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:	Camphill Community Kyle
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	15 September 2025
Centre ID:	OSV-0003625
Fieldwork ID:	MON-0047900

About the designated centre

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

Camphill Community Kyle provides long-term residential services for a maximum of 16 residents, over the age of 18, with intellectual disabilities, physical disabilities and autism. The centre is located in a rural setting and comprises five units of two-storey detached houses with each accommodating between one and five residents. All residents have their own bedrooms and other facilities throughout the centre include kitchens, dining rooms, sitting rooms, utility rooms, bathrooms and staff offices. In line with the provider's model of care, residents are supported by a mix of paid staff including social care staff and care assistants and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	15

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
Monday 15 September 2025	11:00hrs to 16:00hrs	Marie Byrne	Lead
Monday 15 September 2025	11:00hrs to 16:00hrs	Conor Brady	Support

What residents told us and what inspectors observed

In July 2025, the Chief Inspector of Social Services issued a notice of proposed decision to cancel the registration of this centre. This was due to the continuous failure of the provider to implement actions to come into compliance with key regulations, which was having a direct impact on the quality and safety of care provided for residents.

The provider responded to the notice with a written representation, outlining the actions that they would take to address the areas of concern.

The purpose of this inspection was to ensure that residents were safe and well cared for and that appropriate action was being taken by the provider in this centre.

Overall, the findings indicated that the provider had made progress in several areas and, as such, had achieved improved levels of regulatory compliance. However, a number of key actions were still in progress and had not yet been completed. These actions related to outstanding premises works, resident transitions and the finalisation of arrangements to financially reimburse residents who were owed monies by the provider.

Camphill Community Kyle is a large residential service providing care and support for up to 16 residents with an intellectual disability. The centre comprises five houses on a rural campus-based setting in County Kilkenny. There were 15 residents living in the centre at the time of the inspection.

During the inspection, inspectors had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting eight residents, five staff, the two team leaders, a person participating in the management of the designated centre (PPIM), the compliance, safeguarding and risk manager and the Chief Executive Officer (CEO). Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to the actions detailed in the provider's compliance plan and representation.

Over the course of the inspection, inspectors had an opportunity to visit and complete a walk around of each of the five houses that make up the designated centre. Residents and staff spoke about some of the improvements that had occurred since the last inspection. They showed inspectors some of the works that occurred to some premises and the grounds. These works were found to have resulted in a reduction of some presenting risks for residents. Examples of the works completed included internal painting in a number of the houses, the replacement of flooring in a number of areas and, the replacement of door saddles and skirting boards. Banisters were sanded and painted, windowsills were sanded and painted, a number of wooden floors were sanded and varnished, some furniture was replaced and a deep clean by an external company had been carried out in a number of the

houses. These works had led to improvements in relation to how homely and clean residents' homes appeared. Further works were required and scheduled, and these will be discussed further under Regulation 17: Premises.

Inspectors found that the staff team was working hard to ensure that residents were accessing meaningful activities, employment and educational opportunities. One resident had recently completed work experience and was now enrolled in, and attending, college. A number of residents were out and about when inspectors visited their homes. Some residents were attending day services, one resident was visiting their family, one resident had gone for a massage and others were engaging in activities of their choice in their local community.

An inspector met one resident as they arrived home from working on a farm operated by the provider. They had brought home some fresh vegetables for dinner. Staff spoke about the positive impact of the two additional vehicles that were being leased since the last inspection, while the provider sourced two suitable vehicles. One resident was planning to go for a short holiday down the country in the days after the inspection.

Over the course of the inspection, inspectors observed residents being supported in a kind and caring manner by the staff team. The provider had employed the services of a recruitment agency and had filled a number of posts; however, staff vacancies remained and there continued to be a high volume of shifts covered by agency staff.

Overall, while improvements had been made in relation to the premises and risk management in the centre, it remained the case that improvements were required to ensure that the premises and grounds were fully meeting residents' needs. In addition, action was required to ensure that residents impacted by financial safeguarding concerns were reimbursed. The provider had employed a number of staff and efforts had been made to improve continuity of care and support; however, further improvements were required.

