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:	Ballynakelly
Name of provider:	Cheeverstown House CLG
Address of centre:	Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	26 February 2026
Centre ID:	OSV-0008691
Fieldwork ID:	MON-0048023

About the designated centre

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

Ballynakelly is a designated centre registered to provide community-based residential care and support service on a full-time basis for up to three adults with an intellectual disability, mental health diagnosis or other assessed health and social care needs. This centre is a detached bungalow in a suburban residential area in Co. Dublin, in which each resident has a single bedroom and shared use of a communal living room, kitchen and dining room, garden spaces, accessible bathroom facilities and accessible vehicle. The support team consists of social care workers, with nursing and clinical support available as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 26 February 2026	10:00hrs to 17:30hrs	Brendan Kelly	Lead

What residents told us and what inspectors observed

This unannounced inspection was completed in Ballynakelly to monitor progress of an assurance plan submitted by the provider to the Chief Inspector of Social Services in December 2025 for all their residential centres. The inspection also assessed the provider's ongoing compliance with The Health Act 2007 (Care and Support of Residents in Designated Centres (Children and Adults) with Disabilities) Regulations 2013. Overall, the inspection found the provider had taken positive steps in implementing their service wide assurance plan. The inspection also found high levels of compliance with the regulations reviewed.

Ballynakelly is a three bedroom bungalow located in a quiet housing estate in Co. Dublin. The centre is registered to support a maximum of three residents and on the day of inspection there were no resident vacancies in the centre. Each resident living in the premises had their own bedroom and access to a spacious living room, an open plan kitchen-dining space and two bathrooms. The premises had a large garden to the rear that was fully accessible to all residents including wheelchair users.

On the day of inspection, the inspector had the opportunity to meet with and speak to the three residents living in the centre, the person in charge, a member of the provider's senior management team and members of the front line staff team on duty. Through the day of inspection the inspector observed the day-to-day operation of the centre, including interactions between staff and residents and the care and support provided to them.

On arriving at the centre the inspector was met by a front line staff member. The inspector completed a walk around of the premises with the staff member before sitting down and talking to the staff member about their role. The premises was observed to be warm and homely with photos of residents displayed throughout. The premises was also observed to be clean and tidy. The inspector observed that each residents' bedroom was decorated to their choosing, family photos were in each of the residents' bedrooms along with evidence of resident hobbies for example residents favourite sports teams.

The inspector met one resident relaxing in their bedroom while waiting on a family member who was coming for a visit. The resident appeared to be happy and comfortable in their room. They engaged positively with the staff member and appeared at ease in their presence.

The inspector talked to the staff member about their role in the centre. The staff member told the inspector they were very happy in their role. The staff member told the inspector they have been working with the residents since they transitioned to this centre. The staff member was knowledgeable in terms of resident needs and spoke of key risks and care plans within the centre. The staff member told the

inspector the management in the centre is effective and that the supervision process is meaningful and supports the staff team.

Later in the day the inspector had the opportunity to meet with the remaining two residents living in the centre. The residents both appeared comfortable in their home and were happy to be in the presence of the staff team. The interactions between residents and staff observed by the inspector were caring and warm at all times. The inspector observed that staff were knowledgeable of resident needs and all residents in the centre appeared to be healthy.

The next two sections of the report will outline in greater detail the providers capacity and capability to oversee the day-to-day management of the centre and the impact these systems have on the quality and safety of residents lived experience.

Capacity and capability

The provider had governance and oversight systems in place that ensured they had the capacity and capability required to operate the centre. However, improvements were required in the frequency and effectiveness of all meetings, reviews and audits taking place.

The centre had a full staff team with no staffing vacancies on the day of inspection, although improvements were required in terms of the provider's contingency planning for leave cover.

The staff team comprised of care staff and staff nurses with the provider ensuring all staff had been in receipt of the required training. Where staff required refresher training the person in charge had the required systems to schedule training. A supervision plan was also in place to ensure staff were supervised and supported in line with company policy.

Residents had detailed contracts of care that provided clarity in terms of what fees and charges are incurred by residents and what the provider provides for residents.

The provider had submitted a provider assurance plan to the Chief Inspector. The inspector observed that the actions outlined in the plan in terms of capacity and capability were either complete or in the process of being completed in this centre.

Regulation 15: Staffing

The provider had ensured that the centre was fully staffed with no staffing vacancies. The staff team consisted of care staff and staff nurses. The provider used

an online roster system. The person in charge maintained planned and actual rosters which were sent to staff via a mobile phone app. A printed version of the roster was also available. On the day of inspection the inspector reviewed rosters from January and February 2026.

In reviewing the rosters the inspector observed that the names and grades of all staff were noted. The rosters outlined the hours the person in charge is in the premises and outlined each shift pattern. The inspector observed the rosters showed no staffing gaps in the months reviewed.

