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:	Kare DC9
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	13 November 2025
Centre ID:	OSV-0003715
Fieldwork ID:	MON-0036118

About the designated centre

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

DC9 designated centre comprises of three separate houses that can accommodate a maximum of 9 male and or female adults with an intellectual disability. Person centred supports are provided to meet the physical, emotional, social and psychological needs of each person living in each of the houses. The premises are located close to local amenities and public transport links. The staffing compliment for the centre includes a social care leader, social care workers and care assistants who provide full time residential care to the residents living in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Thursday 13 November 2025	09:00hrs to 17:00hrs	Karen Leen	Lead

What residents told us and what inspectors observed

This was an unannounced inspection carried out to monitor ongoing regulatory compliance in the designated centre. The inspection found that overall the systems in relation to transitions and admissions of new residents were not robust nor comprehensive. There were significant gaps in the assessment of need process and allocation of resources. This had caused a negative impact on residents quality of service and was leading to a number of safeguarding concerns. In addition, a number of restrictive practices in the centre were implemented to ensure residents could remain safe while living in the same house.

The designated centre consists of three premises located close to a village in County Kildare. The centre is close to a number of amenities such as restaurants, cafes, shops and public transport. The designated centre was registered for nine residential beds, at the time of the inspection there was three vacancies. The inspector had the opportunity to meet with five residents, one resident was away from the centre with staff at a planned engagement

The inspection found that despite the person in charge implementing a number of quality review and governance systems in the centre, planned admissions to the centre had taken place without a thorough compatibility assessment or assessment of need taking place which identified if the centre had the appropriate resources in place to meet the assessed needs of residents or the compatibility of all residents in the designated centre. This significant gap in reviews was causing a negative impact on the lived experience of residents in the centre.

The inspector visited one of the three premises that formed part of the designated centre. One premises was unoccupied on the day of inspection as no residents were living in this part of the centre

On the day of the inspection the centre was conducting a staff meeting. The inspector met with the person in charge, operations manager and seven support staff. In the afternoon the inspector had the opportunity to meet with all staff. From review of documentation, staff had highlighted a number of concerns to the provider in relation to the resources available in the centre and in relation to the age profile of all residents in the centre aligning to new transitions and admissions. Support staff discussed with the inspector that a number of restrictive practices had been implemented in the centre and this was having an impact on all residents. Furthermore, the support staff highlighted that the centre had undergone adaptations in order to support an aging demographic in the centre. Support staff discussed that until recently the age profile in the centre ranged from residents from their fifties to mid-sixties. Since the admission of new residents the age range spanned from 28 years with the next age group of residents fifty.

One resident told the inspector about their job in the local community. They discussed that they had also been part of a local men's shed but decided to take a

break as they felt they could be more involved with some of the activities required around their home. The resident discussed that they like to keep the garden tidy and regularly cut the grass. The resident informed the inspector that they love their home, however, they found it difficult having to remember to lock the doors in the house. The resident discussed that they think about locking the doors to keep other people in their house safe and that they would worry if the door was not locked to keep peer members safe.

One resident told the inspector that a new person had moved into their home. The resident told the inspector that there peer member was very young and that they were making a lot of noise in the house. The resident discussed that they did not like the increase in the noise level. They also noted that they are not happy with the resident trying to enter their bedroom and that staff have to try to stop them. The inspector discussed the residents' concerns with the person in charge and the operations manager during the course of the inspection.

The inspector met with one resident on their return from day service. The resident was smiling and laughing with staff. The inspector noted that the resident required the support of two staff throughout the afternoon. The inspector observed staff directing the resident from entering the bedrooms of peers and redirecting the resident to other activities in their home. The inspector observed one resident discussing that they would like to go to their room as the house was very noisy. The inspector noted that while the staff could offer verbal reassurance to the resident they could not immediately engage and support until the resident was redirected from the area.

One resident required the support of two staff for activities in the local community. The inspector observed support staff offered the resident a drive in the local community after dinner. The inspector observed the remaining residents in the centre to be relaxing in the living room, with one resident dozing on the couch waiting for a TV show to commence.

Residents had access to a number of activities both in their home and in their local community. The inspector observed that residents had gone on a number of holidays with family, friends or support staff throughout the year. One resident told the inspector that they are good friends with the people they live with and that they enjoy doing things together and also have hobbies that they do alone. For example, residents enjoyed taking part in local activities such as pool, bowling, swimming, bowls, golf and meals out.

The inspector observed kind and caring interactions between support staff and residents throughout the day. Residents were observed to be telling jokes and laughing at stories from staff. The inspector found that staff working in the centre had a clear knowledge and understanding of each resident's personality and was encouraging residents to be advocate and speak to staff about their concerns.

