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:	Avalon
Name of provider:	Avista CLG
Address of centre:	Dublin 15
Type of inspection:	Short Notice Announced
Date of inspection:	17 September 2025
Centre ID:	OSV-0003728
Fieldwork ID:	MON-0048066

About the designated centre

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

Avalon is a large bungalow on a campus setting which provides care and support to 3 residents with an intellectual disability and underlying medical needs. The house has three separate living areas with a shared kitchen and visitors room. There are sufficient bathrooms and shower facilities available for residents. There are also laundry facilities available and a number of communal areas. Residents are supported 24 hours a day, 7 days a week by a staff team led by of a person in charge, clinical nurse managers, staff nurses, care staff and household staff are available to support residents.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 17 September 2025	10:00hrs to 17:30hrs	Erin Clarke	Lead
Wednesday 17 September 2025	10:00hrs to 17:30hrs	Maureen McMahon	Lead

What residents told us and what inspectors observed

This report outlines the findings of a short-notice announced risk inspection carried out on behalf of the Chief Inspector of Social Services to assess the provider's compliance with the regulations. A group inspection methodology was applied, whereby seven inspectors undertook inspections of three designated centres located within the provider's campus on a single day. As part of this process, inspectors also met with senior management to review the governance and oversight arrangements in place across the wider campus setting. Overall, inspectors found that while the centre was well equipped in terms of facilities and space, allowing residents' individual and collective needs to be met, it was also found that the centre had not been appropriately staffed prior to residents moving in. The type of service to be provided in the centre also required further review and clarification to ensure that the centre aim and function were clearly defined and aligned with that identified in the statement of purpose.

The designated centre under inspection is situated within a large, congregated mixed-use campus which accommodates a total of 72 residents across several designated centres. This centre consists of one house and is registered for a maximum of three residents. In addition to residential services, the campus includes administration buildings, a day service, a restaurant with an industrial kitchen, a church, children's disability services, training facilities, and ancillary support services. During the inspection, inspectors had the opportunity to meet the person in charge, service manager, and four staff members.

The provider had applied in February 2025 to vary the conditions of registration for the designated centre. The proposed variation sought to reduce the overall footprint of the centre, amend internal floor plans, and decrease the maximum number of residents accommodated from five to three. As part of this process, residents who had previously lived in the centre were transitioned to another designated centre located on the same campus. Following this transition, two new residents moved into the centre in June 2025 and inspectors met with the two residents living in the centre during the inspection.

Both residents had transitioned into the designated centre from other services within the provider's organisation while awaiting the completion of their new homes in the community. Inspectors were informed that these new community houses were expected to be ready within approximately one year; however, no confirmed timelines were available at the time of inspection. While the transitions into this centre were planned and the Chief Inspector had received requested weekly updates regarding one resident's transition, inspectors found that the centre had not been appropriately resourced to support the residents' move. Staffing levels and recruitment had not been finalised prior to admission, and the recruitment status of core staff remained unclear despite several requests for clarification from inspectors.

Consequently, there was a high reliance on agency and non-permanent staff to maintain the roster and deliver care and support within the centre.

Staff members met by inspectors explained that they had previously supported the residents in another designated centre and had since moved with them to this location. They demonstrated good knowledge of the residents' needs, preferences, and routines. One staff member described how the larger space within the new centre provided a more suitable environment for the resident they supported, offering greater flexibility for their needs compared to their previous home.

Inspectors met with one resident before they left the centre to participate in an activity. The resident appeared relaxed and comfortable in the company of staff. This resident's assessed needs included communication differences. While they did not engage verbally with inspectors, they made eye contact and appeared content to continue with their morning routine, which staff facilitated in a respectful and unobtrusive manner. Staff told inspectors that the resident planned to attend the cinema later that day. Inspectors also met with the second resident prior to their departure for day services. Although this resident did not verbally share their views about living in the centre, they were observed to be at ease and interacted naturally with staff. Staff spoken with described the residents' preferred activities, which included swimming, dining out, visiting local amenities such as the Phoenix Park, and attending nearby pet farms.