The inspector also observed that the provider had not used any relief or agency staff up to the date of the inspection in 2026. This meant that the provider's contingency plan in covering planned and unplanned leave relied entirely on the permanent staff team. The inspector reviewed one staff member's hours for the month of February 2026 to the week end of the inspection. This staff member will have worked over 200 hours including six days in a row and ten days out of fourteen.

In addition the person in charge told the inspector that members of the staff team had also worked additional hours in centres operated by the provider, however, the person in charge was not aware of when this happened. The person in charge is not informed of other centres that require additional staff nor are they informed if one of their staff work these additional shifts. This means that the staff team are potentially working above the legally permitted hours as outlined in the Working Time Act, which requires overarching monitoring by the provider.

The inspector observed the interactions between the staff team and the residents throughout the day of inspection. The staff were at all times warm and caring towards the residents.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had ensured that the staff team had the required training in line with the provider's statement of purpose and the assessed needs of the residents. The provider maintained training records via an online system. The person in charge reviewed the training records and scheduled staff training as and when required.

The person in charge planned staff supervision sessions with the front line staff team. On the day of inspection the inspector reviewed the training records held in the centre and a sample of supervision records between the person in charge and front line staff.

In reviewing the training records the inspector observed staff had been in receipt of mandatory training including:

- Manual Handling

- Fire Safety
- Safeguarding
- Safe Administration of Medication
- Autism Training
- Assisted Decision Making

The inspector reviewed supervision sessions for both a care staff and a staff nurse. The supervision minutes showed agenda items including training, performance, audits and team lead role. The inspector observed the discussion in the sessions reviewed actions from the last supervision meeting, which, for one staff included attending training. Actions were identified for this session and the date of the next session was also included.

Staff who met with the inspector spoke positively in regard to the supervision process and the support from the person in charge.

Judgment: Compliant

Regulation 23: Governance and management

The provider's governance and management systems included an annual review, provider led unannounced six monthly audits, governance meetings and local team meetings. On the day of inspection the inspector reviewed the provider's annual review, previous two unannounced six monthly audits and a sample of meetings that were occurring. In the main, the inspector observed the systems in place were effective although improvements were required in terms of attendance at meetings, the frequency of meetings and ensuring actions were arising from meetings.

The provider had completed a 2025 annual review of the centre. The annual review provided a comprehensive overview of actions from 2025 that were broken into themes. The inspector observed that while the review was comprehensive in terms of a 2025 overview, it did not provide any actions or goals to be worked on for 2026.

The inspector reviewed the provider's two most recent six monthly audits from July 2025 and January 2026. The inspector noted that the person in charge had not seen the finalised report from the unannounced audit completed in January 2026, despite the audit being completed six weeks prior to the day of inspection. By comparison, the July 2025 audit report was with the person in charge two weeks after the audit took place.

Both audits were observed by the inspector to be comprehensive. Audits were broken into outcomes with an action plan in place for each outcome that required an action. Outcome judgements were made using a triangulation approach with auditors outlining if they gathered evidence to support judgements via documentation, observation or interview.

Actions identified in the audits included maintenance issues, policy updates, risk assessment reviews, personal emergency evacuation plans reviews, training needs analysis and all staff to complete fire drills.

The provider's governance meetings between the person in charge and person participating in management were not occurring on a regular basis. The inspector observed one meeting as having taken place in February 2026 with the previous meeting occurring in September 2025. The inspector did not observe a rationale or plan that outlined why governance meetings were not occurring on a more frequent basis.

The February 2026 meeting showed a comprehensive review of the centre. Agenda items included resident updates, environmental issues, safeguarding, staffing, restrictions, risk, audits, finance and maintenance concerns.

The person in charge held weekly team meetings in the centre. The inspector reviewed the meetings that had occurred to the date of inspection in 2026. The inspector observed that the meetings required review to ensure they were attended by members of the staff team and meaningful actions were identified. For example the inspector observed that only two staff were in attendance at each meeting to date in 2026. Not all staff had signed the minutes each week which means that the provider could not guarantee that all team members were aware of updates from meetings. The inspector observed that the standardised agenda was robust and covered important areas such as incident reports, risk, training and, medication management. However, not every meeting discussed all of the agenda items, for example in one meeting reviewed the only agenda item discussed was resident updates.

Each agenda item of discussion in the team meeting minutes had its own action plan section. The inspector observed that not all meetings had action plans attached, for example of the eight team meetings to have occurred in 2026, five had no action plan following the meeting.

The inspector observed that the provider had been making progress with their provider assurance plan submitted to the Chief Inspector. The inspector observed an improvement in terms of the workforce planning for this centre and the promotion of a rights based culture. Both are areas that were identified by the provider as requiting improvement under Regulation 23.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The provider had effective contracts of care in place for each resident. This was an area identified in a previous inspection as requiring improvement.