Overall, the inspector found that despite the good levels of local governance and oversight systems in place in the centre, residents had been negatively impacted due to the lack of an appropriate transition plan and compatibility assessment for

one resident to the designated 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 to each resident living in the centre.

Capacity and capability

The inspector found that the provider had not completed admission of residents to the centre on the basis of transparent criteria in accordance with the designated centre's statement of purpose. As a result of the inspection findings, a regulatory decision was taken following the inspection to convene a cautionary meeting with the provider.

In addition, a service agreement in place for one resident had not been adhered to by the provider on admission. The provider had set an agreement with residents to include services in line with an assessment of need and the centre statement of purpose. However, the provider had failed to complete an assessment of need for one resident prior to the commencement of overnight stays in the centre as part of the transition and admission process.

The education and training provided to staff enabled them to provide care that reflected up to date, evidence-based practice. A supervision schedule and supervision records for all staff were maintained in the designated centre. The inspector found that staff were in receipt of regular, quality supervision, which covered topics relevant to service provision and their professional development. Staff spoken to discussed that they felt supported by the person in charge and that they could voice concerns.

Regulation 14: Persons in charge

The staff team was led by an appropriately qualified and experienced person in charge. The inspector saw that there were systems in place to support the person in charge in fulfilling their regulatory responsibilities.

The inspector found that the person in charge was present within the centre, residents discussed that they felt supported by the person in charge and that they could go to them about any concerns that they may have. Support staff discussed that the person in charge was supportive to them in their role and that the person in charge had escalated concerns to senior management.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix in place for all staff working in the centre and found that there was high level of compliance with engagement in mandatory and refresher training.

All staff were up-to-date in training within required areas such as safeguarding vulnerable adults, infection prevention and control, manual handling and fire safety. The inspector had the opportunity to speak with seven support staff and found that staff were knowledgeable regarding their roles and responsibilities in providing a safe and quality service. The inspector found that staff in the centre were advocating on behalf of all residents in the centre and were escalating concerns to the person in charge and the provider.

Staff had access to regular supervision and staff meetings were occurring in the centre. On the day of the inspection, the staff team were completing a team meeting. The inspector found that residents views and opinions for the running of the designated centre were highlighted and discussed through staff meetings.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the significant gaps in the admission process was having a negative impact on residents which was resulting in a number of safeguarding concerns. The inspector found that the provider had failed to complete a comprehensive assessment of need prior to the agreed transition of a resident to the designated centre.

Additionally the inspector was not assured that the centre was adequately resourced to support residents. Due to the inadequate systems around the assessment of need there was a lack of guidance around key areas such as epilepsy support, maintaining a safe environment and behavioural supports.

The inspector found that in order to maintain the safety of all residents, staff were required to lock the external doors of the designated centre. The doors were locked in order to ensure that one resident could not access the garden without the support of staff as the centre did not have a secure gate in place to support residents to maintain road safety when spending time in the garden. The doors were locked during allocated periods of time, however when the inspector checked the doors outside of this time period they found all external doors where locked.

As the assessment of need process was not comprehensive the inspector found that the staffing levels were not in line with the assessed needs of the residents. For example, for a resident with a diagnosis of nocturnal epilepsy the inspector found that the support plan in place referred to the requirement of a waking night staff. The waking night staff was required to monitor and support residents night time seizure pattern. This was not in place on the day of the inspection. The provider had implemented two sleep over staff to the centre. The support plan for the resident was based on a previous setting and had not been reviewed in line with the resident's admission to this centre.

Regular staff meetings were held, and a record was kept of the discussions and required actions. The presence of the person in charge in the centre provided all staff with opportunities for managerial supervision and support. The inspector reviewed minutes of staff meetings held from May to October 2025 and found that staff had utilised these meetings to highlight concerns in relation to the admission process in the designated centre. The inspector observed that the staff team had requested a further meeting with senior management on 16 October 2025. Staff discussed that this meeting was held, however, minutes of this meeting were not made available to the inspector on the day of the inspection.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed a transition plan for one resident in the centre and found that the provider had not completed the appropriate compatibility reviews or assessment for residents to ensure the suitability of the placement in line with the statement of purpose. The inspector found that recent admissions to the centre were not on the basis of transparent criteria and that the reviews that had taken place did not take into account the resources required to maintain residents' safety in the centre.

The inspector reviewed a compatibility assessment which was completed for the resident prior to the identification of a number of key factors such as, the identified centre that the resident would be transitioning to the supports available and an overview of the peers that would be living in the same centre. The assessment highlighted that the resident should live in an accommodation of two to three people living together. However, when the resident completed their transition to the centre they would be living with four peer members.

