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:	Dunshane Camphill Communities of Ireland
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	30 January 2026
Centre ID:	OSV-0003616
Fieldwork ID:	MON-0049439

About the designated centre

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

Dunshane Camphill Communities of Ireland is a designated centre that provides 24-hours a day, seven days a week care and support for up to 18 residents in a rural location in Co. Kildare. The designated centre consists of seven residential buildings situated on over 20 acres of farming land in a campus-style setting. The centre also provides day activation services from 9am to 5pm Monday to Friday, on site. Some residents participate in these day activities, such as baking, cooking, pottery, basketry, and farming within the grounds of the designated centre or are supported in other interests in the community. The site also contains extensive gardens, walk ways, forest trails, farm land and fields. The centre can accommodate residents, aged 18 and over with intellectual disabilities. Residents are supported by a team of social care workers, assistant support workers and voluntary workers. In line with the co-living model of care residents share communal living spaces with the volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

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 30 January 2026	10:00hrs to 17:30hrs	Erin Clarke	Lead
Friday 30 January 2026	10:00hrs to 17:30hrs	Ciara McShane	Support
Friday 30 January 2026	10:00hrs to 17:30hrs	Tanya Brady	Support

What residents told us and what inspectors observed

This unannounced inspection was completed by three inspectors of social services over the course of one day, for the purposes of reviewing information related to the provider's application to renew the registration of this centre, as submitted under Section 50 of The Health Act 2007 (as amended). The majority of residents were not present on campus during the inspection, as they were out in the community. As a result, inspectors did not have the opportunity to speak with them about their experiences of living in the centre.

The provider was requested to submit an application to renew the registration of this centre by 19 July 2025 to the Chief Inspector of Social Services. The application was not submitted within the required timelines and a reminder was issued to request submission of the application on 21 July 2025. Initial information was subsequently submitted on 22 July 2025 and a further email requesting outstanding information sent on 24 July 2025.

As a result of changing local management and proposed changes to information submitted to the Chief Inspector of Social Services in addition to ongoing findings of non-compliance with regulations throughout 2025 this inspection was completed to verify information. This included information as outlined on floor plans and in other governance documentation such as the centre's statement of purpose and the resident's guide. The regulations reviewed were in line with the focus of the inspection.

Overall, findings indicated that while some of the provider's actions had been addressed since the previous inspection, inspectors were not assured that sufficient improvements had happened in the centre to make a decision at this time on the renewal of registration. Continued poor levels of compliance were noted in the areas of governance and management, staffing, premises and risk management in particular.

Inspectors met with one resident in the morning who invited them to come and see a newly developed part of the premises with them. Inspectors observed that in order to access the newly developed apartment the resident entered and moved through two other homes. This was of concern as transitioning through other residents' homes does not uphold their rights to privacy in their home. When inspectors asked why access was not planned to be through the external door, staff and the resident expressed that the external stairs to the door were too challenging for the resident to ascend safely. Inspectors later reviewed an occupational therapy recommendation that stated that 'ground floor accommodation would be gold standard however, for safety the resident had to use the internal stairs'. This was of concern as the provider had developed an upstairs area for the resident without full

consideration of the impact to their peers that needing to enter their homes may have. It was not apparent that this had been risk assessed or fully considered.

Inspectors visited all homes that comprise this centre over the course of the day. Inspectors found that all houses except for the one which was the current home for the resident mentioned above, were empty with all residents reported as having left the centre for the day to engage in a variety of activities. Inspectors were informed by the centre management that it was usual for a Friday that no-one would be in their home. As an outcome inspectors were not in a position to meet or speak with any other residents. Inspectors did meet and speak with five staff, the person in charge, residential services manager, team leader, and safeguarding risk and compliance manager over the course of the day.

Inspectors observed that staff training was taking place on site with the provider's funder providing this training. Later in the morning a staff member told inspectors that they had been asked to leave the training to be present in one of the houses because inspectors were on site which they stated meant they would not receive the training until a later date. It was not demonstrated how training arrangements would be sustained over the long term given the significant staffing shortfall. In addition it was not demonstrated how the provider would build capacity to provide training in the absence of the significant resources in place by the funder.

