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:	Centre 6 - Cheeverstown Community Services
Name of provider:	Cheeverstown House CLG
Address of centre:	Dublin 6w
Type of inspection:	Unannounced
Date of inspection:	21 October 2025
Centre ID:	OSV-0004129
Fieldwork ID:	MON-0048008

About the designated centre

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

This designated centre comprises of four houses located between two towns in Co. Dublin. The centre provides full-time residential services for male and female adult residents with an intellectual disability. The designated centre is registered to accommodate up to 13 people in total. Within the centre there are three two-storey semi-detached residential homes and one bungalow. Each resident has a single private bedroom, and access to suitable communal, bathroom, kitchen and garden areas. There is accessible transport available to all houses. The person in charge shares their working hours between the four houses within the designated centre. There are nurses, social care workers and care assistants employed in this centre to support residents with their assessed needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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 21 October 2025	10:50hrs to 15:35hrs	Erin Clarke	Lead
Wednesday 22 October 2025	09:55hrs to 16:30hrs	Erin Clarke	Lead
Tuesday 21 October 2025	10:50hrs to 14:50hrs	Karen Leen	Support
Wednesday 22 October 2025	09:40hrs to 16:30hrs	Karen Leen	Support

What residents told us and what inspectors observed

Residents told inspectors that they were happy in their homes and enjoyed positive relationships with staff, who supported them to engage in meaningful daily activities and community life. Inspectors observed warm interactions and strong involvement from multidisciplinary teams in meeting residents' changing needs. While the centre had a stable core staff team and recent refurbishment works had improved parts of the premises, improvements were required in areas such as fire safety, risk management, and oversight of residents' personal possessions and financial autonomy. Two urgent actions were issued in relation to these matters, which the provider responded to with assurances that mitigating action had been taken.

This designated centre comprises four houses located between two towns in Co. Dublin. The centre provides full-time residential services for male and female adult residents with an intellectual disability. The designated centre is registered to accommodate up to 13 people in total. The provider had applied to vary the centre's footprint by adding an additional house to the designated centre to provide more suitable accommodation for one resident already living in the centre.

On the first day of the inspection, inspectors met with one resident who was being supported by staff to get ready to go out clothes shopping. The resident told the inspectors that they were heading out on the bus for the afternoon and would be back for dinner. They commented that their house had recently been refurbished and that they were very happy with the changes that had been made. The inspectors observed significant modifications had been made to the premises which included a full refurbishment of the kitchen area meaning that all residents could come together for meals if they chose. The premises had a large back garden, which had been laid out with all-weather accessible grass and an accessible pathway from the backdoor which covered the outline of the back garden.

Inspectors noted that changes had been made to the internal layout of the designated centre, including the addition of a garden room. This structure had not been included in the centre's approved floor plan or submitted through the required application processes to the Office of the Chief Inspector. Inspectors identified potential fire safety implications associated with the altered layout. The provider was advised of these concerns during the inspection and was requested to address the matter through the appropriate regulatory pathways.

In a second house visited during the afternoon, the inspector who visited met with one resident who wished to engage. A second resident chose not to speak with the inspector, and the third resident was out at the time of the visit. The resident who engaged welcomed the inspector and offered to make a cup of tea. They spoke openly about their likes and dislikes and demonstrated a warm and familiar relationship with staff. They described the activities they enjoyed and gave examples of their interactions with staff. The resident also outlined aspects of the home they liked less, including occasional noise disturbances from another resident.

Staff were aware of these issues and of the safeguarding considerations associated with them, and they described the measures in place to mitigate potential risks.

On the second day of the inspection, inspectors arrived to one house in the centre to meet residents before they went to their places of work, local day opportunities centre and local cookery classes. On arrival inspectors met with three residents who were relaxing in the sitting room of their home waiting for different transport options. The residents told the inspectors that they love their home. One resident commented that the centre is central to a number of shopping centres, restaurants, pubs, libraries, cinemas and that there is excellent transport system. Another resident told the inspectors that they like their home as it is close to their family and their friends. The residents discussed with the inspectors that family and friends visit regularly.