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

Capacity and capability

Inspectors found that while some improvements had been made since the last inspection, the longstanding issues relating to the suitability of some premises remained. In addition, financial reimbursement of residents remained outstanding.

This inspection identified improvements in governance and oversight as the provider had employed, or promoted a number of key personnel. The provider had successfully recruited an area service manager, promoted two staff to house co-ordinator posts and employed a clinical support officer in the behaviour support role.

Inspectors were also informed that the provider had also successfully recruited to fill the vacant head of services post.

Improvements had been made to oversight and monitoring and a number of planned actions had progressed. Areas such as risk, safeguarding, health and safety and, compliance were all found to be reviewed and monitored. However, approximately 45% of actions from the provider's representation action plan still remained outstanding at the time of the inspection. While evidence of progress was observed, inspectors highlighted the need to see further work completed in this regard.

Regulation 15: Staffing

In line with the findings of previous inspections, the centre was operating below the staffing requirement outlined in the statement of purpose.

Staff members spoken with and observed by inspectors were seen to be caring, supporting residents well and very responsive to residents' needs.

The provider had employed the services of a recruitment agency and a number of staff were successfully recruited, promoted and inducted since the last inspection. In addition, they had raised the whole time equivalent (WTE) numbers in line with residents' updated assessments of need and presenting risks. This had resulted in an increase in staffing from two to three, to support residents in two of the houses during the day. Plans were in place to introduce an additional waking night staff in one of the houses once residents returned from holidays. However, 12.93 WTE vacancies remained at the time of this inspection. This equated to 28% of the required WTE for this centre.

Inspectors reviewed a sample of two months of rosters and found that there remained an over-reliance on agency staff to cover shifts in the centre. While efforts had been made to increase the continuity of the agency staff employed, it remained the case that on average 900 hours per month were covered by agency staff.

Judgment: Not compliant

Regulation 23: Governance and management

Inspectors found that improvements had been made in relation to governance and oversight in the centre. The person in charge was on leave and the inspection was facilitated by the two team leaders. Since the last inspection, they were no longer part of the staffing arrangements in the houses. For the most part, they were now supporting the person in charge in relation to the provision of oversight and the day-to-day management of the designated centre. In addition, as previously mentioned,

the provider had employed an area service manager and promoted two staff members to house coordinator posts in this centre. Inspectors were also informed that plans were in place to recruit a further house-cordinator to cover planned leave.

Inspectors were shown a draft annual review, however, this was not finalised and therefore progress on actions could not be measured. Inspectors also reviewed the latest six-monthly review which had been completed by the provider. There were 46 actions relating to staff training, positive behaviour support, personal plans and the premises. The majority of actions were future dated, however 17% were overdue for completion at the time of this inspection.

The provider had developed a quality improvement plan. This plan combined actions related to governance, risk management, safeguarding and staffing. This document demonstrated that 27% of actions were complete, 9% were overdue for completion and 63% were in progress. Some of the overdue and outstanding actions related to audits and reviews, the premises and staffing. As previously mentioned, approximately 45% of the actions (submitted as part of the providers representation) had not yet been completed and while progress had been made, these areas of premises, staffing, risk, safeguarding and resident transitions, all needed to be brought to a successful conclusion.

Judgment: Not compliant

Quality and safety

Overall inspectors found that while progress had been made to the quality and safety of care and support for residents, improvements were still required in relation to their homes, the grounds and the implementation of safeguarding measures.

In line with the findings of previous inspections, it was identified that the provider had failed to effectively address premises issues in this designated centre. This was impacting on the lived experience for some residents. For example, it remained the case that some parts of one resident's home were not accessible to them.

As identified in the previous inspection report, two residents were due to transition from the centre. One resident was due to be discharged and work was ongoing with them to identify a suitable placement in line with their wishes and preferences. For the other resident, delays continued around their move. However, there was evidence to demonstrate that they were involved in their transition planning and were being regularly updated on any progress made by the provider in relation to their transition. One resident spoke to inspectors about their planned move.