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

Capacity and capability

The purpose of the inspection as stated, was to assess the provider’s application to renew the registration of the designated centre. As discussed with the local management team on the day of inspection, a number of discrepancies in the application were identified in relation to resident numbers, the current management team, planning compliance documentation, fire safety information, floor plans, and an outdated statement of purpose. As a result, Registration Regulation 5: Application for registration or renewal of registration was found to be not compliant, and the inspectors were unable to consider making a recommendation regarding renewal of registration until a revised and accurate application was submitted by the provider.

On the day of inspection, inspectors found an emerging strengthening of oversight arrangements was evident. This was noted to have been achieved by the on-site presence of the safeguarding, risk, and compliance manager for four days per week. The Area Service Manager also had taken on the person in charge role, however the arrangements for a full time person in charge was not yet achieved by the provider.

Inspection findings indicated that while new systems were being developed and audits and reviews had happened since the centre's previous inspection, risk identification and management continued to be poor, along with the arrangements in place to ensure a core and consistent staff team was in place.

Overall, the systems in place were not yet effective in driving meaningful improvements across all areas of service provision.

Staffing levels had decreased since the previous inspection, despite ongoing recruitment efforts by the provider. This further impacted the provider's ability to demonstrate that staffing arrangements were sufficient and sustainable to meet the assessed needs of residents and ensure the safe and effective operation of the centre.

Registration Regulation 5: Application for registration or renewal of registration

At the time of inspection, the provider had submitted an application for renewal of registration; however, the information provided did not fully reflect the current operation of the centre. The documentation did not accurately reflect the governance and management structures in place at the time of the inspection, including reporting lines and oversight arrangements.

Further discrepancies related to the physical layout of the designated centre. Inspectors found that floor plans submitted as part of the application did not align with the layout in use, and that the information provided regarding resident bedrooms and how accommodation was allocated did not match the arrangements observed.

Judgment: Not compliant

Regulation 15: Staffing

Inspectors found that staffing remained a significant area of concern in the centre. The ongoing staffing deficit continued to impact on the provider's ability to provide consistent care and support for residents. In addition the staffing deficit impacted on the provider's ability to sustain and implement emerging systems of oversight.

Records reviewed referenced a substantial shortfall in staffing resources, with the centre operating at 17.07 whole-time equivalents (WTE) against an assessed requirement of 39.9 WTE. This staffing deficit was a reduction from the level at the previous inspection in December 2025 of 18.63 WTE. The deficit contributed to an ongoing heavy reliance on agency staffing.

Inspectors were informed that recruitment efforts were underway to stabilise the staffing complement and reduce reliance on agency cover. At the time of review, one healthcare assistant had commenced employment at 0.5 WTE, and further staffing commencements were anticipated in the coming weeks, including the appointment of a house coordinator. Despite these measures, the provider continued to experience challenges associated with staffing arrangements, recruitment and retention.

Judgment: Not compliant

Regulation 23: Governance and management

Overall, the new systems in place were not effective in demonstrating that they could drive meaningful improvements across all areas of service provision in a sustained manner. This was significantly impacted by the lack of a core and consistent staff team in place to utilise and implement these systems. Also as already stated, the provider was currently reliant on the presence of their safeguarding, risk and compliance manager being present on site for four days a week to identify and develop required actions. However, this arrangement was not reflected in the centre's statement of purpose or governance structures. It was also not demonstrated how this level of oversight would be sustained in the longer term when the individual returned to their wider national organisational remit. In addition, as stated, the area service manager was covering the role of person in charge in an interim capacity while the provider sought to recruit into this position. Due to their other regional responsibilities they were allocated 0.25 wf their whole time role to this centre which was identified on the centre statement of purpose. Inspectors acknowledge and understand the reason for the allocation of these additional resources at present however, continuing and sustaining this level of governance and oversight had not been evidenced.

