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:	Kare DC15
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	04 June 2026
Centre ID:	OSV-0001993
Fieldwork ID:	MON-0044891

About the designated centre

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

Kare DC15 is a bungalow situated in a town in County Kildare and in walking distance to many local amenities and public transport links. Each resident has their own bedroom with access to living areas, kitchen/dining area, sun room and bathrooms. This designated centre provides a home to a maximum of four adults with an intellectual disability. Person centred supports are provided to meet the physical, emotional, social and psychological needs of each person in the house. Full time residential care is provided by a person in charge, social care workers and social care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 4 June 2026	09:30hrs to 17:00hrs	Linda Dowling	Lead

What residents told us and what inspectors observed

This was an unannounced inspection, conducted to assess the provider's regulatory compliance in relation to the care and welfare of residents who were living in the centre. It was completed by one inspector over the course of one day.

Residents were seen to be given opportunities to make decisions regarding their care and support, they decided who and where they wished to spend their time and they had input into the running of the centre including weekly shopping and menu decisions. Through conversations with residents however, they highlighted areas they were dissatisfied with including accessibility of the premises and availability of transport to go on spontaneous short or longer day trips. From review of documentation, discussions with the person in charge, staff team and residents the inspector also found evidence that improvements were required in premises, notification of incidents to the Chief inspector of Social Services, risk management, staff training and safeguarding of residents' finances.

The centre comprises a large bungalow, each resident had their own bedroom and there was a kitchen/dining area, sitting room and conservatory as communal spaces. The residents shared a shower room and additional toilet facilities. The centre had capacity for four adults to receive full time residential care, there were no vacancies on the day of inspection. The inspector had an opportunity to meet and spend time with all the residents who lived in the centre.

On arrival to the centre, three residents were in the kitchen having some breakfast. One resident was finished and was waiting to go for a shower. One resident was still in their bedroom and other residents told the inspector they like to have a lie on in the morning. Residents welcomed the inspector and when asked if it was ok to spend time in their home today they said they were very happy with this, two residents were particularly eager to talk to the inspector and tell them about the absence of transport at the centre. The inspector had observed a bus to the rear of the house, although residents said it 'wasn't safe to drive as the mirror was damaged' and it 'was only borrowed'. When the inspector asked about the need for a bus the residents told them they could go locally to shops and cafés but they would like to go further away and plan day trips. They also highlighted "you cant just go somewhere on a nice day, we have to plan it in advance like holidays". The residents highlighted this was an ongoing issue and was documented in the previous inspection report. From review of the compliance plan from the previous inspection the provider had identified local public transport, some staff had insurance on their own cars and there was a bookable bus available. Although the bookable bus created difficulty as it had limited times of availability and the need for staff to collect and return the bus on each occasion it was used. The provider was also covering the cost of a taxi if there was a necessary trip such as medical appointments.

Throughout the day residents were seen to go on short trips to a nearby shopping centre for a coffee or lunch, one or two residents would go at a time. One resident was observed to sit in the conservatory of the house for long periods of time looking out the window. There was art and craft supplies available although the resident was not observed to be supported with this or independently seek it out. Residents were observed moving around their home and one resident enjoyed their own space in an additional sitting room at the end of the hallway, they had a TV, photos and an electronic tablet which they were seen to use. They did not wish for the inspector to spend much time in the room and said "go on now" when they wanted space.

One resident was seen to independently move around their home although they struggle to get in and out doorways including their bedroom, sitting room, kitchen and bathroom. When asked if it was difficult they replied they often hurt their hands and knuckles, they showed the inspector areas of red colour on their hands where they had got caught between the wheel and the door frame. While the provider had identified work was required to make the premises suitable for this resident this work had not yet commenced.

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

Capacity and capability

The provider had systems in place to monitor the quality and safety of services provided for the residents including, unannounced provider audits every six-months, and an annual review. The centre had a suitably qualified and experienced person in charge in place who was seen to be in the centre regularly.

While improvements were required in premises, notification of incidents to the Chief Inspector of Social Services, staff training, risk management and protection of residents finances, residents were being supported to make decisions about how they wished to spend their time and make choices around their everyday living.

Regulation 14: Persons in charge

The registered provider had appointed a full-time, suitably qualified and experienced person in charge to the centre. The person in charge demonstrated good understanding and knowledge about the requirements of the Health Act 2007, regulations and standards.They were appointed to this centre in March 2026 and were becoming familiar with the residents' health and social care needs. The person in charge was also responsible for one other designated centre operated by the

same provider. The person in charge reported to and received support from an operations manager. It was evident daily oversight was appropriately delegated to ensure care was delivered as expected. For example, discussions at team meetings and supervision meetings.