Inspectors found that the provider had made improvements to the implementation of their risk management systems. This was resulting in a reduction of presenting

risks for a number of residents and increased control measures and oversight in key risk areas. This was a positive improvement.

Regulation 17: Premises

The provider had commissioned a comprehensive review of the premises and these findings were being discussed during weekly maintenance meetings. There were two maintenance personnel and a number of contractors completing maintenance, repairs and premises works at the time of the inspection. However, as previously discussed, significant works were still required to some residents' homes and the grounds.

Some of the outstanding works included;

- ensuring that the bedroom/living area of a resident who uses a wheelchair was fully accessible
- works to replace and/or repair flooring in one of the houses
- uneven areas of the grounds, pathways and footpaths
- the kitchens were due to be replaced in three of the houses
- renovations were due to be completed in three bathrooms.

Judgment: Not compliant

Regulation 26: Risk management procedures

Previous inspections found that the provider's systems for oversight and monitoring of risks had not been effective. However, this inspection found that a number of improvements had been made in relation to risk management and more were planned.

Inspectors reviewed the operation risk register and found that there were 24 recorded risks. These included risks relating to safeguarding, staffing, the premises not meeting residents' needs and risks relating to the grounds and farm. Inspectors found that the risk register was now reflective of presenting risks and control measures. It also reflected the impact of implementing additional control measures on reducing presenting risks. For example, as previously mentioned, there was a heavy reliance on agency staff to complete shifts in this designated centre. Since the last inspection the provider had taken a number of steps to mitigate this risk. This included the creation of a detailed area specific induction folder for each of the five houses in the centre. These folders included a map of the campus, contact details for key personnel, guidance for on-call arrangements out-of-hours and the escalation pathway for emergencies. In addition, there was an agency staff induction pack specific to each house which included welcome and introductions, a walk around the premises, and introduction to each resident, a review of staffing

arrangements, staff roles and responsibilities, reporting structures, a summary of residents' specific supports needs and presenting risks and controls and a review of health and safety procedures.

A number of works had been completed to reduce risks relating to the grounds and pathways since the last inspection. For example, the pathways had been replaced around one of the houses and more works were scheduled to other pathways and the grounds.

Inspectors reviewed a sample of incident reviews since the last inspection, risk assessments for five residents and a crisis management plan for one resident. These documents had been recently reviewed and were found to be reflective of the presenting risks and the control measures in place. For some residents, a number of additional control measures had been implemented and these were proving effective. For example, one resident who was experiencing an increase in falls at the time of the last inspection had not experienced any further falls. Additional controls included an increase in staffing, a number of reviews by allied health professionals and the implementation of their recommendations. Another resident had experienced an increase in bruising in the weeks prior to the inspection and a review of their environment had been arranged and was completed by an occupational therapist. Additional padding was added to areas of their home and a raised bench was added to their activity room to reduce the presenting risks relating to bending over and causing themselves harm.

Judgment: Compliant

Regulation 8: Protection

Inspectors found that the provider's systems for safeguarding residents had improved since the last inspection. However, further improvements were required to ensure that all residents' finances were safeguarded on an ongoing basis.

Prior to the last inspection, a serious safeguarding concern had occurred regarding the protection of residents' finances and this had a negative impact for residents. There had been a number of systems failures and sufficient oversight of residents' finances had not occurred. A number of improvements had been made to strengthen the systems and oversight. Arrangements had also progressed since the last inspection but residents had not been actually reimbursed monies owed, with the provider stating that this would occur by November 2025.

In line with the findings of previous inspections, inspectors found that there continued to be delays in commencing and completing trust in care and safeguarding investigations. For example, the provider had identified that a trust in care investigation was required following a significant event for a resident in March 2025. This investigation had commenced since the last inspection and inspectors requested an update which indicated that the investigation was ongoing.

