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:	Carrick on Suir Camphill Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Tipperary
Type of inspection:	Unannounced
Date of inspection:	04 November 2025
Centre ID:	OSV-0003608
Fieldwork ID:	MON-0047890

About the designated centre

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

Carrick on Suir Camphill Community, located in a town, provides long-term residential care to 16 both male and female residents over the age of 18 with intellectual disabilities, autism and physical support needs who require medium levels of support. The centre comprises six units in total combining a mixture of residential houses and individual semi-independent supported houses. All residents have their own bedrooms and facilities throughout the units which make up this centre include kitchens, sitting rooms, dining rooms and bathroom facilities. In line with the provider's model of care, residents are supported by a mix of paid staff (social care staff) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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 4 November 2025	09:30hrs to 17:00hrs	Marie Byrne	Lead
Wednesday 5 November 2025	09:50hrs to 14:50hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

This unannounced risk-based inspection was completed to provide assurance that residents were in receipt of a good quality and safe service in this centre. The inspection was completed to follow up on the findings of a regulatory programme of inspections of centres operated by this provider in June and July 2025 in response to information received by the Chief Inspector of Social Services. This inspection was completed by one inspector of social services over two days. Overall, the findings of this inspection were that residents were in receipt of a good quality service; however, improvements were required in relation to governance and management and staffing and this will be discussed further in the report.

In Carrick on Suir Camphill Community, care and support is provided for up to 16 residents with an intellectual disability. There were 12 residents living in the centre at the time of this inspection. The centre comprises two houses and three single occupancy units on a campus and three additional houses in housing estates close to the campus. Over the course of the inspection, the inspector visited each of the premises in the designated centre.

During the inspection, the inspector had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting nine residents, nine staff, the team leader, a person participating in the management of the designated centre (PPIM) and the provider's newly appointed head of human resources and head of services. Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre.

Residents used a variety of means to communicate their needs, wishes and preferences. Some residents used speech while others used sign language, vocalisations, facial expressions and body language to communicate. Over the course of the inspection some residents told the inspector that they were happy and felt safe living in the centre and others used sign language to indicate they were happy. The inspector also used observations, discussions with staff and a review of documentation to capture the lived experience of residents. Throughout the inspection each resident was observed to appear content and comfortable in their home and in the presence of staff.

Throughout the inspection, staff were observed to be aware of residents communication preferences. Warm, kind, and caring interactions were observed between residents and staff. Staff were observed taking time to chat with and to listen to residents. They were observed to treat residents with dignity and respect and to respect their right to privacy. For example, they were observed knocking on residents' doors prior to entering and to ask their permission to enter their bedrooms. When speaking with the inspector staff took every opportunity to speak about residents' abilities and strengths. Over the course of the inspection, a number

of residents who spoke with the inspector were complimentary towards the supports they receive from the staff team.

Over the course of the two days of the inspection, the inspector had opportunities to engage with residents and observe aspects of their day. Residents spoke about planning their own day and choosing how and where they spent their time. A number of residents were number of residents were regularly attending day services, some were employed by local businesses and others were attending college and completing courses. One resident was also completing a placement as part of their college course and another spoke about looking forward to their upcoming graduation following a course they completed.

Based on a review of documentation and discussions with residents and staff, residents were regularly spending time with their family and friends and regularly engaging in many different activities both at home and in the community. Examples of these included, going to horse therapy, for massages, to the gym, canoeing, sea swimming, zumba, bowling, soccer and chair exercise classes. They were also using local services such as financial institutions, beauticians and hairdressers.

A number of residents spoke about regularly enjoying meals and snacks in local cafes, restaurants and hotels. On the day of the inspection three residents were meeting up to go shopping and out for a meal in a nearby city. Residents also spoke about attending events such as riverdance and enjoying hotel stays. On the first day of the inspection two residents communicated with the inspector that they were looking forward to a hotel stay the next day. They were looking forward to the holiday and the meals and drinks while they were away. One resident told the inspector and staff that they were looking forward to the drive and a big glass of wine.