One inspector was brought on a tour of the house by two of the residents as one resident had left for their local day service with support from a local centre staff. Residents discussed that they have a large accessible garden. One resident noted that they do not require the garden to have a ramp however, they have a number of family members or friends that visit and this is required for them. One resident also told the inspector that as they get older they find having a ramp in and out of their garden very helpful.

Inspectors observed the atmosphere in all three houses visited during the course of the two day inspection to be filled with activities, visitors and happy exchanges between supports staff in the house, transport staff assisting residents to day activities and friends contacted the houses on the telephone. Residents told the inspectors that they regularly have visitors in their home and that when they go out to activities during the day they will often come home for lunch or a small snack and leave again for another activity or meet up with friends. The provider had identified gaps within the rosters arising from emerging needs in some of the houses, particularly on certain mornings when residents required additional support with personal care and on some evenings to facilitate activities. The provider was found to be actively recruiting to address these gaps and ensure that staffing levels aligned with residents' assessed needs.

In one house, inspectors identified that a key risk related to a resident who, when unsettled, could leave the house without informing staff. Staff were aware of this behaviour pattern, and there was evidence of discussions with the resident and relevant representatives to support safer routines. Another resident in the same house was largely independent and able to leave the house alone. Residents in this house attended day services throughout the week; the person in charge explained that additional staffing was required on specific days to ensure personal care and activity needs were fully supported. Staff were knowledgeable about the residents' overall needs, and inspectors were informed that one resident attending a specialist clinic was stable at the time of inspection.

The provider was managing a number of transitions for residents who were moving between houses, returning from hospital admissions, or experiencing changes in their support needs. Inspectors observed positive efforts by the person in charge

and the person participating in management to involve families, multidisciplinary professionals and relevant external supports where appropriate. Inspectors noted that admission processes did not consistently ensure that residents had straightforward access to their finances from the outset. While local management were actively working to improve this and advocating on residents' behalf, the lack of clear policy guidance had resulted in residents experiencing delays in exercising full financial autonomy after admission.

Inspectors also found that some residents had purchased their own fitted wardrobes, and this prompted discussions during the inspection about how decisions relating to personal possessions were being managed. It was reported that residents expressed that they wanted this type of storage in their bedrooms; however, provider policies had not clearly set out how residents' storage needs would be met by the service or how financial decisions of this nature would be supported. This meant that residents were using their own funds to purchase fitted furniture without clear documentary evidence of choice, rationale or informed consent. It was also not established whether these units could move with residents if they relocated to another house within the centre.

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

Capacity and capability

Overall, while there were strong elements of governance and a committed workforce, targeted improvements were required to ensure all regulatory responsibilities were fully met.

During the inspection, inspectors observed positive staff–resident interactions, and staff demonstrated good knowledge of residents' routines, preferences and support needs. A stable core staff team was in place in several houses, and the provider was actively recruiting to fill identified vacancies. Residents told inspectors that they liked the staff working with them, and inspectors saw staff supporting residents to maintain their preferred activities and community connections.

The person in charge and social care leaders provided day-to-day oversight, and there was evidence of organisational governance through unannounced visits and ongoing monitoring; however, further strengthening of oversight was required in areas such as registration changes and policy implementation.

Staff had access to comprehensive training, and supervision arrangements were in place to support role clarity and development, though one training area required attention where it had been identified as a risk control. Complaints reviewed by

inspectors showed that residents' concerns were listened to, investigated and responded to appropriately.

Regulation 15: Staffing

Inspectors reviewed the staffing arrangements in place and noted that the provider had a structured roster supported by a core team of nurses, social care workers and healthcare assistants.

At the time of the inspection the designated centre was operating with four whole-time equivalent staff vacancies. The provider had endeavoured to fill the staff vacancies with permanent staff working extra shifts as well as agency and relief staff. The inspectors reviewed rosters for August and September 2025 and the current roster for the centre and found that the person in charge had attempted to utilise the same agency and relief where possible to fill the vacancies. Support staff completing additional hours had led to a significant decrease in the use of agency. Inspectors found that on average the centre required two shifts a week to be covered by agency staff in order to meet the needs of residents.