Inspectors acknowledge that efforts were being made to ensure that residents had unrestricted access to their finances and that the provider had oversight of one resident's finances. However, it remained the case that some residents did not have full access to their finances, in line with historical restrictions implemented by a financial institution.
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	
Regulation 15: Staffing	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Camphill Community Kyle OSV-0003625

Inspection ID: MON-0047900

Date of inspection: 15/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • A full review of staffing levels in Kyle Community was completed on the 31/08/2025 with the Person in Charge overseeing all rosters to ensure that there is continued continuity of care. This is monitored on an ongoing basis until the full staff compliment can be reached. 28/02/2026 • All rosters continue to be based on the current needs of the community members, and all needs assessments were reviewed and updated. This was completed on the 10/10/2025. They will be monitored and reviewed no later than twelve months and/or in the event of a changing need. • The Person in Charge will complete the organisational SUIT Tool to further review the needs of the community members. This is scheduled to be completed by the 10/11/25. • There are 3 staff currently onboarding which will reduce the gap in the WTE and there is continued effort with recruitment in collaboration with the HR Department, with interviews being planned after the selection process. • The Person in Charge is attending an Open Day in a college in a recruitment effort on the 22/10/25. • The Registered Provider continues to engage with a recruitment agency since the inspection to assist in filling all vacant positions within the community. • The PIC is continuing to work closely with staffing agencies to ensure that consistent agency staff with the required skills and knowledge are deployed in the community. There is established continuity with the agency staff that are supporting the staffing deficits in the community. This is monitored continuously. • The PIC retains overall responsibility and oversight of all staff rosters, ensuring that care standards are consistently upheld. Where staffing levels temporarily fall below assessed requirements, a structured support plan is promptly implemented to maintain continuity of care and safeguard service quality. During such periods, oversight is maintained by either a Team Leader or the PIC to ensure adequate staff coverage at all times. • Conclusion: Although staffing shortfalls remain, significant progress has been made since the	

inspection, and robust interim measures are in place to ensure continuity of care.
• CCoI is fully committed to achieving compliance with Regulation 15. The workforce plan will continue to be reviewed and updated to reflect residents' evolving needs and regulatory requirements. Ongoing internal audits and oversight mechanisms are in place to monitor the effectiveness of staffing arrangements and their impact on residents' outcomes.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The remaining House Co-ordinator position is now officially vacant since the 17/10/2025, this will be advertised the week on the 20/10/25.
• The Centres annual review has been re-reviewed since the inspection and is no longer in draft. The actions are being progressed in a timely fashion and noted on the report, with a completion date of March 2026 for the works on the premises.
• The Property and Asset Management Lead for CCOI is on site daily in Camphill Kyle to monitor progress of all works and is holding daily site meetings with all contractors to access the works. The update on the premises works will be elaborated under Regulation 17.
• All upgrades to properties are being completed in line with the residents' needs and accessibility and following recommendations from an OT and the Housing Guidelines that were developed by Senior OTs.
• The six-monthly provider audit actions are being routinely followed up on by the Person in Charge with actions being closed out as completed with evidence on the Viclarity system. They are then reviewed by the ASM for sign off. There are a number of larger premises actions that are underway with a planned completion date of March 2026.
• The Quality Improvement Plan is being reviewed weekly with the ASM, CEO and PIC and will include the newly appointed Head of Services from the 22/10/25. This is to review progress and maintain traction on the action plan and to support the PIC with progressing outstanding actions.
• There are ongoing efforts being made with recruitment. There are 3 staff currently onboarding which will reduce the gap in the WTE and there is continued effort with recruitment in collaboration with the HR Department, with interviews being planned after the selection process.
• The Registered Provider continues to engage with a recruitment agency since the inspection to assist in filling all vacant positions within the community.
• Until such a time where the centre meets the WTE in line with the assessed needs of the residents the Person In Charge is monitoring the rosters on a daily basis to ensure that the skill mix is appropriate across the community.
• The Team Leaders remain in a supernumerary capacity of 40 hrs to support the Person in Charge to fulfil the regulatory responsibilities.
• The Area Services manager is visiting the community regularly to support the Person in