Judgment: Compliant

Regulation 15: Staffing

On the day of inspection, there was an experienced and consistent staff team in place in this centre. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner.

The inspector reviewed a sample of the roster and found that there was a core staff team in place which ensured continuity of care and support to residents. Planned and actual rotas were also maintained and found to contain the required information. Local management were seen to utilise relief staff who were familiar with the residents to cover any gaps in the roster, there was no requirement for agency use at the time of inspection. On-call arrangements were in place and communicated to staff to ensure access to managerial support at times when this may be required.

For the most part team meetings were held monthly with a pre-set agenda in place. The inspector reviewed the minutes and saw that discussions were happening in areas such as risk assessments, staff training, roles and responsibilities and updates on residents health and well being.

Judgment: Compliant

Regulation 16: Training and staff development

While the provider had a policy and system in place to manage training of staff, a number of staff within the centre were due refresher training in mandatory and centre specific training.

From review of the training matrix provided on the day of inspection, the inspector found, two staff were due to complete safe administration of medication, two staff were due to complete manual handling training since November 2025 and two staff were due safety intervention training one since October 2025. Local management identified a limitation on training available and as a result staff are waiting a number of months to receive necessary training or refresher courses, this required review.

The inspector reviewed the provider's new annual review and reflection system, all staff had engaged in an initial meeting and details were captured in relation to

wellbeing, your roles, workload and professional development. This system was still in its infancy and would need time to become more established. Staff and management had been supported with a short training video on the process prior to it commencing.

Judgment: Substantially compliant

Regulation 23: Governance and management

The centre was managed by a suitably qualified, skilled and experienced person in charge who was in the role since March 2026. Over the previous three years there had been a number of changes to the person in charge of the centre and the effect from these changes were evident in actions taking longer than anticipated to completed, notifications to the Chief inspector of Social Services not submitted and missed team meetings during times of person in charge absence. These findings are reflected throughout the relevant areas of the report.

Since the appointment of the new person in charge there was a clearly defined management structure that identified lines of authority and accountability and staff who spoke with inspectors were aware of their roles and responsibilities and how to escalate any concerns they may have.

The inspector found that the provider had systems in place to complete provider level audits and reviews. These included systems to ensure that annual and six monthly reviews were completed in relation to residents' care and support. The provider annual review was completed for the year 2025. This review included feedback from residents and their representatives, all recorded commentary was positive stating residents liked living in the centre, staff are good to them and they were happy. While premises adaptations had been recorded as an area for improvement there was no defined list of actions or time frame on when they would be completed this is captured in regulation 17: Premises. The provider had arranged completion of two six- monthly unannounced audits one in July 2025 and one in January 2026.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

On review of the providers incident and accident records it was evident that not all incidents requiring notification to the Chief Inspector of Social Services had been submitted as per the requirements of the regulation. Incidents of minor injuries and the use of a monitor and removal of one resident's electronic device at night had not

been reported as restrictive practices. No quarterly returns had been reported for Q3 or Q4 2025.

Judgment: Not compliant

Quality and safety

Overall, residents were seen to be provided with person centred care, the staff members spoken to and spoke about residents in a respectful manner and residents were seen to approach staff when they had questions or required support. Residents spoke positively about their experience of living in the centre. They were educated on their human rights and were seen to highlight areas were they were not happy.

From what the inspector observed, speaking with residents, local management and members of the staff team, and from the documentation reviewed it was evident there were a number of areas that required improvements. Not all residents' finances were protected, works were identified in a number of areas around the property and not all residents' risks were identified.

Regulation 12: Personal possessions

The inspector reviewed the systems in place regarding the management of residents' finances and found that improvements were required.

One resident had been supported to have a capacity assessment completed which determined they had capacity to make decisions regarding their finances. The resident was also supported by an advocate and had chosen to have a family member manage their finances and hold their bank card despite them having been assessed to have capacity. The family member supports the resident regularly to withdraw money from their account and the resident then spends their cash as they wish. The family member also provided the centre with the withdrawal slip and regular statements showing the residents income, cash withdrawals and balance.

For the above resident the centre only kept a record of cash withdrawals but no cash expenditure records were kept such as receipts for these withdrawals therefore, no oversight of the resident's day to day expenditure was documented. This was of particular concern where large cash withdrawals were recorded as there was no mechanism in place to safeguard the resident's finances. In addition, the resident's 'my money management plan' identifies that the resident would like to contribute to the upkeep of their family home which they visit regularly. The plan identifies items such as property tax, tv licence and oil as potential expenses,

although no further details around cost was identified and the provider was unclear if their contributions were fair and proportionate.

In addition, all residents in the centre had been supported to sign a service agreement, while these agreements outlined expenses encored by the resident including rent it did not specify what RASSMAC charges they were expected to pay.

