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:	Greenville House
Name of provider:	Praxis Care
Address of centre:	Cork
Type of inspection:	Unannounced
Date of inspection:	10 June 2025
Centre ID:	OSV-0002113
Fieldwork ID:	MON-0047346

About the designated centre

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

The centre provides residential care specifically for adults with autism. The centre is set in five acres of land outside a village in a picturesque environment and there is also a day service and other facilities, such as horticulture and outdoor gym equipment in the grounds. The centre comprises a main house and seven cottages and can accommodate 14 residents. The main house can accommodate five residents and the cottages can accommodate either one or two residents. Residents were supported on a 24/7 basis by support workers, team leaders and a social care leader. A person in charge is appointed to maintain day to day oversight of operations within the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	14

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 10 June 2025	09:15hrs to 17:30hrs	Robert Hennessy	Lead
Wednesday 11 June 2025	09:30hrs to 14:00hrs	Robert Hennessy	Lead

What residents told us and what inspectors observed

This was an unannounced inspection following information submitted, by the registered provider, to the chief inspector. The designated centre compromised of seven different homes and the inspection was completed over two days. Each home was visited by the inspector and the inspector met with eight of the residents during the inspection. Residents were seen leaving the centre throughout the two day of the inspection to undertake various activities.

On arrival at the centre the inspector met with a member staff and then met with the person in charge. This was followed by a walk around of the designated centre with the person in charge. It was explained to the residents why the inspector was there to all the residents met on the walk around. Some of the residents were met on this walk around but other residents were undertaking their morning routine and this was not interrupted. One of the residents met was ready to go on a trip to a nearby tourist attraction and was seen heading off with staff and they were gone for the day. The resident appeared to be happy that trip was taking place. On the second day of the inspection it was reported that the resident had enjoyed this day trip. Other residents were seen relaxing in their homes with the support of staff. A second walk around of the centre was undertaken on the second day of the inspection at a later in the day.

One resident met with spoke with the inspector about the garden they maintained in their home. There was a bright conservatory space that had been added to the home. There was a plan to develop a similar type of space in another home in the designated centre to increase the communal space for the residents. This was identified on the last inspection of the centre and is discussed further in the report. The other homes in the designated centre had adequate communal space there. In the main the centre was well maintained and it was evident that areas of this had been recently decorated. Resident had access to laundry areas in each home. The residents had outdoor areas which they could use during the day. Residents were seen relaxing in their homes throughout both days. Residents showed the inspector their artwork that was used to decorate areas of the designated centre. Residents appeared comfortable in the designated centre and were seen interacting with staff in a positive manner.

It was evident that staff spoken with were aware of the residents' needs and how best to work with them. New staff in the centre explained that they were given time to get to know the residents and read their personal plans to give them the knowledge to support them. Residents planned their own day and it was evident that staff were responsive to this. For example a resident undertook their morning routine in an unhurried manner, which was important to the resident. Staff were seen and heard to interact with residents in a kind and respectful manner. It was apparent from taking with staff that they advocated for residents and their best interests.

Residents were encouraged to engage with each other throughout the centre. A recent milestone birthday had been celebrated and other residents from the centre celebrated with the resident in their garden. There were pictures throughout the centre of residents undertaking activities. One resident from the centre had gone on holidays with their family. Residents that required picture schedules had them available in their homes. These were available and updated for residents during the inspection.

Some of the staff spoken with identified that staff shortages in the centre had meant the residents could not be supported in their daily activities as well as the staff had wished. Staffing levels on the days of the inspection were adequate to support residents and residents that required one to one support were receiving this.

Documentation was reviewed as part of the inspection process. This documentation was provided to the inspector when requested in a timely manner and enabled the inspector to review the personal plans, reports and audits taking place in the centre

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

Capacity and capability

There was an overall governance structure in the centre and it was evident that the staff team were working towards giving the residents a good quality of life. Staffing vacancies and recruitment are discussed under Regulation 15.

The person in charge had ensured staff training was up to date and staff were appropriately supervised. Assurances were provided regarding agency staff working in the designated centre and the training they received. There was evidence that new staff were well inducted into the organisation and were given time to be familiar with their roles and the residents' needs.

The notification of incidents to the chief inspector office had not occurred in line with the regulations, with one notification in relation to an allegation of abuse of resident not being submitted within three days. A notification required to be submitted in the case of any unexplained absence of a resident from the designated centre had not been submitted prior to the inspection. This was submitted when the inspector identified it to the management of the centre following a review of the incident log of the designated centre.

Regulation 15: Staffing

There was a planned and actual staffing rota that was properly maintained. Management in the centre were endeavoring to maintain the continuity within the staff team and ensure that residents were having familiar staff support them.