Residents living in the centre accessed external day services in line with their assessed needs and personal preferences. One resident attended a day service five days per week, while the other attended three days per week. These opportunities supported residents to participate in meaningful and enjoyable activities in line with their interests and routines. Residents' were involved in how they lived in the centre. Each residents' likes, dislikes and preferences were gathered through the personal planning process, by observation and from information supplied by others who knew them well. Inspectors saw records of weekly resident meetings were resident choices were discussed and agreed.

Inspectors conducted a walk-through of the building and observed that the centre was configured for single occupancy for three residents. This arrangement reflected the provider's assessment that residents required to live separately from one another, and it formed part of the provider's approved application to reconfigure the centre. Each of the two current residents had their own designated living and dining areas; however, they did not have unrestricted access to the kitchen due to identified risks relating to one resident. While residents were permitted to enter the kitchen when cooking was not taking place, inspectors observed an incident that had occurred in the kitchen during such a time, suggesting that access remained limited in practice. Inspectors were therefore not assured that residents had clear or consistent access to drinks and snacks, or that alternative arrangements to support choice and communication in this regard had been effectively implemented.

The third bedroom was located within a space that also contained an overhead hoist, dining area, and living area. The layout and mixed use of the area were not suitable for long-term occupancy. Inspectors were informed that this room was

intended for use as a convalescent or respite space. Inspectors requested that the provider update the centre's statement of purpose and subsequently submit it to the Chief Inspector to clarify the centre's overall function and the intended use of the third bedroom. At the time of inspection, the statement of purpose did not clearly outline the nature of admissions permitted or whether the centre provided short-term residential care.

Overall, inspectors found fragmented systems of governance and management, with gaps in oversight in areas such as staffing, staff training, risk management, contracts of care and positive behaviour support. The next two sections of this report will discuss those governance and management arrangements and how they did or did not ensure and assure the quality and safety of the service.

Capacity and capability

Overall, inspectors were concerned that the centre had reopened for the current residents without sufficient staffing in place. On the day of the inspection, only three core staff members were assigned to the centre, one of whom was an agency staff member. These staff had previously supported the residents in other locations operated by the provider and had moved with them to this centre. The service remained heavily reliant on agency staff to maintain rostered shifts, with an additional 10 staff required to meet the centre's staffing needs. Furthermore, the provider did not furnish evidence of recruitment campaigns or interview processes to demonstrate an active commitment to filling the staffing gaps in this centre.

The statement of purpose, a key governance document which clearly defines what a service provides, who it is for, and how and where that service is delivered was reviewed by inspectors. It should accurately describe the model of care and support available to current and prospective residents, inspectors found that it did not clearly set out these key elements.

Regulation 15: Staffing

Inspectors found that the staffing arrangements in the designated centre were insufficient to meet the assessed needs of residents. Staff who had previously worked in this centre had since moved to another area of the campus. When the two residents relocated to this location, only three staff members transferred with them. Apart from these three individuals, no additional permanent staff had been recruited.

According to the centre's statement of purpose, a whole-time equivalent of 10.6 staff members was required to meet the needs of the residents currently living there. The centre remained heavily reliant on agency and relief staff to fill rostered

shifts. Inspectors reviewed nine weeks of rosters and found that a total of thirty-three different agency and relief staff had worked in the centre during this period. This high level of staff turnover and inconsistency did not promote the delivery of safe, person-centred care.

The night staffing team consisted solely of individuals who worked exclusively on night duty. As a result, there was limited continuity of care and communication between day and night staff teams. Inspectors also found that due to staffing deficits within the residential service, staff from the day service were required to assist with residents' personal care in the mornings.

Judgment: Not compliant

Regulation 16: Training and staff development

Inspectors found that the provider had not ensured that all staff working in the centre had received appropriate training and induction to enable them to carry out their roles effectively and safely. Inspectors requested the training records for all staff who had worked in the centre over the previous nine weeks; however, due to the large number of personnel involved, this information could not be provided during the inspection. As a result, inspectors were unable to determine whether all staff had completed the required mandatory training or whether their competencies had been verified prior to commencing work in the centre.

