Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	No. 4 Portsmouth
Name of provider:	Corlann
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	20 February 2026
Centre ID:	OSV-0008755
Fieldwork ID:	MON-0044747

About the designated centre

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

No.4 Portsmouth comprises one house located on a campus operated by the provider on the outskirts of Cork City. The centre (which is adjoined to another designated centre) is divided into two apartment areas albeit with some shared facilities. Each apartment supports one resident each and overall the centre provides full-time residential services to a maximum of two adults of both genders over the age of 18. The centre can support those with intellectual disabilities including those with autism, behaviours that challenge and who may have dual diagnosis of mental health and intellectual disability. One apartment in the centre has a kitchen, day-dining room, utility room and relaxation room while the other has a kitchen-dining room and living room. Both residents have their own individual bedrooms and are supported by the person in charge, a social care leader, social care workers and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Friday 20 February 2026	08:20hrs to 16:30hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

This inspection was a monitoring inspection to assess the centre's compliance with relevant regulations following its previous inspection in January 2025. Overall, this inspection did find a good level of compliance although some regulatory actions were identified relating to fire doors and risk management.

No.4 Portsmouth was located on a campus setting and was adjoined to another designated centre. The current centre was divided up into two apartment areas with each apartment providing a home for one resident each. Both residents were met on the day of inspection but neither resident engaged significantly with the inspector. The inspector's opportunities to observe residents in their home environment were limited on account of both residents leaving the centre at times during the day and directions given by staff. The inspector did get speak with two members of staff, a social care leader and the person in charge (PIC) while present in the centre.

On arrival to the centre, the inspector was informed that both residents living in the centre were still in bed. As such the inspector used the initial time in the centre to speak with some staff and hold an introduction meeting with the centre's PIC. After this meeting, the inspector was informed that one resident was up and that the inspector could met them. The inspector then accompanied the social care leader to the resident's apartment where the he was introduced to the resident. Aside from briefly looking at the inspector, this resident did not interact with the inspector at this time. The resident soon left the centre to go for a drive with staff using the centre's assigned vehicle.

The inspector then went to the other apartment where he met the resident living there. This resident did greet the inspector and was waiting to leave the centre to go to their day services at the time. While this resident did communicate verbally, they did not respond to some general questions asked by the inspector. However, a staff a member present at the time, who engaged pleasantly and jovially with the resident, spoke about the resident going to fast food restaurant later in the day. Shortly after this, the resident was collected to attend their day services meaning that both residents were away from the centre for the remainder of the morning.

With no residents present, the inspector used this time to review aspects of the premises provided for these residents to live in. While doing so he observed issues and defects with some fire doors in the centre. This will be returned to later in the report. While the centre was divided up into two apartment areas, a staff office was located between both apartments which could be used to access both apartments. The inspector was informed that whenever either resident was in the centre, a door from one apartment to the office was to be kept locked for safeguarding reasons and due to the risk of absconding. It was also indicated to the inspector that some

floors in the centre had recently been replaced and that further floors were also to be replaced.

Although the flooring in one kitchen of the centre was seen to be discoloured, the centre overall was seen to be clean and well-furnished on the day of inspection. For example, one resident's living room was seen to be nicely decorated with colourful soft furnishings present while additional sensory equipment had been installed in a relaxation room for the other resident. While the centre was set up to provide each resident with their own living areas, it was highlighted that one resident did not have direct access to laundry facilities in their apartment. It was noted that this resident had been offered the chance to do their laundry elsewhere on the campus but had chosen not to. The other resident did not have a bath in their apartment. This will be returned to later in the report.

In the afternoon of the inspection, one resident had returned to their apartment. While the inspector was speaking with a staff member in the other apartment, this resident entered the apartment via the staff office door which was unlocked at the time. The resident returned to their own apartment after a few minutes following redirection from staff. This resident then left the centre with staff to go swimming soon before again returning to centre. While the resident was out swimming, the inspector as advised to move from the apartment of one resident to the other apartment before the resident living there returned from their day service. The inspector followed this request but was then requested to go to the staff office when the other resident returned from swimming.