The provider had recently completed a review of the assessed needs of the residents in the centre, this review was carried out due to the changing needs of residents and additional supports required for residents in areas such as mobility and a noted decline due to age related health supports. In order to support residents in their home the provider had increased staffing supports in one house in the designated centre. This increase in staff support was identified within the four whole time equivalent vacancies for the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors reviewed the 2025 training matrix for the designated centre and also reviewed a sample of supervision records maintained by the person in charge in the centre.

The person in charge maintained a comprehensive training matrix that recorded mandatory, site specific, in-person and online training. Inspectors reviewed training records for permanent staff in the mandatory training areas of fire training, safeguarding, manual handling and positive behaviour support. All permanent staff were found to have completed the required trainings in these areas in line with provider requirements. Inspectors found that staff had access to a wide range of non mandatory training which were further enhancing the lived experience for residents. Examples of non mandatory training for staff included Dementia training,

supporting people with an intellectual disability through bereavement and grief, communication supports, sensory workshops and epilepsy support.

The provider had identified through a risk assessment related to a resident's assessed needs that all staff working in one house in the designated centre were required to have first aid training. However, on review of the training matrix two out of six staff had completed training. This will be discussed further in Regulation 26: risk management.

Inspectors reviewed the supervision records of six staff in the designated centre. Staff were in receipt of both formal and informal supervision. The person in charge had devised a supervision schedule for the remainder of the year to ensure that staff were in receipt of supervision and support.
Supervision with staff had last been completed in July 2025 by the person in charge, and records showed that performance and role responsibilities were discussed as part of these meetings, with appropriate follow-up completed where required.

Judgment: Compliant

Regulation 23: Governance and management

The person in charge was supported by four social care leaders who had delegated responsibilities across the houses, as well as administrative support. Social care leaders told inspectors that their duties included conducting fire drills, completing rosters, carrying out audits and providing day-to-day oversight within their assigned houses.

The provider had completed a six-monthly unannounced visit to the centre and produced a report outlining areas for improvement, including the frequency of team meetings and the recording and tracking of actions arising from them.

Inspectors found that the management team and staff were actively advocating for residents, particularly in relation to financial autonomy and ensuring access to external services. Management also advocated on residents' behalf where procedural barriers were impacting their rights. For example, a recent change in a hospital's discharge procedures was creating difficulties for residents, and this was appropriately escalated by the provider to ensure continuity of care and safe discharge plans.

It had been previously identified that some provider policies, particularly those relating to residents' finances, were not sufficiently comprehensive to guide staff practice and ensure residents' financial autonomy. These policies were under review at the time of inspection. The centre was actively addressing a concern for one resident with positive outcomes noted; however, the response was retrospective and highlighted that the resident's rights to their finances had not been fully explained or ensured at the point of admission.

Two urgent actions were issued during the inspection, arising from deficits in risk management and fire safety oversight. Inspectors also found that a structural addition to the centre had not been submitted through the required regulatory processes, and updated floor plans were required to accurately reflect the current layout of the designated centre. These issues highlighted the need for strengthened governance oversight to ensure that emerging risks, environmental changes and policy implementation were consistently monitored and addressed.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Inspectors found that residents' complaints were taken seriously by staff and management. Records showed that residents felt comfortable raising concerns and that complaints were reviewed, investigated and responded to in a timely manner. Communication of outcomes was clearly documented, and there was evidence that learning from complaints informed local improvements.

Judgment: Compliant

Quality and safety

Overall, inspectors found that residents experienced a good quality of life, meaningful daily routines and positive relationships, but improvements were required to ensure that risk management, fire precautions and financial rights were fully upheld in line with regulatory requirements.

Inspectors observed residents participating in a wide range of meaningful activities, such as social clubs, reflexology, outings and community-based programmes. Houses were lively and busy, with residents coming and going throughout the day, engaging with friends, staff and visitors. Staff were knowledgeable about residents' support needs, and positive support plans showed clear input from multidisciplinary professionals. Internal physiotherapy and occupational therapy services responded promptly to residents' changing needs, and the provider used additional medical resources within the organisation to support residents with increasing healthcare complexity. Transition planning was evident for residents moving houses or returning from hospital.