The provider's policy stated that only nurses, social care workers, and agency healthcare assistants who had completed appropriate training were authorised to administer medicines. This created a gap in practice for provider-employed healthcare assistants who were unable to facilitate community outings independently for one resident who required medicine-trained staff during such activities. Inspectors were informed that the healthcare assistant was booked to undertake this training, but it was not in place yet, despite working in the centre since June 2025.

Inspectors also reviewed orientation and induction records for new agency and relief staff. Of the thirty-three agency and relief staff who had worked in the centre during the previous nine weeks, only fifteen completed and recorded inductions were available for review. This level of inconsistency in induction practices did not provide assurance that all staff had been appropriately familiarised with residents' assessed needs, safety procedures, or the operational practices within the centre.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had applied to reconfigure this designated centre to meet the needs of residents who required individualised supports and single-occupancy accommodation. However, despite the planned nature of these admissions, inspectors found no evidence to demonstrate that adequate planning or preparatory work had been completed to ensure that appropriate staffing and resources were in place prior to residents moving in.

During the inspection, inspectors requested evidence of the efforts made to recruit staff into the centre, including details of recruitment campaigns, the number of interviews held, and positions offered. None of this information was provided. As a result, inspectors were unable to determine what actions had been taken by the provider to secure a stable workforce in advance of the transition. This absence of planning and accountability resulted in the centre opening without the required staffing complement as set out in the centre's statement of purpose.

Judgment: Not compliant

Regulation 3: Statement of purpose

While the statement of purpose stated that the centre consisted of living accommodation for three individuals, it did not provide sufficient detail regarding the layout or the intended use of all areas within the premises. For example, one area of the centre was described as a combined living room, dining area, and bedroom, but it was unclear who this space was intended for, or whether it was suitable for resident use.

Given the congregated nature of the campus and the national policy commitment to no new admissions to congregated settings, the statement of purpose did not make reference to this or outline how the centre would ensure compliance with this national policy.

In addition, the admission procedure described in the statement of purpose referred broadly to the provider organisation as a whole rather than to this specific designated centre. It did not outline the specific criteria, processes, or decision-making arrangements applicable to admissions into this centre. The document also failed to specify whether emergency admissions were permitted and, if so, under what circumstances such admissions would be considered.

Judgment: Not compliant

Quality and safety

Inspectors found that while aspects of care and support promoted residents' privacy and comfort, there were significant areas that required improvement to ensure that care was delivered in a consistently safe, effective and compliant manner.

Inspectors carried out a walk-through of the centre to assess the layout, design and condition of the premises. The centre comprised a range of communal, private and staff facilities distributed throughout a single-storey building. Overall, the premises were found to be of sufficient size and layout to meet the assessed needs of residents, with separate provision for staff facilities and service rooms. However, as referenced under Regulation 3, one bedroom was not suitable for residential use and required review by the provider.

Overall, while there were systems in place to identify and manage risks, gaps in staff training, environmental safety measures and the updating of risk assessments indicated that the provider's implementation of its risk management procedures was not sufficiently robust to ensure residents' ongoing safety. Inspectors also found improvements were required to ensure that all restrictive practices in use were accurately identified, appropriately risk-assessed, and clearly documented within residents' behaviour support plans.

At the time of inspection, there were no active safeguarding concerns, and staff demonstrated a clear understanding of safeguarding procedures, including their responsibility to report any allegation or suspicion of abuse.

Regulation 17: Premises

The centre contained four bedrooms in total, three for residents and one designated for staff. The residential areas were divided into three separate sleeping and living spaces, with access between individual resident areas controlled by swipe-door systems. Both residents living in the centre were accommodated in bedrooms of sufficient size to allow for personalisation and storage of their belongings. Each resident had access to an en-suite bathroom, and inspectors observed that while bedroom sizes and layouts varied, they overall promoted privacy, dignity and comfort.