Again the inspector followed this request and spent most of the remainder of the inspection in the staff office. While there one resident was heard vocalising at times following their return to their apartment but such vocalisations eased over time. The other resident briefly entered the staff office where the inspector was with a staff member present requesting that the inspector leave the staff office at this time. This request was also followed. The remainder of the inspection was quiet overall with the inspector saying goodbye to both residents as he left the centre. One of these residents was watching television at the time while the other was in the hall area of their apartment.

In summary, both residents living in this centre left their home during the inspection day. No direct feedback from residents on what life was like in the centre was received from them. Feedback from staff and management was positive. Some regulatory actions were identified during this inspection which will be discussed elsewhere in this report.

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

Capacity and capability

Good compliance was found during this inspection including around the staffing arrangements for the centre. However, some regulatory actions were identified in areas including the centre's statement of purpose.

This centre was registered until August 2027 and had been previously inspected on behalf of the Chief Inspector of Social Services in January 2025. That inspection found an overall good level of compliance with the regulations. The current inspection was conducted to assess compliance in more recent times and to assess some regulations that were not considered during the January 2025 inspection. Overall, the current inspection found evidence of monitoring of the services provided and good compliance with the regulations. For example, no issues were identified regarding the PIC's remit, staffing arrangements nor complaints. Some regulatory actions were identified though. These included the centre's statement of purpose not being reviewed in a timely manner and some training gaps being noted. Other actions were identified relating to areas such as risk management and fire safety which are discussed later in this report.

Regulation 14: Persons in charge

A PIC had been appointed for this centre who and held a PIC role for one other designated centre on the same campus where No.4 Portsmouth was located. Based on documentation provided previously to the Chief Inspector, this PIC had the necessary qualifications and experience to meet the requirements of this regulation. The PIC held an area manager role with the provider and the January 2025 inspection of this centre raised a query as to the level of involvement of the PIC in this centre. However, on the current inspection no such queries were raised based on discussions with staff and documentation reviewed. For example, the PIC had attended two staff team meetings in the centre since September 2025 and had participated in a recent compliance audit for the centre. Taking into account the overall findings of the current inspection, no concerns were identified that the PIC's existing remit was negatively impacting the governance, operational management and administration No.4 Portsmouth.

Judgment: Compliant

Regulation 15: Staffing

Under this regulation, staffing arrangements in a centre must be in accordance with the needs of residents. To meet the needs of residents, specific staffing arrangements were outlined for residents by management of the centre. Staff rotas for the centre were reviewed from January 2026 on with these rotas maintained in a

planned and actual format as required under this regulation. The actual rotas reviewed indicated that the staffing arrangements outlined to the inspector were maintained. This was also confirmed by the two staff members spoken with on the day of inspection with such staffing arrangements observed to be present on the day of inspection.

Judgment: Compliant

Regulation 16: Training and staff development

Two staff members spoken with during this inspection indicated that they had recently received supervision with management of the centre. A training matrix provided following the inspection indicated that most staff had completed up-to-date training in areas such as fire safety. However, some gaps were noted in this matrix. For example, one staff had not completed safeguarding training, two staff had not completed some training in infection prevention and control and five staff had not completed first aid training.

Judgment: Substantially compliant

Regulation 23: Governance and management

An overall good level of compliance was found during this inspection which indicated that the management systems in operation were ensuring that residents were well supported. There was also evidence of monitoring of the services provided in the centre. Examples of this included:

- Three staff meetings having been conducted for the centre since 27 September 2025. Notes of these meetings indicated that they were attended by centre management and that issues relating to the running of the centre were being discussed.
- An annual compliance audit that had been completed for the centre in February 2026. This audit covered areas such as personal plans and staff inductions.
- Further audits that had been conducted for the centre since November 2025 in specific areas including medicines management and infection prevention and control
- Two unannounced visits to the centre had been carried out by a representative of the provider in March 2025 and September 2025. These reports were reflected in written reports and assessed areas such as residents' rights and safeguarding. Action plans were in place for each visit

report for any areas for improvement identified. All actions included in these action plans were recorded as being done.

