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 DC2
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	11 August 2026
Centre ID:	OSV-0001992
Fieldwork ID:	MON-0051033

About the designated centre

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

This designated centre provides a full-time residential service to three adults over the age of eighteen years with an intellectual disability. The house is a bungalow is on the outskirts of a large town in Co. Kildare. The designated centre consists of four bedrooms, one bathroom (wet-room), a kitchen, a sitting room, a personal computer room, a toilet and a utility room. There is a small patio area out the back of the house and to the front a small garden area. A bus is made available to this centre in the evenings and during the day if required. The person in charge divides their time between this centre and one other. There are social care workers and social care assistants employed in this centre. The staff provide support to the residents during the day and night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 11 August 2026	09:40hrs to 16:30hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

This inspection was unannounced and completed by one inspector of social services over one day. Based on observations and what they were told, the inspector found that residents were in receipt of a good quality of care and support in this designated centre. Areas of good practice were identified in several areas, and most regulations were found compliant. However, areas for improvement were identified in relation to provider oversight, transport arrangements and safeguarding. These areas will be discussed later in the report.

Kare DC2 provides 24/7 residential care and support for up to three adults with intellectual disabilities. Support is provided by social care workers and social care assistants. The person in charge shares their time between this and another designated centre close to this one. The designated centre comprises one house in an estate on the outskirts of a large town in County Kildare. The transport available to the centre was shared with a local day service. A resident expressed their dissatisfaction with this arrangement, and the type of transport available to them during the inspection. This will be discussed under Regulation 23: Governance and Management.

There were two residents living in the centre at the time of this inspection. During the inspection, the inspector had an opportunity spend some time with them both and to observe them as they went about their day. Both residents had their own bedroom and there were several communal spaces available to them. The inspector also had an opportunity to meet and speak with three staff members, the person in charge and a person participating in the management of the designated centre (PPIM). Documentation was 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.

The inspector had an opportunity to sit and have a drink with residents while they had their breakfast. They told the inspector what it was like to use this service. They were complimentary towards the team supporting them and the supports in place. They spoke about how they liked to spend their time and about the important people in their life.

Over the course of the inspection, they both spoke about holidays they had enjoyed in the past and holidays they were looking forward to. One person was planning to go to a house in the country with a staff member and another resident was planning to go abroad to a theme park where they had been before. They spoke about saving for their holiday and how they were looking forward to sitting with staff to book it.

One resident was retired and the other was working. They spoke about how much they enjoyed shopping in their local town and spending time with their friends. One resident spoke about a job they had in the past and how much they were enjoying

their current job. They spoke about using public transport to get to their job, the different bus numbers they can get and which ones are most reliable.

During the day, one resident left to go to work. The other resident asked staff to go to the shop to buy them some items and spent their day chatting with staff and making puzzles. Both residents appeared very comfortable in the presence of the person in charge and the staff supporting them. Warm, kind and caring interactions were observed throughout the inspection. Staff were found to be very familiar with residents' care and support needs. Both residents were aware of and using the complaints process if required.

One resident had transitioned to another designated centre operated by the provider since the last inspection. Based on what residents and staff said, and a review of incidents in the centre, this had led to a significant reduction in risks relating to safeguarding concerns in this centre. Both residents described some of the positive aspects such as the smaller number of people sharing their home and the increased availability of staff to support them.

Overall, the inspector found that both residents appeared happy in their home. They were supported by a staff team who they were familiar with and who were familiar with their likes, dislikes and preferences.

The next two sections of this report will 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 provided.

Capacity and capability

The findings of this unannounced inspection were that residents were in receipt of a good quality of care and support in this centre. For the most part, the provider was identifying areas of good practice and areas where improvements were required in their own audits and reviews. However, some improvements were required in relation to the provider's audits and reviews, to arrangements in place to safeguard residents' finances. In addition, one resident was not satisfied with the current transport arrangements.

There was a clear management structure in the centre which was outlined in the statement of purpose. The person in charge provided supervision and support to the staff team. The person in charge received supervision and support from a person participating in the management of the designated centre (PPIM). Staff members spoke about the on-call service available out-of-hours.

The centre was not fully staffed at the time of this inspection but this was not found to be impacting on continuity of care and support for residents. Staff were in receipt

of training and supervision to support them to carry out their roles and responsibilities to the best of their abilities.

Regulation 14: Persons in charge

The person in charge had the qualifications and experience to fulfill the role. They were full-time and also had responsibility for the day-to-day operation of another designated centre close to this one.

During the inspection, the inspector reviewed the systems they had for oversight and monitoring for this centre and found that they were effective in identifying areas of good practice and areas where improvements were required.

Both residents were observed to be very familiar with them and appeared comfortable and content in their presence. Each staff member who spoke with the inspector were complimentary towards the support they provided to them.

Judgment: Compliant

Regulation 15: Staffing

The provider was ensuring that there were enough staff to meet the assessed needs of residents.

