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:	Tús Álainn
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	04 February 2026
Centre ID:	OSV-0005731
Fieldwork ID:	MON-0043652

About the designated centre

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

Tús Álainn is a designated centre operated by Saint Patrick's Centre, Kilkenny. The designated centre is a detached bungalow located in the suburbs of Kilkenny city and ideally located for residents to engage with local amenities, to promote and support their social inclusion and integration with the local community. The designated centre has a capacity for three adult residents, and the provider has decided that the centre is for female gender only. Tús Álainn designated centre provides full-time residential services for people with intellectual disabilities and complex health care needs. This individuals living in this designated centre are supported by a staff team comprising nursing, social care worker and health care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 4 February 2026	09:05hrs to 17:05hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

This unannounced inspection was completed by one inspector of social services over one day. It was carried out to assess the provider's regulatory compliance. The findings of this inspection were positive in relation to residents' care and support; however, improvements were required to staffing and oversight and monitoring across a number of areas such as residents' finances, risk management and fire safety. These areas will be discussed further in the body of the report.

In Tús Álainn full-time residential care is provided for up to three adult residents with an intellectual disability. The centre comprises a bungalow on its own grounds in a residential estate on the outskirts of Kilkenny City. It is close to good variety of local amenities such as shops, restaurants and local transport links. The bungalow comprises a sitting room, a large kitchen come dining room, three resident bedrooms one of which has an ensuite bathroom, two shared bathrooms, a utility room and a staff office.

Over the course of the inspection, the inspector had an opportunity to meet two of the three residents living in the centre. The third resident was in hospital at the time of the inspection. As residents did not tell the inspector what it was like to live in the centre using words, the inspector used observations, a review of documentation and discussions with staff, were used to capture the lived experience of residents. In addition to meeting two residents, the inspector also had an opportunity to meet and speak with the person in charge, one staff on duty, the director of service and a wellness, culture and integration manager.

On arrival both residents were in bed and the inspector briefly met a staff as they left to go and support the resident who was in hospital. The inspector observed a calm and relaxed atmosphere in the centre on arrival and throughout the inspection. Residents were observed to move around their home freely and to spend time in the favorite parts of the house. The staff member on duty was observed to be very busy but to make themselves available everytime residents' indicated they required support.

Due to one resident being in hospital and staffing numbers decreasing in the house in offer to support them, residents' engaged in activities of their choice in their home. They were observed to watch television, spend time with staff, to listen to music and to use sensory equipment.

Residents had a variety of communication support needs and used vocalisations, gestures, facial expressions, behaviour and body language to communicate. The staff on duty and person in charge were observed to be very familiar with residents' strengths, preferences, support needs and communication preferences. They were observed to pick up on and respond to residents verbal and non-verbal cues throughout the inspection. They used person first language and took every

opportunity to speak with the inspector about residents' strengths, skills, talents and ways that they contribute in their home and local community. For example, one resident liked to bake and was regularly donating baked goods to a local charity.

There was information available in poster and easy-to-read formats in the house relating to areas such as complaints, residents rights and safeguarding. In residents' files social stories and easy-to-read documents were in place relating to their specific support needs. Staff were reviewing these with residents and the date reviewed was recorded on the documents. There were picture rosters and menu planners on display. Resident meetings were held weekly and areas such as complaints, safeguarding, activities and menu planning were regularly discussed.

The house appeared very homely and comfortable. Both the garden and premises were well-designed and well maintained. Residents' bedrooms were decorated in line with their preferences. They had their favourite possessions and a number of photos and pictures on display.

The provider was capturing the views of residents and their representatives as part of their audits and reviews, and using the complaints and compliments process. The inspector reviewed a recent compliment from a residents' family member expressing their gratitude to staff for the "care and kindness" they show to their relative. They described staff as "absolutely brilliant" and said "they go above and beyond".