Communal and individual resident areas included two dining rooms, a living area, a visitor room, and several lobbies and foyers that provided connections between individual resident living areas.The premises also contained a range of support and utility rooms, including a kitchen, laundry room, cleaner's room, boiler house, and multiple storage areas. There were also seven sanitary facilities throughout the building, comprising both resident and staff toilets, as well as combined shower/toilet rooms.

Overall, the design and layout of the premises were suitable for the delivery of care in accordance with residents' needs. However, the provider was required to review the use of one identified bedroom to ensure its configuration and purpose are

consistent with the centre's statement of purpose and the requirements of the regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had procedures in place to support the assessment, response and monitoring of risk in the centre; however, the system required improvement to ensure that identified risks were appropriately overseen and managed in practice.

Inspectors observed that oxygen cylinders were being stored in the centre's office, despite no residents being prescribed oxygen. On the day of inspection, the office door was found not to close properly. This presented a significant fire safety risk, as in the event of a fire, effective containment may not be possible.

Inspectors also found that not all staff members supporting a resident with a diagnosis of epilepsy, who had been prescribed emergency medication, had received training in the administration of this medication.

Inspectors reviewed all residents' individual risk management plans. Where specific resident risks were identified, individual risk assessments were in place. However, some required further review to ensure they were accurate, current and reflective of residents' support needs. For example, one resident's risk assessment identified that items such as twigs presented an ingestion risk. Despite this, inspectors observed that the garden area accessible to the resident contained twigs, decorative bark and weeds. Staff spoken with confirmed that these materials were unsuitable for the resident.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

An inspector saw that an assessment of residents' health, personal and social care needs was completed and a plan was in place to support each resident. Residents, their representatives and other relevant stakeholders had input into these plans.

An inspector reviewed two personal plans. These plans were found to be person-centered and up-to-date. Personal plans reviewed included an epilepsy care plan and a specific care plan for feeding, eating and drinking skills. The epilepsy plan was detailed, for example the type of seizure that may occur and the response to this event. Personal plans reviewed included a quality of life experiences and activity record for each resident. The quality of life experiences record was used to plan goals and supports they needed to achieve them. An inspector saw pictures of

residents progressing their identified goals. For example, pictures of a resident visiting a theme park in Ireland, this was a step in a residents' goal to visit Disneyland.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors reviewed the systems in place to support residents with behaviours of concern and found that while behaviour support plans were in place and restrictive practices were subject to review, the overall quality of these reviews required improvement. Behaviour support plans reviewed by inspectors were generic in nature and did not always provide clear, individualised guidance for staff on the implementation of proactive or reactive strategies.

Inspectors observed that some interventions being used in practice, such as physical redirection and physical holds, were not documented within one resident's behaviour support plan. For example, inspectors observed staff physically redirecting a resident from one area of the centre to another, and staff were also observed removing unsafe items from the resident's possession. Staff members spoken with confirmed that physical redirection was sometimes necessary to support the resident safely. However, the lack of documentation meant these interventions were not formally assessed, approved, or monitored as restrictive practices, thereby limiting oversight and consistency in their use.

There were a number of restrictive practices in operation in the centre for the purposes of residents' safety, including the use of a wheelchair harness and locked external doors. These practices were reviewed periodically by the provider's restrictive practice committee and on a quarterly basis by the management team. However, inspectors found that not all restrictive practices were accurately recorded or reflected in the relevant risk assessments and records. For example, while a resident had free access to a secure garden area, the corresponding risk assessment inaccurately described this access as restricted.

Judgment: Not compliant

Regulation 8: Protection

The provider had established systems in place to safeguard residents from harm and abuse. These included an up-to-date safeguarding policy that reflected current national guidance and provided directions to staff on how to identify, report, and respond to safeguarding concerns. Each resident had an individual intimate care plan in place, developed in consultation with the resident and their representative,

which outlined the supports required to ensure personal care was delivered safely and with dignity.