On the day of inspection, the inspector reviewed two contracts of care for residents living in the premises. The inspector observed that clarity was provided in the contracts for residents outlining what they will be expected to contribute towards. The inspector observed that the provider will be responsible for all household bills and pharmacy charges.

The inspector also observed evidence of annual reviews of residents' Residential Support Services Maintenance and Accommodation Contribution (RSSMAC) fees. The reviews ensured that the contribution made by residents was within their means and ensured residents retained an income that allowed them to participate in activities of their choosing.

Judgment: Compliant

Quality and safety

Residents in the centre were in receipt of a safe and effective service. The inspector observed residents who were compatible with each other and appeared to be happy in each others company.

The provider had comprehensive systems in place to identify, assess and review risk. Each resident had individual assessments in place that were scored proportionately with effective control measures. Where restrictions were required, the provider had ensured to outline the rationale for the restriction, data was collated to ensure the restriction was still required and reviews of the use of restrictions were ongoing.

The provider had submitted a provider assurance plan to the Chief Inspector. In terms of the actions relating to quality and safety, the inspector observed the provider had made significant progress in achieving the identified actions.

Regulation 26: Risk management procedures

The provider had effective systems in place to identify, control and assess risk in the location. The inspector observed evidence that the provider had achieved the actions set out in their provider assurance plan in relation to risk management.

Each resident had their own individual risk register and risk assessments in place. The inspector observed that the assessments scored the level of risk both before and after the implementation of the associated control measures. The inspector reviewed the risk register and assessments in place for two residents.

The inspector observed risk assessments in place for areas such as:

- Fire safety
- Kitchen Safety
- Falls
- Choking
- Epilepsy
- Self-Injurious behaviour

The inspector reviewed the assessment regarding kitchen safety as this also included an element of restrictive practice. The assessment was appropriately scored given the evidence available to the provider. The control measures included the required staff supports, the use of the restrictive practice, and how to involve the resident in kitchen based activities. The assessment was also reviewed in December 2025.

The inspector reviewed the risk register for a second resident, and the assessments in place for falls and self-injurious behaviour. Again, the assessments were appropriately scored given the available evidence regarding the number of falls and incidents of self-injurious behaviour. The inspector also observed that the guidance in place for staff was clear and individual to each resident. For example, regarding the resident's falls assessment, staff were guided through the use of hip protectors, intimate care requirements and physiotherapy interventions.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had ensured the implementation of effective and robust fire precaution systems. On the day of inspection the inspector reviewed the provider's emergency plan, personal emergency evacuation plans (PEEPS), fire drill reports, checks outlined by the provider to ensure fire safety, fire risk assessment and the servicing of fire detection and fighting equipment.

The provider's emergency evacuation plan was observed to be comprehensive and provided clear instructions to staff and emergency services. For example the plan outlined for each resident what equipment they would need in order to evacuate safely. It was also outlined in what order residents are recommended to be evacuated.

The PEEPS in place for each resident included step-by-step guidance on how to safely evacuate each resident. The plans also included each residents' reactions and responses to previous fire drills. Guidance was observed by the inspector to be individual to each resident, for example one resident uses a powered wheelchair and separate guidance was in place regarding the use of the powered wheelchair.

The provider had completed the required number of fire drills including a drill at night time with the least amount of staff and most amount of residents. All drills were observed by the inspector to be simulated in different areas of the premises. Drills were also observed to have been completed in a timely manner.

The provider had a system of daily, weekly and quarterly checks that were reviewed by the inspector. Checks were signed off by staff on shift each day. The team had also completed the checks for Q1 of 2026.

The inspector observed evidence of a competent external provider completing checks and testing of fire detection and fire fighting equipment. Testing had occurred in November and December 2025 of the fire alarm, emergency lighting and fire extinguishers.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured each resident had a comprehensive personal plan that offered clear guidance to staff in how to support the resident with their assessed needs. On the day of inspection, the inspector reviewed the care plan for one resident.

The inspector observed that the resident's personal plan had last been reviewed in January 2026. The plan gave an overview of the resident's profile in areas such as:

- Things you need to know about me
- Assessed medical conditions
- Things that cause me distress
- Safety issues for you to be aware of

The inspector observed detailed guidance on the communication preferences for the resident and how staff can offer the resident choice. For example, a weekly planner was in place where the resident communicated their choices for the week ahead. Choices for the resident included sensory activities, swimming, recycling, shopping and family visits.

The communication plan guided staff on how the resident makes choices. For example, staff are informed that the resident can take your hand, point and push things away to inform of their decision.The resident also had a communication dictionary in place to support staff. The dictionary showed staff how the resident communicates hunger, thirst, tiredness, anger, pain and, when they want to go out. The resident's communication plan was last reviewed by a speech and language therapist in November 2025.