In addition demonstrating that meaningful improvements in all areas of service provision could be achieved was also significantly impacted by deficits in development of sustained training for staff and in ensuring that cultural resistance did not impede change.

A focus on strengthening staff oversight and support was starting to become evident. Supervision processes had been progressed, with supervision completed for permanent staff and extended to agency staff working in the centre. Inspectors reviewed supervision records and found that supervision with the residential manager was documented to a good level of detail. In addition, team meetings were scheduled across the houses, with management presence reported. Training needs were also being identified, with catheter care training proposed to support staff competence and safe care delivery.

Inspectors found that training was being delivered on site by the provider's funder on the day of the inspection, and a commitment had been given for a number of

additional sessions to include topics such as reflective practice and provider policies. While this initiative demonstrated engagement with staff development, it was not clear how newly recruited staff would receive this training as part of their onboarding process. Given the high number of vacancies in the centre and the length of time some posts had remained unfilled, inspectors were not assured that there was a structured and sustainable approach identified for staff training. In addition it was not demonstrated how the provider would build capacity to provide training in the absence of the significant resources in place by the funder.

Inspectors reviewed a sample of residents' assessments and personal plans and found evidence of ongoing improvement in care planning processes, however some persistent gaps requiring further action to ensure plans consistently reflected residents' assessed needs and the supports required to meet those needs. This was evident for example for continence management.

Judgment: Not compliant

Quality and safety

Overall, while there had been some improvements since the last inspection in the development of oversight systems to ensure care and support provided was safe, there was not sufficient evidence to demonstrate that the implementation of these systems could be sustained.

Inspectors were concerned with continued poor practices found in the critical areas of risk management and premises. These gaps did not demonstrate comprehensively reviewed quality and safe care practices nor did it demonstrate appropriate oversight and capacity on the part of the provider.

Continued poor practices were also observed in the assessment of residents' needs. High quality care must be assessment led and residents should be supported and stimulated to lead fulfilled meaningful lives. This inspection found there were clear deficits in this regard for some residents living in this centre.

Regulation 26: Risk management procedures

Inspectors acknowledge that the provider had committed to reviewing their risk management policies and procedures by 28 February 2026 which post dated this inspection. However, it was of concern that in the interim period since the previous inspection date of 8 December 2025 and 28 February 2026 that areas of risk, as

observed by inspectors on the day of inspection, had not been identified by the staff team or local management team.

It was also of concern that inspectors identified areas of risk during the inspection that had not been identified by staff on the ground and that required escalation on the day of inspection.

These included broken glass and food remains outside the patio doors of one apartment which was part of a number of items that had been thrown from an upstairs apartment and landed on the step. The risks of injury should a resident have been sitting here and being struck were not considered nor was the risk associated with material left on the ground where it could be accessed by residents without having been cleared.

The inspectors noted the presence of three full bottles of alcohol within the centre, which had not been subject to risk assessment. Staff stated that they did not realise that alcohol was available within this apartment nor was there clarity on how this was stored or accessed by the resident. This was of particular concern as the resident was risk assessed for throwing and breaking items.

Outside one premises, on a wooden porch, inspectors observed that the wooden structure was in poor condition and one area of rotted wood had been covered by a wooden patch. As an inspector stepped on this it was observed that this surface sagged underfoot and appeared unsafe, in addition a screw protruded from the surface. This presented a risk of harm from the screw and the wooden patch, of tripping and of falling. This was adjacent to the exit from a house where a resident with visual challenges lived and the staff member stated to inspectors that while they were aware of the patch and its condition this had not been considered a risk for the residents in this home.

On the previous inspection of the designated centre urgent fire safety concerns were identified and inspectors observed that the provider had completed the immediate identified actions and were waiting for the outcome of an external report. However, there were other doors found not to fully close or function during the review of premises such as a door between the kitchen and hallway in one house where painting was recently completed. It was not apparent that the provider's checks had identified this as a risk.

Judgment: Not compliant

Regulation 17: Premises

Inspectors completed a walk through of the centre and visited all parts of the designated centre. One house only was not entered as the resident and staff team had left for the day and the house was locked so inspectors did not go inside this premises.