A number of residents showed the inspector around their homes. They spoke about their involvement in designing and decorating their home. The spoke about all the works that had been completed to the premises and grounds since the last inspection. On the first day a resident showed the inspector a number of improvements they would like to see in their home and asked the inspector to discuss these with the local management team. On the second day of the inspection a number of these works had been completed and the others were in progress.

Each premises was decorated differently in line with residents' preferences. They each appeared homely and comfortable. There were numerous communal areas where residents could choose to spend their time. There was a maintenance list in place and maintenance jobs were discussed with the provider at a weekly meeting.

As discussed in previous inspection reports, the provider had recognised that one premises was not meeting a resident's needs, particularly relating to accessibility. Plans were in place to support them to move; however, due to the protracted nature of sourcing and completing works to another premises, the residents' transition had not progressed. This will be discussed further under Regulation 23: Governance and Management.

A number of residents spoke about who they would go to if they had any worries or concerns. The complaints process and information on how to access independent advocacy services were on display in the houses. A number of residents had, or were in the process of accessing the support of independent advocates.

In summary, residents were being supported to a engage in a variety of activities at home and in their local community. They were in receipt of a service which promoted and upheld their rights. As previously mentioned, some improvements were required to governance and oversight and staffing.

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

Capacity and capability

This unannounced risk-based inspection found that the provider was identifying areas of good practice and areas where improvements were required in their own audits and reviews. They were in the process of implementing the majority of required actions to bring about these improvements. The provider had successfully filled a number of vacant managements posts since the last inspection and this was found to be having a positive impact on oversight and monitoring. However, further improvements were required in relation to oversight. There was no person in charge in post on the day of the inspection and there were a number of staffing vacancies. In addition in line with the findings of previous inspections, one residents' transition which was in progress since 2023, had not yet progressed.

In the absence of a person in charge, the local management team consisted of a team leader and two house co-ordinators. They reported to and received support from a newly appointed area service manager who is identified as a person participating in the management of the designated centre (PPIM).

As previously mentioned, the centre was not fully staffed in line with the statement of purpose. The inspector found that despite best efforts of the local management team, this was impacting on continuity of care and support for residents. The inspector found that staff were supported to carry out their roles and responsibilities through probation, supervision, training, and opportunities to discuss issues and share learning at team meetings.

Regulation 14: Persons in charge

There was no person in charge in post on the day of the inspection.

The provider had employed and inducted a new person in charge since the last inspection in June 2025. However, they had resigned their post and the inspector was informed that their last working day was on the 24 October 2025. The provider had interviewed a candidate and offered the position. At the time of the inspection the provider was awaiting a response in relation the job offer. Interim arrangements for oversight were in place until the person in charge post was confirmed and operational.

Judgment: Not compliant

Regulation 15: Staffing

The registered provider had not ensured that the number of staff employed was appropriate to the number and needs of residents identified in the statement of purpose for this centre. While efforts were being made to ensure this was not impacting continuity of care and support for residents, this was not always proving possible.

In addition to the person in charge vacancy, there were 5.7 whole time equivalent staff (WTE) vacancies on the day of the inspection. Where possible, the provider was utilising the same three regular agency staff to cover the required shifts. However, this was not always proving possible. For example, over the three month period between July and September 2025, an average of 174 hours per month were being completed by agency staff.

The inspector reviewed rosters for the centre for July to the day of the inspection and found that these were well maintained. As previously mentioned, while it was evident that efforts were being made to ensure continuity of care and support for residents, the vacancies were found to be impacting this. For example, on a sample rosters for one of the houses over four weeks there were 10 occasions when the required staffing levels were not in place. On eight of these occasions the staff shortage was for a full day shift, and for two occasions it was for a number of hours.