In summary, residents in this centre were being well supported. However, a review of staffing numbers was required to ensure that staffing supports were in line with residents' assessed needs and to ensure they could engage in meaningful activities. In addition, improvements were required to oversight and monitoring across a number of areas such as residents' finances, risk management and fire safety. These areas will be discussed further in the body of the report.

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

Capacity and capability

The findings of this announced inspection were that residents were well cared for. However, some improvements were required to ensure they were in receipt of a good quality and safe service. There had been a period since the last inspection where oversight and monitoring was not proving effective.

The management structure had recently changed with a new person in charge and wellness culture and integration manager commencing the first week in January. The inspector reviewed minutes of the latest meeting between the person in charge and wellness culture and integration manager. These reflected areas where

improvement were required in line with the findings of previous six-monthly reviews by the provider, this inspection and the previous inspection in November 2023. For example, they had identified that some notifications had not been submitted to the Chief Inspector, that improvements were required in the areas of risk management and fire safety, that there had been a lack of oversight of residents' finances for approximately six months in 2025. They also found that that staff required support, supervision and training, and that residents required a more predictable and meaningful day. They had developed and action plan (76 actions in total) and assigned dates for completion and the person(s) responsible. There actions needed to progress in a timely manner to bring about the required improvements.

There were a number of staff vacancies and efforts were being made to ensure that this was not impacting on continuity of care and support for residents. This will be discussed under Regulation 15: Staffing.

Regulation 14: Persons in charge

The inspector reviewed the Schedule 2 information for the person in charge in advance of the inspection and found that they had the qualifications and experience to fulfill the requirements of the regulations. They were full-time and also identified as person in charge of two other designated centres.

They had commenced as person in charge of this centre a few weeks before this inspection. During the inspection, the inspector reviewed the systems they had for oversight and monitoring and found that they were effective in identifying areas of good practice and areas where improvements were required in this centre. They required time to implement the actions to bring about these improvements.

Residents were observed to be familiar with them and appeared very comfortable and content in their presence. They were focused on implementing a human-rights based approach to care and support for residents and on ensuring that each resident was happy and felt safe living in this centre.

Judgment: Compliant

Regulation 15: Staffing

Based on a review of residents' assessments and plans it was not clear if the number of staff on duty were meeting residents assessed needs, at times.

The inspector reviewed each residents' assessments of need and risk assessments and found that the assessment process to inform staffing requirements required review. It was not clear what staffing supports were required to meet their assessed needs; therefore it could not be demonstrated that current staffing levels were

meeting their assessed needs. For example, some risk assessments referred to residents being supported by one or two staff. It was not clear how this determination was made and there was one staff on duty at night time in this centre.

There was 2.3 whole time equivalent (WTE) vacancies at the time of the inspection which was approximately 1/3 of the required WTE for this centre. Planned and unplanned leave was not built into the WTE requirement for this centre. Based on a review of rosters between October 2025 and January 2026 and discussions with staff, every effort was being made to ensure that this was not impacting the continuity of care and support for residents. However, this was not always proving possible. For example, over one week of rosters reviewed, 12 shifts were covered by four relief and three agency staff. In addition, on two rosters reviewed between November and December 2025, there were four shifts which were recorded as not covered and therefore it was not demonstrated that the required staffing numbers were not on duty.

Some of the supports in place to ensure that the staff team were carrying out their roles and responsibilities to the best of their abilities included, induction, probation, supervision, training, and opportunities to discuss issues and share learning at team meetings.

Judgment: Substantially compliant

Regulation 22: Insurance

The inspector reviewed the provider's contract of insurance. It was up-to-date and insured against risks in the designated centre such as loss or damage to property.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider had recognised that their systems for oversight and monitoring were not proving fully effective or bringing about the required improvements since the last inspection.