Inspectors were not assured that the premises in all areas internally and externally was maintained to a good standard. Externally inspectors observed that there was rubbish thrown in flower beds and on green areas outside homes, these included empty 'vape' cartridges, empty and partially empty food containers and packaging. Outside one home there was the remains of rotted decking timbers and drain covers with screws and nails protruding from them piled on the grass. Where previous reports had noted the presence of uncovered drainage vents and external pipes the inspectors saw evidence of these again some with warning tape attached. Outside another home there was lead flashing hanging off the edge of a roof. Patio doors and windows required repair and maintenance.

It was evident that recent external building works had been carried out as referred to in previous reports to improve pathways for example however, this had resulted in debris being left alongside some houses and pathways. One staff member commented that they no longer noticed it. The provider had stated in their compliance plan from the inspection completed 08 December 2025 that the senior management team would be completing a full review of the Dunshane campus by 29 January 2026 however, inspectors were informed that this had not yet taken place and that there were no documents available on this for review.

Internally, residents had bedrooms that were personalised for them and had access to comfortable communal rooms. There were aspects of the designated centre however, that continue not to provide all requirements of the regulation and Schedule 6. One resident remains for example, without access to a kitchen and another resident has to go outside and cross to another building in order to access a kitchen assigned to them, no changes have been made for these residents in the last 18 months. Inspectors found areas within the designated centre that were not frequently accessed, to not be maintained or cleaned in line with requirements. In one kitchen area that was part of the designated centre but not in use at the time of inspection there were dead insects on the surfaces and windowsills and the room was visibly unclean.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Not compliant
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 26: Risk management procedures	Not compliant
Regulation 17: Premises	Not compliant

Compliance Plan for Dunshane Camphill Communities of Ireland OSV-0003616

Inspection ID: MON-0049439

Date of inspection: 30/01/2026

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
Registration Regulation 5: Application for registration or renewal of registration	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 5: Application for registration or renewal of registration: The provider will furnish an updated 'Statement of Purpose' which will address the discrepancies identified in the report whilst also including recent changes to 'conditions', this will be done on or before April 10 2026. On Feb 16, 2026, the Head of Service posted an 'application to vary' for Dunshane in respect of registering a new apartment and deregistering the upstairs of another building within the designated centre. This was in tandem with the re-registration. On April 1 2026, Kildare County Council were requested to issue CCOI with the fire certificate for one identified house within the campus. The providers external fire consultants are required to furnish documentation required for a revised fire certificate to be issued; contact has already been established between Kildare County Council and the external fire consultants. The process of supplying an amended/updated Fire Certification from Kildare County Council will be complete on or before June 30 2026. It should be noted the Opinion of Compliance from the external fire consultants was furnished to HIQA on April 16.	
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing:	

The provider acknowledges that staffing is core component of ongoing improvements. Today the WTE within campus stands at 18.96 (excluding PIC, Residential Manager and Team Leads), the provider will reach a WTE of no less than 20 by June 30, 2026

The provider will have recruited a permanent PIC no later than June 30 2026.

Whilst it is acknowledged the designated centre heavily relies upon 'agency staff', the provider has been successful at creating an environment of consistency with the agency staff used. The designated centre today has access to 11 agency staff that are exclusive to the designated centre or predominately allocate themselves to the designated centre, of those agency staff they have a combined experience of 18 years.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider acknowledges that embedding the processes acknowledged by the inspection process is of central importance and has been ongoing since the Head of Service, Area Services Manager and Residential Manager commenced in their roles in October 2025.