Conducting such provider unannounced visits every six months is required under this regulation. Another requirement under this regulation, is for the provider to complete an annual review for the centre of the quality and safety of care and support provided to residents. The annual review should also provide for consultation with residents and their representatives. While the inspector was informed that questionnaires had been sent to obtain feedback for an annual review, at the time of the current inspection, no annual review for the centre had been completed since November 2024.

The provider is also required to ensure that the designated centre is resourced to ensure the effective delivery of care and support. During this inspection the centre was found to have sufficient staffing resources as referenced under Regulation 15 Staffing. The centre was also provided with an assigned vehicle that was seen to be used on the day of inspection although notes of a staff meeting from January 2026 referenced a request for a new vehicle being made. Aside from this, it was highlighted that one resident liked baths. However, the bathroom facilities in the apartment where this resident lived did not have a bath so the resident used the other apartment's bathroom on occasion in order to access a bath. The resident had a priority outcome identified to extend their bathroom but a review comment from September 2025 in their personal plan indicated that there was no funding for this. During the feedback meeting for the inspection, the inspector was informed that this matter was being reviewed.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Under this regulation, the provider must have a statement of purpose in place which most contain specific information and which must be reviewed of intervals of not less than one year. During the inspection day, while the inspector was present in the centre, he saw two copies of the centre’s statement of purpose. While these were found to contain required information, they were both marked as being last being reviewed on 7 December 2024. During the feedback meeting for the inspection (which was held away from the centre), the inspector was provided with a different statement of purpose which was marked as being reviewed on 18 February 2026. Again, this was found to contain required information. However, this version was not present in the centre on the day of inspection and there was gap of 14 months between the statements of purpose being reviewed.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Information about the complaints procedures was seen to be visible in both apartment areas of the centre. A complaints log reviewed for the centre indicated that one complaint had been made since the previous inspection. This complaints log outlined the response to this complaint with the complainant recorded as being satisfied with the outcome.

Judgment: Compliant

Quality and safety

While fire safety systems were present in the centre, the inspector did see some issues relating to fire doors in the centre. Residents had personal plans provided which provided guidance for staff in how to meet their needs.

Fire safety systems were provided in the centre but issues were observed related to some fire doors provided such as gaps being evident around some doors. Residents had personal emergency evacuation plans (PEEPs) to provide guidance on supporting them to evacuate the centre if required. These residents also had personal plans in place which contained guidance on supporting their various needs in areas such as their health and positive behaviour support. Staff had completed relevant training in this area with relevant risk assessments also completed. Such risk assessments outlined control measures but taking into account documentation reviewed and an observation on the day on inspections, the inspector was not assured that one specific control was consistently implemented.

Regulation 11: Visits

Given the layout of the premises into two separate apartment areas, sufficient space was available for both residents to receive visitors in private in a room other than their bedrooms. When reviewing the personal plan of one of these residents, it was documented that the resident had received visits from relatives to the centre.

Judgment: Compliant

Regulation 20: Information for residents

This centre had a residents guide in place as seen by the inspector during this inspection. This guide was found contain all of the required information such as the information about the procedure respecting complaints.

Judgment: Compliant

Regulation 26: Risk management procedures

A risk register was in place for this centre which had been recently reviewed and included risk assessments for identified risks in the centre. Such risk assessments described the risks and outlined control measures to reduce the likelihood of such risks occurring. These risk assessments covered areas related to the needs of residents such as positive behaviour support and absconding. One such risk assessment, indicated that the door from one resident's apartment to the staff office was to be kept locked at all times. A review comment for this risk assessment from December 2025 referenced the door being left unlocked on several occasions. On the day of this inspection, it was observed that this door was left unlocked which resulted in one resident briefly entering the apartment of another resident. Taking into account this observation and the December 2025 review comment, this did not assure that this control measure was consistently implemented.