The inspector observed input from the provider's multi-disciplinary team. A meeting took place in October 2025 that included input from the provider's occupational

therapist, speech and language therapist and social worker. The inspector also observed guidance from the provider's physiotherapist with a review and guidance on the resident's specialised footwear taking place in the last 12 months.

The resident also had a plan in place regarding their meal time experience and supports required for a positive meal time experience. The plan outlined how the resident prefers to be seated, what their preferred meal time environment should look like and what the signs of difficulty are. This guidance was further supplemented by a dietetic review in January 2026 and a daily bowel chart that was completed by staff.

The inspector also reviewed the resident's intimate care plan. Guidance was provided to staff in terms of how the resident engages in oral hygiene, the resident preferences in terms of bathing or showering and what supports are required from staff in regard to dressing. The resident's intimate care plan was last reviewed in January 2026.

Judgment: Compliant

Regulation 7: Positive behavioural support

The provider had ensured effective systems were in place regarding the oversight of behaviour supports where required, and the use of restrictive practices. While no resident required the use of a formal behaviour support plan, guidance was in place for one resident regarding their emotional well-being. This plan was reviewed by the inspector on the day of inspection along with restrictive practice oversight systems used by the provider.

The inspector reviewed one resident's well-being and distress support plan. This plan guided staff on what to be aware of that may cause the resident distress. Guidance was divided into changes in environment, physical and mental health. For example, a lack of sleep, crowds and loud noise were outlined as possible triggers. Staff were guided in how to best support the resident should their emotional well-being become affected by any of the identified triggers. A traffic light system was used to show staff when the residents well-being was strong through to when the residents well-being needed support. Staff were informed of what the residents presentation could be in each of the states of well-being. Added to this, the inspector also observed evidence that the resident had been reviewed by an external mental health specialist. The last review of the resident's mental health plan was January 2026 with the review stating that if the resident continued on their positive path, medications might be reduced in the next review.

The provider used a number of restrictive practices in the location. The restrictive practices were notified to the Chief Inspector as required on a quarterly basis. The inspector also reviewed oversight systems in place regarding restrictive practice and found them to be robust. Each restrictive practice was subject to the provider's

restrictive practice use form. The last review of these forms by the provider was January 2026. The forms tracked the use of the restriction since it was first used.

The inspector reviewed all of the restriction forms for one resident. Restrictions were in place for the use of plastic cups, a best vest for use in service vehicles and the use of a gate in the kitchen. The inspector observed that the staff team collected data for each restrictive practice which was used to inform the ongoing use of restrictive practices. Where possible, the inspector observed evidence of the provider attempting to reduce and remove restrictive practices such as the restrictions in the service vehicle.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Ballynakelly OSV-0008691

Inspection ID: MON-0048023

Date of inspection: 26/02/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The Person in charge has completed a review of current staff roster on the 08/03/26 to ensure that all staff were working in the parameters of the working time act. From this review the provider can confirm that only 1 staff member was in breach of the WTA from January 2026 up to the time of inspection. The Provider has met and completed a supervision with this staff member on 08/03/26 where the WTA was shared and discussed and the importance of compliance with same. The provider will send a communication to all staff on the importance of compliance with WTA which will be completed by the 01/05/26. The provider will meet with the workforce planning manager to ensure that all staff are rostered in line with the WTA by 10/05/26. The Person in charge has also met with the team during a house meeting on the same day to highlight this issue raised by the inspector and the importance of complying with the work time act. Minutes of the meeting has been recorded in the staff-meeting book and staff absent on the meeting have read and signed to acknowledge that they read and understood. A review will be completed of the Centre's Employment Control Framework to ensure that the center is not reliant on permanent staff team to cover planned and unplanned leave.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The Person in charge has met with the Quality Manager and received the completed feedback and actions from the unannounced Provider Visit audit that was done on 12th	

January 2026.

- The PIC will review and revise the staff team meeting template to ensure it is agenda-driven, action-focused, includes assigned action owners, and clear timeframes. This will be completed by 31/05/26, and the updated template will be implemented at all subsequent staff meetings.
- A structured staff meeting schedule has been developed 08/03/26, and all scheduled meetings will be held in line with this schedule over the following 3 months, with attendance and minutes recorded for each meeting.
- The Person in charge has reviewed the 2025 Annual Report and amended to add action plans.
- A structured PIC/PPIM meetings scheduled will devised with meetings scheduled monthly.
- Feedback from the providers visit audit of this Centre has been provided to the PIC and all future provider visits will ensure timely feedback to the PIC.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	31/08/2026
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	31/05/2026
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated	Substantially Compliant	Yellow	30/06/2026

	centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.			