Safeguarding arrangements were effective. Staff demonstrated good awareness of safeguarding procedures, and safeguarding plans contained detailed guidance. Inspectors saw evidence of involvement from psychology and social work where relationships between residents required support.

Inspectors reviewed a significant incident involving a resident who required a rescue technique following a choking episode. An urgent action was issued in relation to the status of staff training at the time of the event. Inspectors also found that an additional structural area had been incorporated into the designated centre without fire detection or linkage to the main alarm system, despite known risks. Fire fighting equipment had not been considered within the fire plan, and several personal emergency evacuation plans did not reflect residents' current support needs. Fire drills lacked variation in staffing, with most completed by the same staff member.

On inspection, it was identified that an additional area had been incorporated into the footprint of the designated centre. This area did not contain any fire detection, alarm, or firefighting equipment to alert or respond in the event of a fire, despite documentary evidence indicating that the associated risk had been previously escalated. Inspectors observed the presence of an electrical heater and multiple combustible materials, including books, within this space. The area, therefore, required review by a competent person in fire safety to ensure compliance with fire safety regulations and to mitigate the identified risks.

Premises were generally well maintained, with one house recently refurbished, but further upgrades were planned across the centre. The provider had applied to add an additional property to the designated centre following renovation works.

Regulation 12: Personal possessions

While management were actively working to promote residents' access to their finances following admission to the centre, inspectors found that practice in this area continued to be guided by an outdated provider policy. This issue had been identified in other designated centres operated by the provider, and inspectors were informed that a policy review was underway to strengthen systems relating to financial autonomy. However, the absence of a clear and comprehensive policy at the point of residents' admission contributed to negative outcomes for some individuals in the centre.

Inspectors also found that residents had purchased their own fitted wardrobes. The regulations place responsibility on the provider to ensure that residents have suitable storage for their personal belongings, and it was not documented why residents were required to fund fitted units themselves. There was no recorded assessment, rationale or evidence of informed consent for these purchases. As the wardrobes were fitted units, it was also unclear whether they could move with residents should a transition to another property occur.

These issues indicated that oversight of residents' rights and financial decision-making required improvement.

Judgment: Not compliant

Regulation 17: Premises

The provider informed inspectors that refurbishment and upgrades within the houses remained an ongoing priority. One house had undergone significant renovation works earlier in the year, requiring residents to temporarily relocate for several months. Plans were in progress to further develop the service, including a recent application to extend the designated centre to include an additional house following proposed renovation works in a currently vacant property.

One kitchen in one of the houses had been identified as requiring upgrading; however, there was no time-bound plan in place to progress this work. Inspectors also found that the provider had not yet ensured that all requirements under Schedule 6 were met in relation to providing suitable storage facilities for residents.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

In one of the houses within the centre, inspectors reviewed documentation which identified a resident with a known choking risk. One of the control measures in place required that all staff working in the house had completed first aid training. However, it was established that not all staff assigned to this house had undertaken this mandatory training. A significant incident occurred in October, during which the resident required an emergency response involving the Heimlich manoeuvre. There was no evidence to demonstrate that the identified training deficit had been addressed or that interim control measures were implemented while the required training was being sourced, to prevent a recurrence of such an event.

Judgment: Not compliant

Regulation 28: Fire precautions

During the course of the inspection, the inspectors completed a walk through of one house in the designated centre which had recently completed a number of refurbishment works. Inspectors found that the provider had installed a large cabin room in the back garden of the designated centre, which was purposely built for one resident to enjoy activities outside of the main home. Inspectors found that the cabin had not been fitted with smoke detectors and there was no detection system linked to the main house to alert residents or staff if a fire should occur in the cabin. Furthermore, inspectors found that the nearest firefighting equipment was in the

kitchen area of the designated centre and had not been included in the fire plan for the centre.

