and volunteers in their consultation. Staff members spoken with told the inspector that they enjoyed working in the centre and that they felt supported by the management team.

Judgment: Compliant

Regulation 31: Notification of incidents

A record of all incidents was maintained and where required these were notified to the Chief Inspector of Social Services in line with the requirements of the regulation. The inspector reviewed records of all incidents occurring in the centre in the preceding three month period and found that they had been appropriately recorded and responded to. Where required, these were notified to the Chief Inspector, within the time frames required in the regulations.

Judgment: Compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place which had been reviewed in October 2025. It was found to contain the information set out in Schedule 1 of the Regulations. However, the outlined facilities provided and the description of the rooms and layout in the floor plans did not include two outdoor rooms which had

been installed to the rear of two of the houses. These rooms were accessed daily by identified residents, one from each house, for recreation and relaxation purposes. The floor plans reviewed had been linked to the provider's conditions of registration. Consequently, the specific facilities as set out in the statement of purpose and the floor plans as agreed with the Chief Inspector at the time of registration were not being provided. An application to vary the conditions of registration to change the foot-print of the centre to include these rooms had not been made.

Judgment: Not compliant

Quality and safety

Overall, residents were found to be receiving person-centred care which promoted their human rights, and residents were engaging in activities that they enjoyed. However, on the day on inspection, a resident in one of the houses told the inspector that the behaviours of another resident who was living in their home had a significant negative psychological impact on them. The resident told the inspector that they had not raised their concerns with staff or the management team prior to speaking with the inspector. Formal compatibility assessments to assess the suitability for the two residents to be living together had not been completed despite a significant age gap between both residents, and differing support needs and interests.

Suitable care plans were in place to guide staff in meeting individual residents' assessed needs. A small number of residents had end-of-life care plans in place. Residents had access to health and social care professionals where required. There were healthcare plans in place for assessed needs, and staff demonstrated they were familiar with aspects of these plans. Each resident had access to a general practitioner and a range of health and social care professionals such as physiotherapists, occupational therapists, speech and language therapists. They had access to medical consultants where required including neurologists, psychiatry and ophthalmology. Residents had health passports in place so that in the event of an acute medical emergency, their important information was readily available. Residents who were eligible for National Screening Programmes such as BreastCheck and BowelScreen were supported to access these services.

There were systems in place for the identification, assessment and management of risks in the centre, including a system of responding to emergencies. Adverse incidents were reported in line with the provider's policy, and responded to, in a timely manner where required. A quarterly review of incidents took place to enable the provider to identify any trends, and to put in place additional measures where they were required. Learning from incidents was an agenda item for staff meetings so as to decrease the likelihood of a re occurrence.

Regulation 17: Premises

The inspector visited all three houses on the day of the inspection with the person in charge. A new heating system had been installed in one of the houses in the preceding period. However, this had resulted in worn and broken surfaces on a number of walls. In addition there was worn paint on a number of door frames and doors in each of the houses. A small amount of a mould-like substance was observed on the ceiling of .a shower room in one of the three houses. The exterior windows and doors on one of the houses were noted to be in a poor state of repair. A kitchenette used on occasions by one resident in the larger house was noted to have worn surfaces. The main kitchen in this house had paint applied to kitchen wall tiles which was noted to be worn and broken in areas. Overall residents' bedrooms were reflective of their unique interests and life stories, and communal areas were found to be homely and nicely decorated.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Each of the houses had detection and containment measures in place such as smoke alarms and fire doors. However, fire containment and detection arrangements were not in place in two outdoor rooms which had been installed to the rear of two of the houses. There was fire-fighting equipment in each house and emergency lighting. Fire orders were on display and there was evidence that servicing and maintenance were carried out on all equipment. Regular checks of equipment was carried out by staff at defined intervals as part of health and safety audits.

Each resident had a personal emergency evacuation plan which outlined procedures for day and night-time evacuation. Regular fire drills were completed in each of the houses and further to the last inspection, documentation and oversight arrangements for fire drills had been improved to include details of possible fire scenarios and each area was found to be evacuated in a timely manner.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents' medical needs and welfare were maintained by a good standard of evidence-based care and support. However, on the day of inspection it was identified that formal compatibility assessments to assess the suitability for two residents to live together in the same house had not been completed despite a

significant age gap between both residents, and differing assessed support needs and interests.