The provider had identified, through assessment, that each resident required their own living space based on their individual needs and preferences. As a result, the physical environment had been adapted to ensure that residents could enjoy privacy and personal space, while maintaining access to shared areas for social interaction when desired. Inspectors found that this adaptation had improved compatibility between residents and reduced the potential for safeguarding incidents.

At the time of inspection, there were no active safeguarding concerns, and staff demonstrated a clear understanding of safeguarding procedures, including their responsibility to report any allegation or suspicion of abuse.

In relation to the management of residents' finances, inspectors found that residents were supported in a manner that promoted both independence and protection. Each resident had a financial assessment in place that outlined the level of support required to manage their finances. The person in charge conducted regular audits of residents' finances to ensure transparency, accountability, and compliance with the provider's financial policy.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Avalon OSV-0003728

Inspection ID: MON-0048066

Date of inspection: 17/09/2025

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: The provider will continue to recruit for all current vacancies to ensure delivery of safe and person-centered care. Two full-time Care staff have been recruited since the inspection and are currently undertaking the onboarding process. Further Social Care interviews are scheduled for 17th Nov. Recruitment open day scheduled for 19th Nov for all remaining vacancies. The provider requests regular relief and agency to support consistency and safe delivery of Care during the recruitment process. Night team have provision of one hour support from regular day staff to support communication, continuity of care and induction where required.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: All staff training records will be available on site. The staff training matrix has been updated and any training required has been booked with the training department. Care staff has completed Safe medication management and is currently undergoing competency assessment. Thereafter training course in relation to Epilepsy awareness and the administration of Buccal Midazolam medication will be completed.	

Non-Mandatary training course in relation to Epilepsy awareness and the administration of Buccal Midazolam medication is currently under review. All recruited Care staff will be scheduled for training upon commencement of duty to to facilitate individual community participation.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider has provided an updated Statement of Purpose in accordance with regulations.

PPIM meetings will take place monthly with the Person in Charge to ensure there is governance and management over the center in accordance with KPI.

The provider will meet with PPIM and PIC to monthly review actions and progress.

The provider will ensure all documentation is in place as per Hiqa standards and regulations

Regulation 3: Statement of purpose	Not Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of purpose has been reviewed and updated to accurately reflect the delivery of care in the center.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Fire door closure was corrected on the day of inspection.
Oxygen therapy was reviewed and currently there is no requirement within the designated center. Local System will be implemented for responding to emergency situations

Care staff has completed Safe medication management and is currently undergoing competency assessment. Thereafter training course in relation to Epilepsy awareness and the administration of Buccal Midazolam medication will be completed.

Non-Mandatary training course in relation to Epilepsy awareness and the administration of Buccal Midazolam medication is currently under review.
All recruited Care staff will be scheduled for training upon commencement of duty to facilitate individual community participation.

Risk Management will be implemented in the designated Centre in accordance with schedule 5.

Risk Assessments are under review, and all individual risks will be identified to ensure same are accurate current and reflective of resident's support needs and appropriate measures will be implemented.

The Garden area has been risk assessed and control measures are under implementation to ensure available garden space is safe and secure for the individual.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
The CNS in Behavior support is currently reviewing the Behavior support plan with the MDT Team to ensure that it is individualized and provides clear guidance for staff in proactive and reactive strategies.

The behavior support plan will clearly reflect all current interventions in relation to restrictive practice for consideration. They will be formally assessed, approved and monitored and documented in line with Service policy and regulation.

All staff will be inducted to Behaviour Support plan and approved interventions.

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	01/03/2026
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.	Not Compliant	Orange	01/03/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to	Not Compliant	Orange	30/03/2026

	appropriate training, including refresher training, as part of a continuous professional development programme.			
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/12/2026
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	01/03/2026
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.	Not Compliant	Orange	30/11/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	30/11/2025

	assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 03(1)	The registered provider shall prepare in writing a statement of purpose containing the information set out in Schedule 1.	Not Compliant	Orange	11/11/2025
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	30/04/2026
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/12/2025