A number of residents were very complimentary towards staff and the local management team during the inspection. They told the inspector that regular staff really listen to them. They were aware of the complaints process and stated that they would feel comfortable discussing and worries or concerns with the staff team. One resident told the inspector that they preferred when regular staff were on duty as it took time for them to communicate their wishes and preferences to each new agency staff.

Planned and actual rosters were in place and they were well maintained. A review of a sample of three staff files, and the files of three regular agency staff was completed and they contained the information required under Schedule 2. In one staff file reviewed, gaps were identified relating to their employment history. This

was rectified during the inspection and the required documentation was added to the staff members file.

Judgment: Substantially compliant

Regulation 23: Governance and management

The inspector found that while improvements were noted to oversight and monitoring since the last inspection, further improvements were required. The centre was not fully resourced to meet the number and needs of residents and this is captured under Regulation 15: Staffing.

There was a clear management structure in place which outlined roles and responsibilities and lines of reporting. The provider had successfully filled a number of vacant management posts since the last inspection including the area service manager and head of service roles. As staff to these roles had only been recently appointed into the positions they were still completing their own inductions and probation periods.

However, as previously mentioned the person in charge post was vacant at the time of the inspection. In the interim, the provider had ensured that the team lead role had full-time administration duties and they were responsible for the day to day running of the centre. In addition, to support the team lead in their role, the administration hours for the house co-ordinators had been increased. There was also an increased in-person presence of the area service manager (PPIM). For example, they had been present in the centre for two days the week before the inspection and for two days on the week of the inspection. There was an on-call roster in place to ensure that support was available for residents and staff out-of-hours.

Through a review the minutes of two recent staff meetings and four management meetings and through discussions with residents and staff, the inspector found that improvements had been made since the last inspection in relation to how the provider's systems to monitor the quality and safety of care and support were being utilised. For example, staff and management meetings were occurring and discussions were being held regularly in relation to residents' wellbeing, incidents, safeguarding, advocacy, fire safety, health and safety, restrictive practices, risk management, resident feedback, audits and actions, and complaints and compliments.

The provider's systems to monitor the quality and safety of service provided for residents included; unannounced provider visits every six months, area specific audits, and an annual review. The inspector reviewed the provider's last two six-monthly reviews and their latest annual review. Based on this review 20% of actions from the provider's six-monthly review in March 2025 were found to be overdue for completion, and one action (2% of total actions) was overdue for the six-monthly

completed in October 2025. In addition, there were a number of similar findings and repeated actions in both reviews. For example, both reviews identified that communication passports were required for residents. This indicated that actions were not being progressed in a timely manner.

The staff training matrix and a sample of 15 certificates of training were reviewed. This demonstrated that staff had completed training identified as mandatory by the provider. Staff had also completed training in line with residents' assessed needs and more was planned. For example, plans were in place for staff to complete Lámh training (sign system used in Ireland by children and adults to support communication).

A sample of supervision records for three staff were reviewed. While there was evidence of regular supervision for staff, some documentation relating to supporting and performance managing staff were not present in staff files. The inspector acknowledges that updates relating to this were submitted to the Chief Inspector after the inspection.

As previously mentioned one residents' transition had not progressed since the last inspection. Their transition plan was reviewed and had commenced in March 2023. While there was evidence of some recent meetings and assessments, no date was identified for their proposed move.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents were supported to enjoy a good quality of life in this centre. They were regularly taking part in activities they enjoyed and supported to make decisions about their care and support.

There had been a number of areas where improvements were completed to the premises since the last inspection which were found to be contributing to how homely and comfortable each of the premises appeared. In addition improvements had been made to the grounds around five of the premises which had resulted in these areas being more accessible for all. The provider was aware that one premises was not fully meeting a residents' needs and this was discussed under Regulation 23: Governance and management.