There was evidence that goals and activities had been identified for residents. Monitoring of progress in achieving identified goals was clearly documented. An annual review of personal plans which included a review of the effectiveness of the plans, in line with the requirement of the regulations, had been undertaken for the sample of resident files reviewed.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Overall residents were provided with appropriate emotional and behavioural support. A small number of the residents presented with some behaviours which could be difficult for staff to manage in a group-living environment and had the potential to have an impact on other residents. In general these incidents were well managed. However, as discussed under Regulation 8, on the day of this inspection a resident told the inspector that the behaviours of one of the residents living with them had a significant negative psychological impact on their life.

Positive behaviour support plans were found to be in place for residents who were identified to require them and included proactive and reactive strategies to guide staff in supporting individual residents. There were a number of restrictive practices in place which were found to be subject to regular review by the management team. There was evidence that a restriction had been removed in the preceding period. All restrictive practices were recorded on the centre's restrictive practice register.

Judgment: Compliant

Regulation 8: Protection

There were some measures in place to protect residents from being harmed or suffering from abuse. However, on the day of inspection, a resident in one of the houses told the inspector that the behaviours of a peer resident who was living in their home had a negative psychological impact on them. The inspector identified that the layout of the house combined with the established routines for both residents amplified the impact of the identified resident's behavior for their peer. Although, the resident told the inspector that they had not raised their concerns with staff or the management team prior to speaking with the inspector, it was evident that the behaviours of the identified resident were difficult for staff to manage in a group-living environment. This meant that the provider could not be assured that residents were being protected from all forms of abuse. Management

engaged with the resident on the day of inspection and took immediate interim measures to support both residents pending more longer-term arrangements being put in place.

There had been a number of allegations or suspicions of abuse in the preceding 12 month period, mainly pertaining to one of the houses. Measures had been taken by management to respond to these safeguarding concerns, including the transition of a resident who was living in one of the houses to live in another house. Safeguarding information was on display and included information on the nominated safeguarding officer. Staff members spoken with were aware of the various forms of abuse and the actions required on their part if they ever witnessed, suspected or had allegations of abuse reported to them. The provider had a safeguarding policy and procedure in place and the inspector found that the person in charge and staff team were familiar with the procedures it outlined. In addition, each resident had an intimate care plan in place which provided clear guidance for staff in supporting residents' intimate care needs.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 3: Statement of purpose	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for L'Arche Ireland - Dublin OSV-0003418

Inspection ID: MON-0048487

Date of inspection: 27/11/2025

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 3: Statement of purpose	Not Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: An updated SOP detailing a more accurate foot print of the three units will be submitted.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The worn and broken surfaces on a number of walls due to the removal of 30 radiators, due to a heating upgrade (Seolta unit), will be filled and repainted. The worn paint on a number of door frames and doors in each of the houses is a reoccurring issue due the amount of wheelchair users in the three units. However, a plan will be drawn up to repaint where necessary in the three units. The small amount of a mould-like substance that was observed on the ceiling of a shower room, which was due to a broken ceiling fan – which has since been replaced, in the Seolta unit will be treated and repainted. Note: the exterior windows and doors on one of the houses that was noted to be in a poor state of repair – funding has just be secured for a heating upgrade to this house (external insulation and new windows). A plan is being developed to redecorate the kitchenette in the Seolta unit for the resident's use. The main kitchen in the Seolta unit also will have fresh tile paint applied to kitchen wall tiles.	

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire containment and detection arrangements in the two outdoor rooms of the Seolta and Leoithne units are now in place.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Formal compatibility assessments to assess the suitability for residents to live together in the same house will be completed as a pre resquite to placements in the future.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Measures have already been implemented (accompanying resident to TV room and ensuring that the TV and adjoining bedroom are closed over). At a recent review it was decided not to use the front door after 20:00 in the evening as the resident likes to settle to bed early in the evening and listen to his radio. This measure is still in place. The resident in question does not wish at present for other measures to be carried out. However, moving the TV room is a consideration in the very near future if required.

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	31/05/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	31/05/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	12/12/2025
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	30/01/2026

Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	12/12/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	27/11/2025