The centre was not fully staffed at the time of this inspection. There was a 0.5 whole time equivalent (WTE) staff vacancy, and recruitment was ongoing to fill this vacancy. There were planned and actual rosters in place and they were well-maintained. Based on a review of a sample of rosters for three months, all the required shifts were covered. Available shifts due to the staff vacancy were covered by staff doing additional hours. This demonstrated that the vacancy was not having an impact on continuity of care and support for residents.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the staff training matrix demonstrated that staff had completed training listed as mandatory in the provider's policy. This included training in areas such as safeguarding, manual handling, fire safety, the safe administration of medicines, and infection prevention and control (IPC). In addition, they had completed several courses in line with residents' assessed needs such as epilepsy training and positive

behaviour support. Some staff had also completed training in areas such as empowering the individual, guidance on the Assisted Decision Making (Capacity) Act 2015 and applying a human-rights based approach in health and social care.

A review of a sample of records relating to three staff demonstrated that staff supervision, probation and annual performance reviews were being completed in line with the provider's policy. Formal supervision was completed at least twice a year. The agenda for these meetings included staff roles and responsibilities, staff well-being, continuous professional development and the team charter.

Two staff members who spoke with the inspector stated they were well supported. They were aware of who to raise any concerns with that they may have in relation to the day-to-day management of centre or residents' care and support. They spoke about the availability of the person in charge and PPIM should they require support. They also discussed the provider's out-of-hours supports.

The inspector reviewed minutes of four staff meetings. These were well attended and agenda items included residents' quality of life, management updates, maintenance, health and safety, IPC, complaints, incidents and risk management and training.

Overall, the inspector found that the staff team received support and supervision to ensure good practice in the centre.

Judgment: Compliant

Regulation 21: Records

Over the course of the inspection, the inspector found that records set out in the regulations were maintained and available.

Resident and staff records requested were readily available and well-maintained. They were found to be accurate and up-to-date.

Overall, the inspector found that the provider had effective systems and processes in place, including policies and procedures to ensure that documents were created, maintained, stored and destroyed in line with relevant legislation.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider had systems for oversight and monitoring; however, these were not proving fully effective at the time of the inspection. For

example, the provider's annual and six-monthly reviews did not capture risks or actions relating to financial safeguarding in the centre. In addition, it was not demonstrated that the centre was adequately resourced in terms of transport.

The inspector found that the management structure was in line with the statement of purpose. From a review of documentation and discussions with staff, there were clearly identified lines of authority and accountability amongst the team. This meant that all staff were aware of their roles and responsibilities to deliver a safe and good quality service.

Both the person in charge and PPIM were present regularly and demonstrated good monitoring and oversight of the centre. For example, a team plan combining actions from the provider's annual and six-monthly reviews and area specific audits was being regularly reviewed by the person in charge and PPIM. Area specific audits were being completed regularly and covered areas such as medicines management, IPC and house finances.

As previously mentioned one resident was not satisfied with the arrangements in place in relation to transport in the centre. When they met the inspector, the first thing they wanted to discuss was transport. They said "I need a car" and "we should have our own car so we can go where we like, when we like". They told the inspector that they shared the bus with a local day service and the only reason it was outside on the day of the inspection was that day services were closed for holidays. They said "only if staff are indemnified, I can go out. Some staff are not". They had recently had an accident and said they couldn't get into the bus that was available to them. They asked the inspector to discuss the need for a car for sole use by this house with the person in charge and PPIM, which they did. They said they would review the transport arrangements and support the resident to raise a complaint, if they wished to. The inspector was informed that the majority of the staff team in this centre were indemnified to drive their own vehicles and that there were two shared buses available to book through the provider's central office.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Based on discussions and a review of documentation, the required notifications were submitted to the Chief Inspector of Social Services within the time frames specified in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a complaints policy which was regularly reviewed. It clearly detailed the complaints process and staff roles and responsibilities. Posters with a picture of the complaints officer and easy-read document on the complaints process were available. The complaints procedures were also included in the statement of purpose and resident's guide which was available in the house.

Based on discussions with residents and staff and a review of documentation, residents and their representatives were supported to understand the complaints process. A sample of complaints logged in the centre demonstrated that both residents had used the complaints process while living in this centre.

The electronic complaints and compliments folder was reviewed. A sample of compliments were logged from residents and included comments such as "all the staff are good to me", and "you are very good to me and I really appreciate it".

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents were as busy as they wanted to be. They had opportunities to be part of their local community. They were spending time with their families and friends. Their home was warm, homely and well maintained. However, the inspector found that improvements were required to ensure that residents' finances were safeguarded.

The inspector reviewed residents' assessments and personal plans and found that these documents positively described their needs, likes, dislikes and preferences. They were supported to access health and social care professionals in line with their assessed needs. For example, one resident had recently been referred to the provider's behaviour specialist to support them with managing and expressing their emotions.