Inspectors reviewed the personal emergency evacuation plans (PEEP) for four residents in the designated centre. Inspectors found that although the PEEPs had been reviewed by the person in charge, they had not been updated to reflect residents' evacuation plans and did not give detailed information of the support residents required when exiting the premise. For example, one resident's PEEP identified a three step approach to assisting them in the event of a fire. The PEEP stated that the resident "may require assistance from staff" however, the PEEP did not expand on the level or type of support the resident required. Another PEEP discussed that a resident was new to the centre and required evacuations to be completed on a monthly basis in the centre while they got used to their new home. Inspectors found that the resident had moved into their home two years prior and monthly evacuations were no longer required for the resident.

In addition, the inspectors reviewed fire drills which had taken place in the centre in January, April, May and October 2025 and found that three out of the four fire drills had been completed by the same staff member.

Judgment: Not compliant

Regulation 6: Health care

Inspectors observed good involvement of the provider's physiotherapy and occupational therapy services, with timely responses to residents' changing needs. In response to emerging risks, the provider had increased staff deployment and utilised medical resources within the wider organisation to better support residents whose healthcare needs had become more complex. Evidence of transition planning was in place for several residents undergoing changes in their living arrangements or support requirements.

Judgment: Compliant

Regulation 8: Protection

Inspectors reviewed how residents' day-to-day safety, compatibility, and individual risks were being managed across the houses. The centre supported residents with a wide range of needs, and inspectors found that staff were familiar with each person's routines, preferences, and support requirements.

The centre had differing levels of safeguarding considerations, with some residents being highly compatible and others requiring more support to maintain positive

relationships. Inspectors saw evidence of measures taken to improve interactions between residents, including ongoing discussions with residents about their concerns and their experience of living in the centre. Psychology and social work were involved when additional support was required.

There was a good level of awareness among staff regarding the recognition and reporting of incidents with potential safeguarding implications. Where formal safeguarding plans were in place, these contained detailed information to guide staff in maintaining residents' safety and wellbeing. Inspectors reviewed safeguarding updates for a resident whose presentation had changed. Social work was involved, and staff described how they supported the resident through adjustments in routines and environmental changes.

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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Centre 6 - Cheeverstown Community Services OSV-0004129

Inspection ID: MON-0048008

Date of inspection: 22/10/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Provider policies which have been previously identified by the inspector in relation to personal possessions and admissions, discharge and transfers are in the advance stages of completion and due for sign off on 16/01/2026. Two urgent actions which were issued during the inspection, arising from deficits in risk management and fire safety oversight, both of these actions have been completed. Updated floor plans have been submitted to the inspector post inspection.	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: The personal possessions policies which was previously identified by the inspector is in the advance stages of completion and due for sign off on 16/01/2026. An issue that was identified by the inspector in relation to the responsibility of the provider to ensure the residents have suitable storage for their personal belongings will be addressed and residents will be reimbursed for same. The provider has introduced a 'Documenting a Decision Based on My Will & Preference tool' to compliment the Managing my Money Document to capture will and preference of an individual and show evidence of informed consent.	

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Issues identified by the inspector in relation to refurbishment and upgrades to premises in the centre remain an ongoing priority and a schedule of works was devised with a plan for completion for Q3 2026.

The provider will ensure that all requirements under schedule 6 are met.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The provider ensured that a plan was developed and implemented to mitigate the identified training deficit. All staff members working in the house received appropriate training inclusive of Heimlich manoeuvre on 29/10/2025.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The provider has developed a plan which was commenced on 28/10/25 to ensure full compliance in Regulation 28 (3) (a) detecting, containing and extinguishing fires and (3) (b) giving warning of fires as identified by the inspector. All actions were completed.

All PEEPS will be reviewed and updated to reflect residents fire evacuation supports.

Fire Drills schedule will be reviewed in the centre to ensure that all staff members have opportunities to participate in fire drills.

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	16/01/2026
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	30/09/2026
Regulation 17(1)(c)	The registered provider shall	Substantially Compliant	Yellow	30/09/2026

	ensure the premises of the designated centre are clean and suitably decorated.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Substantially Compliant	Yellow	30/09/2026
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	16/01/2026
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.	Not Compliant	Red	05/11/2025
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Red	11/11/2025
Regulation 28(3)(b)	The registered provider shall make adequate arrangements for	Not Compliant	Red	11/11/2025

	giving warning of fires.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Not Compliant	Orange	31/01/2026