As part of a risk management process, it was important that relevant incidents are recorded to inform a review of risk in the centre. During the initial stages of the inspection the inspector requested all incident records since the previous inspection. An incident log was subsequently provided but it was clear that this did not include all incidents occurring in the centre. For example, according to a protocol for the use of a restrictive practice for one resident, certain incidents were to be recorded in a specific monitoring chart, an individual incident report and also entered in this incident log. Specific monitoring charts were found to be in place for uses of this restrictive practice from November and October 2025 although the inspector did observe variance in how certain recordings were made on the use of this restrictive practice.

However, the uses of this restrictive practice in November and October 2025 were not recorded on the centre's incident log. After querying this, the inspector was shown a digital incident recording system but this also did not include all incidents involving the restrictive practice being used. During the feedback meeting for the inspection, it was indicated that the incidents highlighted had been recorded but had not been uploaded to the provider's digital incident recording system. In the days following the inspection, it was confirmed that the November and October 2025 incidents had been recorded as incidents at the time they occurred.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The fire evacuation procedures to be followed in this centre were seen to be on display in both apartment areas of the centre. Both residents living in the centre also had PEEPs in place which had been reviewed in November 2025 and outlined the supports needed for residents to evacuate the centre in the event of a fire. Records of four drills conducted since the previous inspection were also provided. These indicated that fire drills had been conducted at varying times, including one drill to reflect a night-time situation, with evacuation times of two minutes or under recorded. The centre was seen to be equipped with fire safety systems including a fire alarm, emergency lighting and fire extinguishers.

Fire doors were also observed to be present in the centre which are important in preventing the spread of fire and smoke while also providing for a protected evacuation route if required. However, during this inspection, issues and defects were observed with some of these doors. These included:

- Four doors not fitting snugly into their door frames which resulted in noticeable gaps between the doors and door frames and/or the ground.
- One fire door missing some screws in its hinges.
- Two doors not closing fully under their weight while the padding on a door to a relaxation room was seen to prevent the door from closing on the day of inspection.

Such matters negatively impacted the intended function of these fire doors. It was acknowledged though that such issues had been identified internally with the provider the week before this inspection with the inspector informed that new fire doors had been ordered. However, it was not known at the time of this inspection when they would be installed.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

All residents living in a designated centre must have personal plans as required for under this regulation. Such plans are intended to set out the health, personal and social needs of the residents and provide guidance for staff in how to meet these needs. During the course of this inspection, the inspector reviewed the personal plans of the two residents living in this centre. From these it was noted that the plans had been recently reviewed and contained various guidance on supporting the needs of residents in areas such as the health, communication and intimate personal care. As part of the personal planning process, priority outcomes were identified for residents. This included outcomes such as going to a barber in the community, getting a trampoline and setting up a sensory room. Based on documentation reviewed, progress with such goals had been reviewed with progress noted on the

inspection for most priority outcomes. For example, a trampoline was present for one resident just outside their apartment while sensory equipment had been installed in a relaxation room for the same resident.

Judgment: Compliant

Regulation 6: Health care

When reviewing the person plans of both residents, it was seen that these plans contained recently reviewed guidance on how to support their health needs. This was done through specific healthcare management plans for specific health issues with such plans outlining symptoms, preventative measures and treatment to be provided for each health need. Other records within residents' personal plans indicated that residents had been supported to avail of appointments or reviews with various health and social professionals including a dentist and a psychiatrist. Following an issue highlighted in the January 2025 inspection regarding a weight support plan for one resident, it was noted that the resident had been reviewed by a dietitian in September 2025.

The inspector was also informed that both residents had recently had annual health checks done. The inspector reviewed the report of one these and noted that the resident involved was last indicated as receiving vaccines for the flu and COVID-19 in October 2024. The inspector queried if the resident the resident had such vaccines again in 2025. He was informed that the resident was meant to receive these vaccines in 2025 but that because of "a mix up" this had not happened. It was also indicated that this matter had been highlighted to a nurse within the provider and that it was deemed that the resident did not need these vaccines now as flu season had passed.