The provider had completed an annual review and six-monthly unannounced provider visits which met regulatory requirements. These identified areas for improvement in line with the findings of this inspection and an action plan was put in place. However, actions from these remained outstanding or were overdue at the time of this inspection. For example, from the latest six-monthly review 42% of actions were overdue for completion. These related to fire safety, residents' goals

and plans, risk management and residents' finances. In addition, the inspector reviewed an action plan for this centre from September 2024. It had 23 actions with 6 marked complete. There were 17 actions outstanding and these related to areas such as oversight of documentation and records. This demonstrated that audits and reviews were not proving fully effective in bringing about the required improvements in line with the identified time frames.

In line with the findings of the last inspection, the inspector found that improvements were required in relation to risk management and fire safety. Some documentation relating to risk management was not up-to-date or reflective of how effective control measures were at managing risk in this centre. For example, the risk register, general risk assessments and residents' individual risk assessments required review in areas such as fire safety, unexplained absence, medication errors and lone working at night. In addition, it was not demonstrated that learning as a result of fire drills was leading to the required improvements. For example, the staff coming to support with evacuation from another centre operated by the provider had difficulties finding the house with the eircode provided. It was not documented that this had been followed up on, or rectified. Action was also required to ensure that one resident could safely evacuate using the two available options of equipment. Fire drill records demonstrated that they could successfully evacuate using the first piece of equipment, a hoist. However, a recent drill had found that the second option for equipment to support their evacuation, a ski-pad, was not suitable to support them to evacuate safely. While the provider was sourcing a more suitable ski-pad, their evacuation plan was updated to reflect this.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector completed a walk around the premises and reviewed a sample of 2025 incidents reports and found that the provider had not ensured that the Chief Inspector was notified of each of the required incidents in the centre in line with the requirement of the regulations. For example, the inspector reviewed incident reports to show minor injuries for residents in February and September 2025 which had not been notified.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that residents lived in a warm, clean and comfortable home. They were well supported and spending time with their family and friends.

The inspector reviewed each residents' assessments and personal plans and found that these documents positively described their needs, likes, dislikes and preferences. However, their assessments of need did not fully reflect the required staffing supports and this was discussed under Regulation 15: Staffing. Residents were accessing health and social care professionals in line with their assessed needs.

Residents, staff and visitors were protected by the medicines management, safeguarding, fire safety and risk management policies, procedures and practices in the centre. However, improvements were required to documentation to demonstrate how effective risk management and fire safety systems were in the centre. This was discussed under Regulation 23: Governance and management.

Regulation 11: Visits

The provider had appropriate arrangements in place for residents to receive visitors in line with their wishes. These arrangements were detailed in the residents' guide and the statement of purpose for this centre. In addition, the provider had a visitors policy.

Through a review of documentation and discussions with staff, the inspector found that residents were visiting or being visited by their family and friends on a regular basis. For example, one resident was due to go stay with their family overnight on the week of the inspection. Another resident was meeting their neighbour regularly to donate their baked goods to a local charity.

There were a number of communal and private spaces available for residents to receive visitors. Visiting was unrestricted unless it poses a risk to residents or the visitor and if the resident requests the restriction.

Judgment: Compliant

Regulation 12: Personal possessions

In line with the findings of the last inspection, it could not be demonstrated that residents could freely access their personal finances. In additon, the provider's systems to ensure their finances were safeguarded were not being fully utilised or proving effective in this centre.

Residents living in this centre have Health Service Executive (HSE) Private Patient Property Accounts (PPPA). The provider had developed guidance including a flow chart on how to access these accounts. Residents could request access to their funds through a central office operated by the registered provider. They were limited to accessing their funds to office hours Monday to Friday. The provider was aware of these restrictions and while working to update their policies, procedures and practices they were recognising and reporting them as restrictive practices. Work had been completed since the last inspection to increase residents' access to their finances including issuing regular statements of account and introducing a card system. Resident's had their cards topped up by at least €100 weekly; however, they were had to request additional funds through the central office during opening hours.