It was identified that there were staffing vacancies in the centre with seven support worker vacancies and one team leader vacancy on the day of the inspection. There was an active recruitment programme in the centre with ongoing recruitment being underway. It was reported by management that three support workers and a team leader were to begin working in the centre in the weeks following with the inspection, however, one of team leaders in the centre was also due to leave the centre in the following weeks also. The shortfall in the staff team was covered from relief and agency staff. Members of the management team in the centre had to take to take on a more hands on roll in the centre, which meant they could not give sufficient time to their managerial responsibilities. Staffing shortages also meant that staff were unable to attend scheduled team meetings.

Staff files were reviewed and one staff member did not have a full history of employment in their file, while another did not have photographic identification in the file, this was sourced before the end of the inspection and inserted into the file.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured there were effective systems in place for the training and development of the staff team. The person in charge maintained a training matrix to monitor the training needs of staff and ensure these were addressed promptly. The inspector viewed the training matrix for all the staff working in the centre. It was evident that the person in charge was maintaining a good oversight of the training needs of the staff.

The person in charge had ensured effective measures were in place for the appropriate supervision of staff. There was a schedule shown to the inspector on the day for the completion of supervision for staff members working in the centre for the current year.

An induction system was in place for staff and new staff spent time shadowing staff with more experience of working with the residents. New staff working in the centre during the inspection informed the inspector that had been given the time to work with more experienced staff and learn from them.

Assurances were received from employment agencies that supplied agency staff to the designated centre around their training received that was required when working in the designated centre such as safeguarding training.

Judgment: Compliant

Regulation 23: Governance and management

There was a suitable governance and management structure in the designated centre. There was person in charge who was supported by team leaders in various homes in the centre. The management team members met during the inspection knew the residents well. Staffing levels on the day of inspection were not in line with the designated centre's statement of purpose. This deficit was being managed using agency and relief staff.

The registered provider had undertaken a annual review of the service being provided. Residents completed surveys for this annual review to provide their views on how the centre was being run. A monthly unannounced audit was also being undertaken by the registered provider which identified actions in relation to the improvement of the service.

Staff meetings were occurring in the designated centre. Staff were not always able to attend these meetings with staff shortages cited as the reason why. Some actions identified in the monthly unannounced audits were due to be discussed at these meetings. It was not evident from the minutes of the April 2025 team meetings that these items were being discussed. Some meeting minutes were poorly documented with minimal detail contained in them and not showing evidence of the agenda being discussed.

Management of incidents in the centre required better oversight with examples of incidents not being notified or being notified late, this is discussed under Regulation 31.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents that had occurred in the weeks leading up to the inspection had not be reported to the Chief Inspectors office, as required by Schedule 4 of the regulations, within the required time lines. This included an incident where one of the residents had an unexplained absence of a resident from the designated centre which was identified during a review of the incident log. This was discussed with management in the centre during the inspection and was submitted retrospectively. A notification in relation to an allegation, suspected or confirmed abuse of any resident had been submitted prior to the inspection but was not submitted within the three day time frame as required by the regulation.

Judgment: Not compliant

Quality and safety

The inspector found that the staff team working in the centre were respecting the privacy and dignity of the residents in the centre. Staff were working to ensure that residents were working towards gaining more independence and participating in activities that they were interested in.

The premises in the main were well maintained and suitable for the residents. A concern, as identified in a previous inspection, in relation to communal space for two residents in one of the designated centre's home had not been addressed. This was identified again by staff working again on this inspection as being an issue for the residents.

The personal plans of the residents contained information to guide staff in working with them. Goals were created for residents and these appeared realistic for residents. There was evidence that residents were taking part in their local and also had activities provided in the designated centre. Some documentation in the residents' personal plans had not been reviewed in the previous 12 months and other elements had conflicting dates of review on the document.

Risk was managed well in the centre with risk assessment created and reviewed for the centre and for the residents in the centre. Residents had positive behaviour support place when required and it was evident that these were under review and updated as needed.

Safeguarding information was available to residents in an easy to read format. Staff discussed safeguarding issues at staff meetings and staff were aware of safeguarding concerns in the centre. Intimate care plans had the required information to guide staff in this element of supporting residents.

All residents in the centre did not have access to financial accounts in their own name. The management team in the centre had brought outside advocacy input to assist residents and their representatives to set up these accounts. Accounts were being created for residents which would be in their own name and the management team in the centre were working on this.

Regulation 17: Premises

The homes in the centre were well decorated and reflected the interests of the residents such as residents hanging artwork and outside areas where residents

undertook gardening work in the centre.