The inspector reviewed a sample of four residents' assessments and personal plans. These documents were found to positively describe their needs, likes, dislikes and preferences. They were being supported by health and social care professionals in line with their assessed needs.

Residents, staff and visitors were protected by the risk management policies, procedures and practices in the centre. There was a system for responding to emergencies and to ensure the vehicles were serviced and maintained.

Residents were also protected by the safeguarding and protection policies, procedures and practices in the centre. Staff had completed training to ensure they were knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse.

Regulation 26: Risk management procedures

Overall, the inspector found that residents were protected by the risk management policies procedures and practices in the centre.

The provider's risk management policy meets regulatory requirements. The risk register, and 21 individual risk assessments for six residents were reviewed. These were found to be reflective of the presenting risks and incidents occurring in the centre. They were also up-to-date and regularly reviewed.

There were systems in place to record incidents, accidents and near misses. The inspector reviewed records relating to 29 incidents occurring between July and September 2025. Each incident had been reviewed and followed up on by the local management team. A review of incidents was leading to the review and update of risk assessments. For example, following an accident a residents' risk assessments and plans had been updated.

The inspector found that the provider was responding to presenting risks. For example, while a bathroom in one of the houses was being renovated the provider implemented a waking night staff to support residents to access and alternative bathroom during the night. In addition, in response to a review of presenting risks for some residents the provider had reintroduced night staff to support three residents.

There were systems to respond to emergencies and to ensure the vehicles were roadworthy and suitably equipped.

Judgment: Compliant

Regulation 8: Protection

Residents were protected by the provider's polices, procedures and practices relating to safeguarding.

Residents were being supported to care for and protect themselves. Safeguarding was regularly discussed in the sample of resident and keyworker meetings reviewed. There was information relation to safeguarding and protection available and on display in each of the houses. This was available in poster and easy-to-read leaflets with pictures. As previously mentioned, a number of residents told the inspector what they would do and who they would go to if they had any worries or concerns, particularly relating to their safety and welfare.

The provider had a safeguarding policy which clearly detailed staff roles and responsibilities should there be an allegation or suspicion of abuse. From a review of the staff training matrix, 100% of staff had completed safeguarding training.

There had been two safeguarding concerns reported to the Chief Inspector since the last inspection. The inspector found that these had been followed up in line with the providers and national policy. For example, the inspector reviewed preliminary screenings and safeguarding plans and found that the required actions had been taken and the necessary safeguarding measures were being implemented.

Residents were being supported to safeguard their finances. For example, assessments were completed in relation to the levels of support they required (if any) and money management plans were developed around budgeting and saving. The inspector reviewed financial records for four residents and reviewed the balance in two residents' wallets. Balances were correct in residents wallets and receipts for purchases were maintained and reviewed in conjunction with statements from financial institutions on a regular basis. Residents had assets registers in place and a sample of these were reviewed and the named items were present.

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	Not compliant
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Carrick on Suir Camphill Community OSV-0003608

Inspection ID: MON-0047890

Date of inspection: 05/11/2025

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 14: Persons in charge	Not Compliant
Outline how you are going to come into compliance with Regulation 14: Persons in charge: • The provider has completed the recruitment process for the full time Person in Charge position. Following interviews, an offer was extended to the successful candidate, who has formally accepted the role. This person holds the necessary qualifications, skills and experience for the post. The start date for the incoming PIC is 15.12.2025. • The Area Service Manager is currently named as Interim Person in Charge and will remain in the role until new Person in Charge has taken up their post.	
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Interviews for Social Care Workers were completed, and a position has been offered to the one successful candidate on 24.11.2025, who has accepted the position. Garda Vetting has been submitted, start date will be established when in receipt. • A Social Care Assistant has accepted an offer of employment and will commence in the role week of 15/12/25. • A new position for House Coordinator has been advertised, and an interview took place on 3/12/25. This candidate was successful and position offered on 04.12.2025. • HR are actively engaging with three different recruitment agencies to source further SCW candidates. CV will be screened when received and interviews scheduled thereafter.	