The compatibility assessment also highlighted that the resident required a minimum of two staff required at all times in order to support both medical and behaviour support needs. The inspector found that in order to support the resident with this staffing resource there would be one staff member to support the remaining four residents in the centre. Furthermore, the inspector found that there was no behavioural support plan in place for the resident to guide staff practice. Staff were

reliant on a support plan designed to support the resident in a former respite setting and their local day service.

The inspector reviewed a service agreement for one resident dated 07 November 2025 and found that the provider had not adhered to the agreement as signed by the resident. The resident did not have an assessment of need that could be utilised by support staff in order to ensure safe and quality delivery of care.

Judgment: Not compliant

Quality and safety

The inspector found that the assessed needs of all residents in the centre had not been adequately reviewed. This meant that the resources in place were not adequate to mitigate some identified risks and to support residents in line with their specific needs. This was having an adverse impact on the on the quality and safety of the service provided.

In addition, the planned admission of one resident had seen an increase in the use of restrictive practices for all residents in the centre. The inspector identified a number of safeguarding concerns identified by staff which had not been adequately reviewed in order to reduce the risk of recurrence through appropriate safeguarding plans.

The inspector had the opportunity to visit one premises in the designated centre, the inspector found that the premises had recently undergone refurbishment and a number of adaptations in order to support residents to age in place. Corridors in the house had been made wider for residents should they require mobility aids. A large accessible bathroom was available for residents to avail of. The premises was surrounded by a large garden which had a seating area and place for summer BBQs.

Regulation 17: Premises

The registered provider had ensured that the premises was designed and laid out to meet the aims and objectives of the service and the number and needs of residents. Communal rooms and corridors were large enough to accommodate residents' required mobility aids.

The centre was maintained in a good state of repair and was clean and suitably decorated.

The centre had recently been adapted to meet the individual needs of residents while promoting an environment that would assist residents as they aged and to

facilitate possible changes in assessed needs.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the individual assessment and personal plans for three residents in the designated centre. The inspector found that for one resident a comprehensive assessment of need had not been completed prior to their admission to the centre. On review of the residents assessment of need and support plans the inspector found that essential support plans in relation to epilepsy management, emergency information, medical needs and behaviour support needs had not been updated or reviewed following their admission. For example the information in place discussed support measures used in a previous support setting and day service and was not applicable to their current residential setting.

Furthermore, the inspector found that in the absence of essential reviews such as an assessment of need and behavioural supports the provider had failed to ensure that the designated centre was adequately resourced and suitable to meet the needs of residents. As a result, the inspector was not assured that the centre was suitable for the purpose of meeting one residents assessed needs or that there was adequate arrangements in place to meet their needs without the use of restrictive practices in the centre.

Judgment: Not compliant

Regulation 8: Protection

During the course of the inspection, the inspector identified through a review of documentation and discussions with staff that improvements were needed to ensure that incidents of a safeguarding nature occurring in the centre were appropriately documented, screened and escalated through the appropriate channels, as required by the provider's policy.

The inspector reviewed night time documentation from 05 November 2025 that noted that one resident was visibly upset and crying due to behaviours of concern demonstrated by a peer member, however, staff were unable to support the resident during this time of distress as they were required to prevent another resident from entering the bedrooms of peer members leading to further upset of residents in the centre. Staff further documented that another resident said that they could not take the noise levels anymore in the house and that they were

becoming upset that they could not sleep.

Other concerns highlighted by support staff on 03 November 2025 related to the disturbed sleep pattern of residents in the centre due to a peer member attempting to enter bedrooms at 06:30. Staff noted that a resident required the support of staff in order to ensure redirection. Staff identified that this was causing another resident to become restless and agitated with what was a noted change to their daily routine in their home. The inspector found that these incidents had not been appropriately screened or referred to the relevant stakeholders and no safeguarding plans were in place to support residents in the centre.

During the course of the inspection, the inspector observed that one resident required support of two staff throughout the evening. The inspector observed the resident being redirected by support staff as they had attempted to enter the bedrooms of peers on three separate occasions over an hour period. One resident informed the inspector that they did not like peers entering their room and that they were unhappy with it happening. The inspector brought this concern to the person in charge and operations manager during the course of the inspection. The inspector found that staff were not able to offer immediate support to residents post incidents due to the level of support required by another resident.

The inspector found that an intimate care support plan had not been completed for one resident in the designated centre and that the information in place related to care and support for the person was from a day service setting. Furthermore, the inspector found that appropriate supports had not been implemented to ensure that one resident could access intimate care supports in the bathroom in a manner that respected the resident's dignity and bodily integrity

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Kare DC9 OSV-0003715

Inspection ID: MON-0036118

Date of inspection: 13/11/2025

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 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Following this inspection and a review of the individuals support need the Provider made a decision that the transition for one individual in to this designated centre would not continue and the provider is actively engaging with the HSE currently to identify an alternative living arrangement. This transition concluded on the Sunday the 30th of November 2025.