For the most part residents had access to appropriate and well maintained outdoor areas and communal space. The previous inspection completed in July 2024 had identified that the indoor space available to two residents in one of the homes was limited and impacted on their ability to engage in preferred activities in their home at times. The registered provider had engaged in a plan to design the space needed for the residents but building works had not commenced. The compliance plan submitted for the previous inspection had indicated that this work would be completed by the beginning of September 2025. As the works had yet to begin this was now an unrealistic time line for works to be completed.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The registered provider and the person in charge had ensured that risks were being identified in the centre and risk assessments along with appropriate control measures were being put in place. The centre specific risk assessments had been reviewed within the last 12 months. Lone working throughout the designated centre had been appropriately managed as a risk in the designated centre.

Individual risk for the residents were also well managed in the sample reviewed. With appropriate risks identified, assessed and control measures put in place. A interpersonal compatibility risk assessment was completed for some residents to ensure that their living arrangements were as suitable as possible. The personalised risk assessments for residents were reviewed in a timely manner.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Four personal plans were reviewed belonging to residents in the designated centre. Each resident had an assessment of need and personal plan in place. There was evidence that residents had provided consent for elements of their personal plans. Residents had a plan of the activities for the residents throughout the week. Residents were seen to be undertaking these activities during the inspection. Residents had goals created for them, with suitable and meaningful goals being created for residents. One resident in particular was trying to built their community involvement which had diminished during the pandemic. Evidence of multidisciplinary involvement in residents' support was available. Residents had consistent support from positive behaviour support specialists and a speech and

language therapist.

While personal plans contained good information for some of the documentation, there was a lack evidence of review in previous 12 months in areas such as residents' personal emergency evacuation plans, a communication passport for a resident and an end of life care plan. Other elements of the personal plans contained conflicting dates of review. Some agreements in care plans lacked signatures of approval required. Letters had been sent out by the management of the centre to the family members to remind them to sign these documents in the month preceding the inspection.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

There was evidence of review of restrictive practices in the centre. A review committee had met in April 2025 to review the restrictions in the centre. These restrictions were reported to the chief inspector as required on a quarterly basis.

Residents that required positive behaviour support plans had them in place. It was evident that these were being reviewed. A behaviour support specialist was seen to be active in supporting the residents in this area. Positive behaviour support plans were personalised for each resident requiring them and provided good guidance for staff to support residents in this area. Staff were aware of the needs of the residents in this area and how to work with them.

Residents were supported to have good outcomes in relation to their mental health. Residents had access to psychiatry services when required.

Judgment: Compliant

Regulation 8: Protection

Staff working in the centre had all completed safeguarding. New staff members spoke about receiving the training and what they had learned from this training. Safeguarding was discussed in staff meetings when they were taking place. Safeguarding incidents in the designated centre were being reviewed and support was being received from behaviour support specialists in this area.

Residents were provided with safeguarding information in an easy to read format and safeguarding was discussed with residents at their meetings. System were being put in place to created to safeguard residents and staff were familiar with how to work these systems.

Detailed intimate and personal care plans had been created for residents to promote residents rights and dignity when they were being supported in their daily routines.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were being supported to engage in activities they enjoyed. Residents were engaged in many activities during the inspection and transport was available for residents to undertake these activities. Residents meetings were taking place in the centre but the level of what was recorded or the quality of the meetings varied in different parts of the centre. Residents were supported to engage in an easy to read survey to give their views on the service being provided.

Staff support in relation to assisting residents' in their activities was evident, with staff members spoken with knowing the residents' interests and needs well. Residents were seen to be offered choice throughout the inspection were assisted by staff to complete their daily schedules.

As with the last inspection findings a number of residents did not have access to financial accounts in their own name. This was being addressed by management in the designated centre with engagement with families. The management team in the centre reported that a talk from an advocacy group had informed families of residents rights regarding their own finances. Families were responsive to this and were assisting in setting up financial accounts for the residents.

Judgment: Substantially 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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Greenville House OSV-0002113

Inspection ID: MON-0047346

Date of inspection: 11/06/2025

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	Substantially Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

Staffing levels have significantly increased over the past two months within the designated centre. While the use of agency staff continues in one location within the service, permanent staff have been recruited for this area and are currently undergoing the onboarding process.