Judgment: Compliant

Regulation 7: Positive behavioural support

Guidance was present within residents' personal plans on how to support residents to engage in positive behaviour. Two staff spoken with demonstrated a reasonable knowledge of such guidance while a training matrix provided following the inspection confirmed that all staff working in the centre had completed relevant training in de-escalation and intervention. Some restrictive practices were in use in the centre with one of these having been introduced in January 2025 in response to the presentation of one resident at certain times. A clear protocol, which had been reviewed during December 2025, was in use for this restrictive practice. This outlined specific directions for how the use of such this restrictive practice was to be recorded. When reviewing some documentation related to this, the inspector

observed some inconsistencies in the recording of this. This is addressed under Regulation 26 Risk management procedures.

Judgment: Compliant

Regulation 8: Protection

Under this regulation, the provider is required to ensure that residents are protected from all forms of abuse. Since the January 2025 inspection of this centre, the Chief Inspector had been notified of one potential safeguarding concern but this was ultimately found not to have been a matter of abuse. On the current inspection, the inspector was informed that there was no open safeguarding plans for the centre. Documentation reviewed, observations and discussions with staff and management present during the inspection identified no safeguarding concerns. The staff spoken with were aware of what to do in the event that a safeguarding concern did arise.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for No. 4 Portsmouth OSV-0008755

Inspection ID: MON-0044747

Date of inspection: 20/02/2026

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:

<table>
<tr><th>Regulation Heading</th><th>Judgment</th></tr>
<tr><td>Regulation 16: Training and staff development</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 16: Training and staff development:
The Person in Charge will ensure that all staff have access to appropriate mandatory and site specific training including refresher training in line with timelines in the matrix. In particular:
- The PIC has corrected a training renewal due date error on the training matrix that now shows all safeguarding trainings are up to date.
- Will identify and train a number of staff in Emergency First Aid Training to meet the Speech & Language Recommendation that trained staff be available in the event of possible emergency. 31/07/2026</td></tr>
<tr><td>Regulation 23: Governance and management</td><td>Substantially Compliant</td></tr>
<tr><td colspan="2">Outline how you are going to come into compliance with Regulation 23: Governance and management:
The Provider has clarified with the PIC and PPIM that whilst all residents have access to a bath facility one resident has identified through their Personal Plan that they would like to use bath facilities more frequently for relaxation purposes. The PIC has also confirmed this with MDT. Whilst this was identified in 2025 it was not prioritised for funding until 2026 where it is now agreed that the bath should be positioned in the relaxation room which is underused at present by this resident. The works are scheduled to be complete in Q4/2026 when an Application to Vary together with the revised floor plan and SOP will be submitted to the Authority.

The Registered Provider will ensure that there is an annual review of the quality and</td></tr>
</table>

safety of care and support in the designated centre and that this is available on a timely basis. The annual review for the year to November 2025 is now complete. [25/02/2026] The annual review to November 2026 will be complete within 2 months of that period end date.	
Regulation 3: Statement of purpose	Substantially Compliant
Outline how you are going to come into compliance with Regulation 3: Statement of purpose: The Provider will ensure that the Statement of Purpose is reviewed and kept updated at regular intervals and not more than one year. The current SOP has been reviewed and updated. 18/02/2026	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The Registered Provider will ensure that all staff are aware of the systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies by: • Ensuring that staff are aware of, and follow, the protocols and guidelines for reporting & recording and monitoring of incidents. 20/03/2026 • That staff are aware of the risk assessments in place. 20/03/2026 • And that control measures for identified risks are implemented. 20/03/2026	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Provider will. • continue regular fire prevention checks in the Centre and will re-issue guidance on how fire doors should be inspected as part of these fire compliance checks • Ensure all fire doors requiring replacement will be replaced throughout the designated centre. 30/06/2026	

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/07/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/11/2026
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre	Substantially Compliant	Yellow	25/02/2026

	and that such care and support is in accordance with standards.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	20/03/2026
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/06/2026
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	18/02/2026