Judgment: Not compliant

Regulation 17: Premises

The inspector completed a walk around of the property as part of the inspection and noted many areas that required improvement.

The inspector observed dust gathered in corners and in higher areas of the property. Flooring was seen to be cracked and lifting on entry to the sitting room. The carpet at the entrance was stained. Painting throughout the property was worn and marked, especially in the hallway all skirting board and architrave was chipped and broken mainly due to contact by wheelchairs. While the provider had placed protective barriers in a number of places the damage was still evident.

As previously mentioned the inspector observed one resident attempting to move independently around their home, although they struggled to get in and out of doorways including their bedroom, sitting room, kitchen and bathroom. The resident informed the inspector they often hurt their hands and knuckles, they showed the inspector areas of red skin on their hands where they had got caught between the wheel and the door frame. The provider had identified the need to widen doorways throughout the property although on the day of inspection there were only plans in place for the provider's own maintenance to review the residents bedroom door with the view to making it wider. These planned works had no start or completion date available.

There was an absence of defined spaces and storage solutions. For example, there was no defined art space for a resident who has a keen interest in art. The conservatory of the centre has no specific function, it had a kitchen table and some chairs, art and craft storage, one armchair and it was also utilised to store a resident's previous wheelchair, exercise equipment which residents were seen to use on the day of inspection, some handheld weights and a clothing airer.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider's risk management systems required oversight to ensure they were accurate and effective.

For the most part the provider had detailed risk assessments and management plans in place which promoted the safety of the residents and these were subject to regular review. However, the provider had not identified any medical conditions or safeguarding as risks. For example, one resident had a diagnosis of diabetes but this risk was not identified or assessed. Considering the vulnerability of the residents and the record of some minor incidents where residents may have been negatively impacted other residents in the centre, safeguarding was also not identified or assessed as a risk.

The inspector reviewed risk assessments for falls, choking, aggression and behaviours of concern and found them to be suitably risk assessed with control measures in place to manage the risk.

The provider had a system in place to record incidents, accidents and near misses. The inspector reviewed the incidents that had occurred in 2026 and found they were reviewed by the person in charge and learning from incidents was discussed at team meetings.

Judgment: Substantially compliant

Regulation 9: Residents' rights

While there were some areas residents were unhappy with, such as the premises and transport, overall, they reported to like living in the centre. Residents spoke well about and to each other. The inspector heard one resident asking another if they enjoyed their lunch out and if they were going home at the weekend.

Residents were also observed maintaining their home, one resident showed the inspector where the re-turn bottles are stored and others were seen to put items into the dishwasher.

Residents were supported to understand their human rights, how to make a complaint and were supported to have an advocate where necessary. One resident spoke proudly about their role on the 'Voice of Kare' (VOK) group. The group met regularly to voice any concerns and share local news. Recently they explored improved accessibility on public transport and they arrange trips to places of interest such as the Dáil. The resident had some information they had available in the centre and gave it to the inspector to review.

Easy-to-read policies were also available within the centre and these were discussed at residents' meetings. Policies on complaints, restrictive practice and behaviour support and a guide on assisted decision making capacity were all seen to be discussed. Residents' meetings also discussed topics such as VOK updates, hand

hygiene, respect, visitors and health and safety including giving residents opportunities to practice how to unlock a thumb locked door.
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 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kare DC15 OSV-0001993

Inspection ID: MON-0044891

Date of inspection: 04/06/2026

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff who require training are booked in to the necessary courses which will be completed by the end of December 2026. The process for booking on staff on to training is under review and improvements will be made by the end of October 2026. The training policy will be updated to reflect the changes in the training booking process. This will be launched by mid November 2026. The annual review for staff will continue to be implemented by the leader in line with the scheduled review period.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: There is a new person in charge since March 2026. Kare has reviewed the governance learning arising from the inspection and will strengthen management arrangements to ensure continuity of oversight where there is a vacancy in, or planned or unplanned absence of, the Person in Charge.	

A formal PIC absence and vacancy checklist will be developed for the PPIM/Operations Manager to ensure that key responsibilities are clearly allocated, including incident review and notification, team meeting oversight, risk review, staff supervision, resident-related actions, and follow-up of compliance plan actions. For planned periods of absence, alternative management responsibilities will be agreed and documented in advance. For unplanned absence or any future gap in the Person in Charge role, interim arrangements will be put in place immediately and monitored by the Operations Manager to reduce the impact on residents and ensure the service remains safe, consistent and effectively monitored. This will be complete by the end of October 2026.