Records reviewed did not consistently demonstrate that residents' income and expenditure was logged or that withdrawals and spending was recorded accurately. A recent audit by the incoming person in charge found a small number of receipts which had not been maintained for residents' spending in 2025. They had retrospectively completed finance error forms in line with their findings and appropriate action had been taken. In addition, they found that spending had not been reconciled against residents' statements of account over a six month period in 2025. A log of residents' personal possessions was maintained. The inspector reviewed a sample of these and the items listed were present in their rooms.

Each residents' contracts of care were reviewed and found not to reflect current charges.

Judgment: Not compliant

Regulation 17: Premises

The provider had ensured that both the indoor and outdoor areas of the premises was well maintained.

The inspector completed a walk around the house and garden and found that the premises was designed and laid out to meet the number and needs of residents. For example, one bedroom had a ceiling hoist and large accessible ensuite bathroom. There was also a height adjustable bench and sink area in the kitchen. The garden surfaces to the front and back garden were flat and accessible.

There was a paved area in the back garden with a swing seat and table and chairs. There was also a large polytunnel in the back garden with vegetable and fruit plants. There were plant pots and coloured ornaments in the garden which contributed to how attractive the outdoor spaces appeared.

The premises was centrally located with good access to local amenities and services. The size and layout of the house contributed to the calm and relaxing environment observed during the inspection. The premises offers space for residents to enjoy

communal areas or to spend time alone if they wish to. Their bedrooms were personalised to suit their tastes. Both residents were observed to choose to spent time in their bedrooms during the inspection.

Judgment: Compliant

Regulation 18: Food and nutrition

The provider was ensuring that residents had access to good nutritional care, adequate hydration in order to maintain good health.

Residents has specific support needs relating to eating and drinking which were clearly documented in their plans. They had access to the relevant health and social care professionals such as speech and language therapists and dieticians. Risks relating to eating, drinking and nutrition were recognised and risk assessments were also developed and reviewed as required.

The inspector had an opportunity to observe the mealtime experience for one resident on a number of occasions throughout the day. A relaxed and quite atmosphere was observed during mealtimes and the resident was supported to eat and drink in a sensitive and unrushed manner by staff. When they did not wish to eat or drink what was offered by staff, this was respected and the staff offered them alternatives or returned to them a little while later to offer again.

There were adequate stocks and a variety of foods and drinks available to offer choice at mealtimes. There were fresh fruits and vegetables available. The fridge, freezer and kitchen presses were well stocked with a variety of foods and drinks.

Judgment: Compliant

Regulation 20: Information for residents

The inspector reviewed the residents' guide. It contained information required under this regulation such as information about the services and facilities provided, the terms and conditions relating to their residency and arrangements for visits and participation in the running of the centre.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Residents were protected by the medicines management policies, procedures and practices in this centre.

The inspector found that there were effective systems for ordering, storage, receipt, disposal and administration fo medicines.

There had been a trend of medication errors and a near miss in the centre in the months preceding the inspection. A number of responsive actions had been taken by the provider to reduce the risk of reoccurence. This included, moving the medicines storage press from the kitchen area to the office, additional staff training, an emergency staff meeting to discuss the errors and near misses and staff supervision.

The inspector observed a staff prepare medicines on two occasions and they were observed to do this in line with the provider's policies and best practice. For example, they prepared the medicines as per the residents' prescription and then once administered, returned to sign the medicines administration sheet.

Each resident had a medicines plan and folder. These folders and the medicines cabinet were well organised. The date of opening was recorded on medicines and medicines were individually labelled for residents, expiry dates were recorded. There was a separate lockable box available for returns to the pharmacy and to store controlled medicines within a locked press, if required. Stock checks were being completed daily and the inspector reviewed a sample of each residents' medicines and records reviewed matched the amount of stock that should be in place.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant

Compliance Plan for Tús Álainn OSV-0005731

Inspection ID: MON-0043652

Date of inspection: 04/02/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:
The provider has commenced a full review of staffing allocation across all designated centres to ensure people supported have required supports as per their needs and roles identified at their visioning. This will ensure roster management to be in line with people supported needs and funding available.