• The Person in Charge and Deputy Manager are actively recruiting through multiple platforms. Completion Date: 28.10.2025

• The Person in Charge continues to participate in recruitment open days. The most recent event, held on 19/06/2025, resulted in the hiring of two additional support workers, both of whom are currently completing the onboarding process. Completion: 15.08.2025

• A new full time Team Leader has commenced in post on 23.06,2025 within the location where there was a vacant post. Completed: 23.06.2025

• A new Team Leader has been identified to replace the outgoing Team Leader. This is currently at the offer stage, with negotiations ongoing. Completion: 01.09.2025

• The administrative team, in collaboration with the Person in Charge, is conducting a comprehensive review of all staff files. A staff file matrix has been developed to ensure systematic oversight and to track the status of all required documentation. Completion: 15.08.2025

• The Person in Charge and Deputy Manager have revised the structure of staff meetings. Instead of holding separate meetings for each individual cottage, a campus-wide staff meeting format has been introduced to enhance consistency and review key areas including staffing, incidents, complaints, training compliance, and quality improvement initiatives. Administration staff now attend these meetings to ensure accurate and comprehensive documentation of meeting minutes and action points. Staff will be rostered on shift to attend any planned staff meetings Completion: 22.07.2025

Regulation 23: Governance and management	Substantially Compliant

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

• The Person in Charge and Deputy Manager have revised the structure of staff meetings to enhance consistency and promote a more cohesive approach to communication and service delivery. Rather than holding separate meetings for each individual cottage, a campus-wide staff meeting format has been implemented. This new structure allows for the collective review of key operational areas, including staffing, incidents, complaints, training compliance, and quality improvement initiatives. To support this, administrative staff now attend the meetings to ensure the accurate documentation of minutes and the clear recording of action points. Completion: 22.07.2025
The Head of Operations will attend the first revised campus-wide meeting on 22.07.2025 and will review the meeting minutes as part of the monthly monitoring audit process going forward. This will ensure that relevant organisational updates and priorities are consistently disseminated across the staff team and that follow-up actions are tracked and implemented effectively. Completion: 22.07.2025

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• The Person In Charge will ensure going forward that all notifications are submitted within the required timeframe. The notifications referred to in this report were submitted on the day of inspection. Completed: 10.06.2025
• The Person in Charge, in collaboration with the Head of Operations, has organised a local HIQA notifications workshop. The workshop will address the correct categorisation of incidents, reporting timeframes, and the completion of the required notification forms. Completion: 23.07.2025
• The Head of Operations will conduct a monthly review of all incidents during the monthly monitoring visit to ensure that any incidents meeting the threshold for statutory notification are identified and submitted to HIQA in line with regulatory timeframes. This process will be formally documented and monitored as part of the service's quality assurance system. Completion: 15.07.2025
• The Head of Operations will address the importance of compliance with statutory notification requirements during 1:1 supervisions with all Managers and Designated Officers. These discussions will reinforce the responsibility to ensure that all incidents meeting the threshold for statutory notification are promptly identified and submitted to HIQA in accordance with regulatory timelines. This action aims to strengthen accountability, enhance oversight, and ensure a consistent organisational approach to incident reporting.
Completion: 31.07.025

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

Despite current delay to the premises expansion, the Person in Charge is committed to meeting Regulation 17 through the following measures:
• Conduct a thorough space utilisation review to optimize the current layout and use of communal and private areas within the location.
• Encourage residents to make use of available shared spaces on the Greenville campus and within the wider community to support social inclusion and wellbeing
• Continue to engage with HSE to advocate for the allocation of resources necessary to progress this expansion.
Regularly review the effectiveness of interim arrangements to ensure the premises continue to meet the aims and objectives of the service as much as possible. Completion: 30.09.2026

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

• The Person in Charge has developed a structured schedule, presented in the form of a Service User Documentation Matrix, to support the systematic review and updating of all individual assessments and personal plans.
Completion 31.07.2025
• The Person in Charge will conduct audits of personal plans to ensure they are up-to-date, person-centred, and in line with the assessed needs of each resident.
• Completion: 31.07.202
• The Head of Operations will maintain oversight of this process through regular reviews during monthly monitoring audits, ensuring that documentation is up to date, reflective of current needs, and that any gaps are addressed in a timely manner. Completion 31.07.2025
• The individual documents referred to in this report have been updated as required. Completed: 30.06.2025

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The Person in Charge is actively progressing plans to enhance residents' access to and oversight of their personal finances. This will be achieved through the opening of individual Post Office accounts, allowing residents greater autonomy and transparency in the management of their money.
To support this process:
• The Person in Charge will schedule follow-up meetings with the family representatives of each affected resident.
These meetings will ensure that all necessary consents, documentation, and supports are in place to facilitate access to personal accounts in a safe and person-centred manner.

Completion: 31.12.2025

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.	Substantially Compliant	Yellow	28/10/2025
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	28/10/2025
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all	Substantially Compliant	Yellow	15/08/2025

	staff the information and documents specified in Schedule 2.			
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Substantially Compliant	Yellow	30/09/2025
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	22/07/2025
Regulation 31(1)(e)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any unexplained absence of a resident from the designated centre.	Not Compliant	Orange	31/07/2025
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing	Not Compliant	Orange	10/06/2025

	within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/07/2025
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	31/12/2025