Actions relating to premises improvement have been transferred to the compliance plan timeline below, with target completion dates identified. Progress against these actions will be reviewed through local management oversight and included in the 2026 annual review to ensure that identified improvements are tracked, escalated where required, and completed within the agreed timeframe.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All outstanding quarterly returns that were not submitted will be completed and submitted to the Chief Inspector by the end of July 2026. The Person in Charge, with oversight from the Operations Manager, will also review incident records for the relevant period to ensure that any additional notifiable events, including restrictive practices, have been identified and submitted where required. This review will be documented and retained locally as evidence of oversight and completion.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The PIC and staff team will complete a comprehensive review of the financial support arrangements for both residents, including current family involvement, consent arrangements, and decision-making supports prior to the end of September 2026.

The RSSMAC statement for one service user was sought from the finance team with breakdown of payments when the individual stays in the residential house. This has now

been included with financial records and will continue to be included each month going forward. This is in place since June 2026.

The keyworker and PIC are arranging with one family to discuss financial arrangements and a meeting will be scheduled prior to the end of September 2026 to agree governance arrangements.

The keyworker and leader will meet with each resident (and their chosen representative where appropriate) to review their wishes and preferences regarding the management of their finances and document these within their personal plans and financial support plans. This will be complete by the end of September 2026.

The decision support arrangements for one individual who was deemed to have capacity in 2021 is to be reviewed – the referral for this has been completed and the assessment will be planned to be completed by the end of December 2026.

The quality team will conduct a financial audit of all records held during 2026 in each of the residential house. They will identify learning and provide recommendations. This will be completed by March 2027 in line with audit annual plan.

The provider internal Risk escalation forum will discuss residents finances and associated risks in general at the next meeting in September 2026.

The organization risk register related to supporting finances for residents was reviewed and updated in June 2026

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The dust identified in high areas of the property was cleaned in July 2026. High-level cleaning has now been added to the local cleaning schedule and shift plan to ensure this is completed and monitored on an ongoing basis. The Person in Charge will review completion through regular local checks.

Refurbishment works are scheduled to take place in August 2026, during which residents will temporarily move to another designated centre for a short period of time. These works will include widening identified doorways, as reviewed by Occupational Therapy and Kildare County Council, to improve accessibility and support residents to move safely and independently around their home. Funding for these works was approved by the Council following a grant application submitted in 2025. The works will also include repair and replacement of damaged architrave and associated areas impacted by wheelchair use.

Following completion of the refurbishment works, the carpet at the entrance will be professionally cleaned by an external contractor. This will be completed by the end of October 2026.

Painting will be reviewed and updated where required following completion of the construction works. This will be completed by the end of October 2026.

Storage arrangements in the property have been reviewed. New wardrobes are planned for two bedrooms as part of the maintenance works and will be completed by the end of October 2026. Additional storage solutions for art materials will be sourced by the PIC.

The staff team, led by the Person in Charge, will review the function and layout of the conservatory with residents at the next house meeting. Residents' views and preferences will be used to agree how the space should be organised, including whether it should provide a more clearly defined area for art, exercise, relaxation or storage. Any agreed changes will be documented and completed by the end of October 2026.
Progress against all premises actions will be monitored by the Person in Charge and Operations Manager through local management oversight.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A risk assessment for diabetes has been completed for the identified resident by nursing staff and is aligned with the resident's diabetes management support plan. This was completed in July 2026. The Person in Charge will ensure that the completed risk assessment and support plan are reviewed with the staff team at the next team meeting in July 2026, so that staff are clear on the identified risk, control measures, escalation arrangements and their role in supporting the resident safely.

The location risk register has also been reviewed and updated to include a safeguarding risk assessment and associated control plan. This was completed in July 2026. The safeguarding risk is currently rated at 16 and will be reviewed every two months, or sooner if there is any incident, change in presentation, safeguarding concern, or other relevant change in residents' needs or circumstances across all the designated centres in Kare.

The Person in Charge will complete a review of the location risk register to ensure that all known and emerging risks, including health-related risks and safeguarding risks, are clearly identified, assessed and supported by appropriate control measures. The outcome of this review will be documented and retained on CID database as evidence of

completion. This will be completed by the end of September 2026.

Ongoing oversight of risk management will be maintained through regular local management review, team meeting discussion, and Operations Manager oversight. This will ensure that risk assessments remain accurate, current and effective, and that learning from incidents, accidents, near misses or safeguarding concerns is reflected in the risk register and associated control plans.

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	31/12/2026
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	31/12/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/10/2026

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
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	31/10/2026
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.	Substantially Compliant	Yellow	30/09/2026
Regulation 31(1)(a)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: the unexpected death of any resident, including the death of any resident	Not Compliant	Orange	31/07/2026

	following transfer to hospital from the designated centre.			