Kare are reviewing the 'Accessing Kare policy' which will be updated and launched to the Heads on Unit group as a revised version by the end of February 2025. This will include updated processes based on the learning from this review.

Kare are developing a new Transition policy that will support the improvement of the transition process and ensure the learning from this transition review is reflected within that policy. This will be launched at the Heads of Unit meeting by the end of February 2025.

The tools that Kare use linked to these policies will be updated further to reflect learning – these include the transition checklist (including communication requirements needed across Kare to various departments) and plan as well as the living needs assessment and compatibility assessment. The assessment of need requirement to be completed within 28 days will be reflected within the policies. These actions will be completed and launched to staff in Kare by the end of March 2025.

The doors in designated centre are no longer locked unless at night time for security purposes – this is reflected in the shift plan for staff.

The staffing now reflects the statement of purpose and the needs of the house.

The meeting minutes between and with PPIM on 16 October 2025 are available for

review by the inspector if required at a future inspection.

The leader met with the staff team as part of the staff training day to inform them of the updates in relation to the transition on the 4th of December 2025. This will be discussed at the staff team meeting on the 09th of December and minutes of that conversation will be available.

The leader met with the service user as part of a house meeting on the 1st of December 2025 in relation to the transition. The minutes of this meeting is held on the Team site on Kare connect.

On the 27th of November 2025 future compatibility considerations for one individual was discussed to ensure that learning from this transition process was recorded accurately. There were representatives from local service, residential and the leadership team.

Regulation 24: Admissions and contract for the provision of services	Not Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Following this inspection and a review of the individuals support need the Provider made a decision that the transition for one individual in to this designated centre would not continue and are actively engaging with the HSE to identify an alternative living arrangement. This transition concluded on the Sunday the 30th of November 2025.

Kare are reviewing the 'Accessing Kare policy' which will be updated and launched to the Heads on Unit group as a revised version by the end of February 2025. This will include updated processes based on the learning from this review.

Kare are developing a new Transition policy that will support the improvement of the transition process and ensure the learning from this transition review is reflected within that policy. This will be launched at the Heads of Unit meeting by the end of February 2025.

The tools that Kare use linked to these policies will be updated further to reflect learning – these include the transition checklist (including communication requirements needed across Kare to various departments) and plan as well as the living needs assessment and compatibility assessment. The assessment of need requirement to be completed within 28 days will be reflected within the policies. These actions will be completed and launched to staff in Kare by the end of March 2025

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
Following this inspection and a review of the individuals support need the Provider made a decision that the transition for one individual in to this designated centre would not continue and are actively engaging with the HSE to identify an alternative living arrangement. This transition concluded on the Sunday the 30th of November 2025.

Kare are reviewing the 'Accessing Kare policy' which will be updated and launched to the Heads on Unit group as a revised version by the end of February 2025. This will include updated processes based on the learning from this review.

Kare are developing a new Transition policy that will support the improvement of the transition process and ensure the learning from this transition review is reflected within that policy. This will be launched at the Heads of Unit meeting by the end of February 2025.

The tools that Kare use linked to these policies will be updated further to reflect learning – these include the transition checklist (including communication requirements needed across Kare to various departments) and plan as well as the living needs assessment and compatibility assessment. The assessment of need requirement to be completed within 28 days will be reflected within the policies. These actions will be completed and launched to staff in Kare by the end of March 2025.

There are no restrictive practices in place in this designated centre.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Following this inspection and a review of the individuals support need the Provider made a decision that the transition for one individual in to this designated centre would not continue and are actively engaging with the HSE to identify an alternative living arrangement. This transition concluded on the Sunday the 30th of November 2025.

All safeguarding reports have been completed on Kare internal CID database and onward reporting to HSE safeguarding protection team as well as NF06 to HIQA. This was completed by the leader by the end of November 2025.

All complaints were logged and progressed by the leader on Kare internal CID database.

One of these complaints remains open pending further discussion with a staff member who is on leave. The aim of the leader is to have the complaint closed by the end of December 2025.

There have been no further safeguarding incidents reported since the transition concluded in this designated centre.

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 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Not Compliant	Orange	31/03/2026
Regulation 24(1)(a)	The registered provider shall ensure that each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.	Not Compliant	Orange	31/03/2026
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from	Not Compliant	Orange	31/03/2026

	abuse by their peers.			
Regulation 05(1)(a)	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 prior to admission to the designated centre.	Not Compliant	Orange	31/03/2026
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/03/2026
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/03/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2025