• The local management team have liaised with the Social Media Lead on 01.12.2025 to ensure there is a drive with the recruitment campaign for Carrick Community. The Social Media Lead is visiting Carrick Community on 11/12/2025 to conduct testimonials from staff (three staff have been identified on 03.12.2025). Vacancies have been advertised through the social media platform on 03.12.2025 and will continue to be advertised. The Social Media Lead is also liaising with local radio stations and newspapers for advertising by 15/12/2025.

• Rosters are reviewed weekly by local and senior management to ensure staffing allocations meet residents' assessed needs and to minimise use of unfamiliar agency staff. Rosters will be updated accordingly to include actual shifts worked by staff including when the Team Leader provides cover.

• Where agency cover is required, the service endeavours to use a consistent pool of regular agency staff who are familiar with residents, their communication needs and support plans. All agency staff complete a local induction process and receive resident-specific guidance prior to commencing shifts.

• Enhanced handover procedures occur daily in both the morning and evening (where there is a changeover of staff) to ensure that relevant care information, risk updates and personal preferences are clearly communicated between staff teams.

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A successful candidate has now accepted the full time Person in Charge position and the start date is 15.12.2025.
In the interim, the Area Service Manager (ASM) is fulfilling the PIC role to ensure continuous governance and oversight with daily operations.
• The ASM (interim PIC) is present in the centre weekly and is supported to fulfil their role by a full time Team Leader.
• 06.11.2025: the proposed PIC, and ASM, along with Property & Housing visited the proposed designated centre site to assess the works required form the previous OT report. A revised plan was proposed by all stakeholders on the day to ensure future planning mechanisms could be achieved for the proposed resident. It was agreed to re-schedule the OT to discuss the revised plan and ensure it meets the accessibility requirements.
• 13.11.2025: The ASM had a discussion with a relevant HIQA Inspector regarding the revised plan, registration, floor plans and bathroom options.
• 17.11.2025: The proposed PIC and ASM, Property & Housing and the OT meet at the proposed designated centre to discuss the revised plan. The OT was in agreement that

the revised plan would lead to improved outcomes for the individual in terms of future planning and accessibility.
• 20.11.2025: The proposed PIC and ASM visited Carrick Community to meet with the proposed resident, staff team and Team Lead and gather information regarding the care and support needs of the resident. The proposed PIC and ASM also visited the resident's current location to assess equipment which may require replacing or may impact on space requirements in the new location.
• 01.12.2025: Revised OT report received by all stakeholders.
• 11.12.2025: A meeting is scheduled with the ASM and Property & Housing to review the revised OT recommendations and develop a plan for actioning.
• Review meeting regarding the proposed new designated centre is scheduled for 29.01.2026. This will include a discussion of the progress regarding the property/maintenance to date and the progress on the application for registration to the Chief Inspector. In addition, the resident transition will be discussed.

• The Compliance Team will develop a new Quality Improvement Plan (QIP) for the centre by 10.01.2026. The QIP will include actions from HIQA inspections, provider audits, national audits and all internal audits carried out within the Community where all identified actions will be in one place in support of more robust oversight mechanisms. Additionally, actions arising from team meetings, resident meetings, consultation with residents and staff and actions arising from observation of practice and walk arounds completed in the community will be added to the QIP. This is a live version with access to the QIP from the local management team, the ASM, and the HOS who all have oversight and will review the progress on actions. Additionally, to ensure actions are closed out appropriately, all completed actions will be verified by a second person.

• The review of communication passports has commenced and will be completed by 10.12.2025.

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 14(1)	The registered provider shall appoint a person in charge of the designated centre.	Not Compliant	Orange	15/12/2025
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	31/03/2026
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.	Substantially Compliant	Yellow	02/02/2026

Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	10/01/2026
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	11/12/2025