The PIC has commenced a full review of risk assessments in line with supports required. The supports required for one person supported especially by night time was reviewed and updated to ensure it reflects supports for personal care during evening routine.

Aurora has commenced implementation of a new HR and roster management system in 2025, moving away from the previous time management system. The new system is supporting better oversight not only on local but also provider level on all rosters in line with the approved staffing complement, which determines also worked and approved hours and payroll. It is now, at this point from 09.03.2026, that Aurora is fully live on the new system with rosters and demonstrate required staffing numbers are on duty to support the needs of the people supported living in Tus Alainn, even when agency staff are required, due to leaves.

Roster gaps in Tus Alainn due to vacancies have been filled by consistent agency staff and/or relief staff in 2026. The service has a responsive relief group and each PIC has been assigned relief staff in accordance with vacancies in their WTE. Currently, Tus Alainn has been assigned 4 relief staff.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The current PIC & WCIM both commenced as managers in this designated centre on 05.01.2026. The PIC has responsibility for two other designated centres and oversight systems in place to support her remit. Since the inspection took place, a team leader has commenced on the 02.03.2026 for one of the other designated centres under this PIC's remit. With this additional support, the PIC can be present in this designated centre for further governance, oversight, management and support to the team and the people supported.

WCI manager agreed following timelines with the PIC for completion of annual and 6 monthly audit actions from 2025:
- 6 Monthly audits - 11 actions for completion by the 20.03.2026
- Annual review -1 action for completion by the 13.03.2026

Aurora's updated Risk management policy is now implemented. A Workshop was completed with all PIC on the 19.02.2026 to support in all areas of risk management.

PIC attended further fire training workshop, delivered by the fire officer in Kilkenny on the 18.02.2026. Health & Safety department in attendance, to support.

Review of risk assessments has commenced by the current PIC in relation to fire safety, unexplained absence, medication errors and lone working by night.

Fire drill learnings and actions have been added to each month's team meeting agenda and discussed at the February team meeting on 04.02.2026

PIC is completing her weekly status reports and submitting to WCIM for review. Template and report have been reviewed by ADOS & WCIM for final review by PIC before governance meeting on the 12.03.2026. Improvements made to comply with governance and management of designated centres.

Quality conversation/ governance meetings have been planned scheduled between WCIM & PIC. One completed in January 2026 and next meeting planned for 31.03.2026. Governance/ Quality conversations to occur in the designated centre with full 'walk around" in house.

Planning for re-registration has commenced, DOS met with PIC's on the 23.01.2026. Re-registration template with actions discussed between PIC & WCIM on 26.02.2026 Additional support, available from Quality department and other departments.

Suitable second option for evacuation has been researched in line with fire drill actions. Further reviews to occur and PEEP to be finalised by 31.03.2026.

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Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
PIC ensures that all notifications to the Chief Inspector are notified as required by Regulation 31, including minor injuries logged on quarterly returns, in line with time deadlines.

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Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
PIC is completing finance audits each month. Finance audit template has been updated, as practice development in line with improvements required in line with governance/ management in 2026.

PIC has commenced OJM with staff in Tus Alainn in relation to designated persons/ keyworker/ staff responsibility in line with person supported finances pathway.
Added agenda item on team meetings and discussed at the team meeting on the 04.02.2026.

Contracts of care (Aurora Service Provision Documents) were reviewed and are reflecting the accurate charges.

A more in-depth review of the Person Supported Finance Policy is ongoing and yet to be finalised to ensure detail and transparency in processes and the policy.

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Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	21/03/2026
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.	Substantially Compliant	Yellow	30/03/2026
Regulation 15(3)	The registered provider shall	Substantially Compliant	Yellow	30/03/2026

	ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.			
Regulation 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	30/03/2026
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	01/07/2026]