The provider has heavily utilised wider organisational governance structures, with the support of the Quality Department to drive a Quality Improvement Plan at Dunshane. This ongoing support will continue over coming weeks to ensure actions on the QIP are being completed as required. Any changes to supports will only be reviewed in the context of recruitment of a permanent PIC which is planned for no later than June 30, 2026
It is noteworthy that the designated centre does have a 'Residential Manager' who with the passing of time is increasing their managerial experience, the inspectors report acknowledged improvements in supervision and regularity of governance meetings and the Residential Manager has taken a lead in these areas

The Inspector report flags concern around sustainability with particular attention around training. With regards to training the designated centre as a compliance rate of 85.57% in mandatory training. The provider has worked well with the HSE our funder and they have provided training support particularly around the HIQA standards and these training sessions have worked very well and the trainers have on each occasion made a note of flagging the level of commitment and engagement of staff present, the provider does

believe the provision of this additional training is sustainable and values the outcomes.

The provider will continue training for staff on the HIQA standards and a further three sessions will be agreed with the HSE by May 31 2026. The provider will make the 'HIQA Standards' a feature of the training schedule in the designated centre into 2027 with one group training session per quarter.

On February 24, 2026 an oversight meeting including the CEO and representatives of operations and quality departments to review trending of incident reports, updates from Behaviour Support Officer and Clinical Support Officer as well as a general update on potential community member moves. It was confirmed that key working sessions had been held with all community members to establish preferences for moves and compatibility and risk assessments had also taken place. It was noted that no moves could be initiated until re-registration from HIQA had taken place. This matter is dealt with under Regulation 5.

Further to previous compliance plans, on March 30 2026, the Provider gave further consideration of the governance structure of the designated centre. It was decided that at that time, it would not be appropriate to split the centre into two designated centres so as not to dilute governance clarity amidst ongoing recovery plans. This will be further reviewed on May 30 2026.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Following the inspection of January 30, 2026, a risk assessment was immediately formulated post inspection concerning a residents preference to drink alcohol occasionally. This matter was added to the local risk register on February 3, 2026 and notified to HIQA.

The provider arranged for an additional provider audit outside of schedule to review previously non compliant regulations. This additional provider audit reviewed the risk assessments on file for all community members and found all risk assessments to be in date. This additional audit took place on March 18 2026.

The provider acknowledges that there is an issue with debris coming from one location, the provider has installed netting to mitigate the expulsion of debris and this is complete. There is now in place a daily schedule of walk arounds to the target area, this is done three times by on duty staff and additionally by daily walk arounds of local management

The defective porch identified on the day of inspection was fully repaired on February 7, 2026. In reference to the doors identified on the day of inspection that did not fully close or function, the provider tasked the maintenance team to inspect every door throughout the campus which is complete on foot of these inspections a list of remedial works were identified. All remedial works will be completed on or before 30.04.2026

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider is working with the family of one resident to identify an opportune time to install a kitchen. This will involve extensive works which must be planned very sensitively, noting the potential impact of changes on the community member. The installation of a kitchen is planned as part of the project plan for refurbishing the entire home. This project plan is dependent on the wider campus moves which are pending re-registration from HIQA.

Reference was made to Lead flashing. A remedial repair was made tomake the issue safe while full repairs to the flashing will be complete on or before April 30, 2026. All ground works to the campus are now complete and regular walk around inspections since inspection indicate a litter free campus.

Our HR Department is embarking on review of smoking and vaping of staff within the community. This review will be completed May 31 2026.

The area of the designated centre identified as not in use but unclean has been cleaned, since inspection the provider has used cleaning contractors to provide deep cleans and daily inspections are in place.

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
Registration Regulation 5(2)	A person seeking to renew the registration of a designated centre shall make an application for the renewal of registration to the chief inspector in the form determined by the chief inspector and shall include the information set out in Schedule 2.	Not Compliant	Orange	31/05/2026
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	30/06/2026
Regulation 15(3)	The registered provider shall	Not Compliant	Orange	30/06/2026

	ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/06/2026
Regulation 17(6)	The registered provider shall ensure that the designated centre adheres to best practice in achieving and promoting accessibility. He. she, regularly reviews its accessibility with reference to the statement of purpose and carries out any required alterations to the premises of the designated centre to ensure it is accessible to all.	Not Compliant	Orange	30/04/2026
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/06/2026

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.	Not Compliant	Orange	30/06/2026
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.	Not Compliant	Orange	30/06/2026
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	07/04/2026