Charge in their role and escalates any requirement for additional support.
• A review has taken place on the schedule of audits by the Quality, Compliance and Risk Team in order to streamline and ensure that they are more efficient.
• The Quality, Compliance and Risk Team have reviewed and updated the Restrictive Practice Policy with improved documentation and processes for more robust reviews of restrictive practices within the community. Updates were also made to the individual risk assessment template, the needs assessment template and the support plan template for the residents. There is further planning in place to review all documentation relating to residents to ensure it is more efficient. This will be completed by 31.12.25 with a pilot occurring in two communities prior to roll out across the organisation, planned for March 2026.
• The transitions for 2 residents have been discussed at the ADT panel, and the PIC is continuing to follow up. One resident has chosen the place that they would like to transition to and is awaiting an assessment from this unit and for the Fair Deal Application to be processed. The PIC is now attending meetings in relation to the transition for the other resident and is receiving updates. The residents are informed of progress and updates as they arise and are fully involved in their transitions.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The Registered Provider has ensured that the Property and Asset Management Lead for CCOI is on site daily in Camphill Kyle to monitor progress of all works and is holding daily site meetings with all contractors to access the works.
• The Provider will ensure that all upgrades to properties are being completed in line with the residents' needs and accessibility and following recommendations from an OT and the Housing Guidelines that were developed by Senior OTs.
• One House has had a new kitchen installed which is accessible and suitable to the resident's needs. There is a timeline planned for the installation of the remaining two kitchens. This has been reviewed and is now due to be completed by February 2026.
• Rooms in a house are being renovated to make them larger and to ensure that they are in line with recommendations on an environmental assessment completed by an OT.
• The houses are being modified with assistive technology to maintain the resident's independence throughout their home.
• A new hoist has been commissioned for the upgrades and will be installed once the renovations are completed.
• Flooring has been upgraded throughout the community, and this will continue as the upgrades occur, this is scheduled and planned and due for completion in March 2026.
• The Community has been resurfaced throughout; all carparks are completed and up to the doors of the house where a resident who is a wheelchair user resides and there are scheduled works planned to create a new evacuation area for this resident.
• The Health and Safety representative supported by the Person in Charge continues to complete a health and safety walk around weekly to identify and escalate any premises issues that may arise. The Person in Charge follows up with the Property and Housing

Department regarding actions.
• There are 3 bathrooms currently under renovation with a plan to renovate another 2 in other locations once the current works are completed.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The Registered Provider has commissioned an independent reviewer to support the organisation in identifying areas for improvement, implementing best practices, and addressing any shortcomings that may require action. Following sharing of information pertaining to the investigation, the initial meeting was completed with the Person in Charge on the 10/10/25 with follow up meetings scheduled for the 23/10/25 and 24/10/25.
• The Registered Provider will ensure residents are reimbursed monies owed by the 30/11/25 following a review of all financial files. This process has begun.
• The Registered Provider has ensured the current finance policy is under review and is due to be reviewed by the National Compliance, Risk and Safeguarding Manager alongside the newly appointed Head of Service in conjunction with the Finance Department the week of the 03/11/25.
• Following the outcome of the independent investigation, the Registered Provider will ensure that the Finance Policy will be re-reviewed with all findings considered for implementation.
• The Provider will ensure that all staff are aware of their responsibilities regarding the Finance Policy when it is issued, through team meetings and/or staff supervision.
• The Registered Provider has ensured that the Person in Charge is continuing to link in with the ADM lead in the Safeguarding and Protection Team regarding the financial restrictions imposed from banking institutions and has had contact with the Irish Human Rights and Equality Commission Solicitors regarding setting up a meeting to discuss the issues. This will continue to be an ongoing piece of work.
• The HR Department in CCoI have concluded the outstanding Trust in Care.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(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	28/02/2026
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	20/10/2025
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	31/03/2026

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	31/03/2026
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	31/03/2026
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	Not Compliant	Orange	28/02/2026

	accordance with the statement of purpose.			
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	20/10/2025
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 and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	20/10/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	20/10/2025