Residents, staff and visitors were protected by the risk management policies, procedures and practices in the centre. There were procedures and guidelines to follow in the event of an emergency.

Regulation 11: Visits

The provider had visiting policies and procedures in place. Information relating to visiting arrangements was also available in the statement of purpose and residents' guide for this centre.

As previously mentioned, the inspector spoke with residents about visiting and being visited by their family and friends. For example, one resident spoke about visiting their family member every week.

There were several communal spaces available to residents to meet their visitors. This included the open plan kitchen-dining room space and two sitting rooms. Residents could also choose to meet their visitors in their bedroom if they wished. There were no restrictions on visiting unless they posed a risk to residents, or were at the request of residents.

Judgment: Compliant

Regulation 17: Premises

The bungalow was designed and laid out to meet the number and needs of residents living there. It was clean, homely and well-maintained. There were systems to ensure that maintenance and repairs were completed in a timely manner.

Residents had access to an open-plan kitchen/dining area, two sitting rooms, their own bedrooms and two bathrooms. They were observed to move freely around their home throughout the inspection and to spend time in different parts of the house.

One resident showed the inspector their bedroom. They had their favourite possessions and memorabilia on display. For example, they had a picture with a music artist when they went to see their concert. They had a wardrobe and large chest of drawers and showed the inspector how they liked to organise their clothes. They also showed the inspector the television they had bought and a large collection of fragrances. They spoke about which fragrances were their favourite and where they had got them from.

Judgment: Compliant

Regulation 18: Food and nutrition

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

Residents had access to the relevant health and social care professionals such as dieticians. There was information available for them in healthy choices in line with the recommendations following dietician reviews.

The inspector had an opportunity to observe the mealtime experience for both residents. They were observed to independently get some of the things they wanted and requested staff support, if required. For example, staff boiled some eggs for them at their request. Residents were choosing if they wished to take part in meal preparation and cooking or baking.

There were adequate stocks and a variety of food and drinks available to offer choice at mealtimes. There were fresh fruits and vegetables available. The fridge, freezer and kitchen presses were well stocked with a variety of foods and drinks. Dates of opening were recorded on foods in the fridge. There were colour coded chopping boards and staff were observed to engage in hygienic practices when preparing food.

Menu planning was regularly discussed and residents then decided daily what they would like to eat and drink. Their preferences were supported in the shopping list and they were deciding if they wished to shop for their own items daily.

Judgment: Compliant

Regulation 26: Risk management procedures

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

The provider has a risk management policy that met regulatory requirements.

The risk register, area-specific and seven resident risk assessments were reviewed. These were reflective of presenting risks. Residents' assessments and plans detailed the control measures in place to reduce presenting risks. The risk register and risk assessments were regularly reviewed.

There was a system for recording incidents, and there were regular reviews of incidents completed. Incidents were also reviewed as part of the provider's audits and reviews and discussed at staff and meetings.

Based on a review of incidents, there was a reduction in incidents relating to safeguarding since a resident moved to this designated centre. There was an increase in incidents for one resident, and a referral had been made to the provider's behaviour support specialist.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector found that residents were protected by the medicines management policies, procedures and practices in this centre.

There were effective systems for ordering, receipt, storage, administration and disposal of medicines. There were systems for stock control in place. Audits and stock checks were completed regularly. A staff member showed the inspector the systems in place. They were knowledgeable in relation to safe practices relating to medicines management and in relation to the medicines prescribed for residents.

Both residents had assessments in place in relation to the self-administration of medicines. One resident was supported by staff, and the other resident was fully independent in relation to medicines management. They showed the inspector the safe in their room and spoke about collecting their medicines from the pharmacy and administering their medicines independently.

The prescription and drug recording records for one resident were reviewed. These demonstrated that the resident was in receipt of their medicines, as prescribed. There had been two recent incidents involving medication omissions and when this was reviewed, it was identified that the medicines were sticking to the inside of the blister pack. This was brought to the attention of the pharmacy and new packaging was sourced and now in place.

The inspector reviewed the contents of the medicines storage press in the office. The contents were stored securely and products that required it, had a date of opening added. Medicines were labelled with the resident's name and were in date.

Staff had completed training and prior to administering medicines had been completed a number of assessments.

Judgment: Compliant

Regulation 8: Protection

Based on a review of documentation and discussions with staff, the inspector found that residents were not fully protected by the procedures and practices relating to safeguarding in this centre.

The risks relating to financial safeguarding were captured in the local risk register and in residents' risk assessments. For one resident the risk related to changes in the arrangement for staff to review their financial records with them, to ensure they were being safeguarded. For the other resident, the risk related to the current arrangement of an external party having access to and oversight of their finances.

In line with their preferences, one resident was managing their own finances. They had a financial assessment in place which indicated they managed their finances independently. In line with presenting risk relating to financial safeguarding, a financial support plan had been implemented and agreed upon in 2025. The resident had agreed to sit with a named staff to review their online accounts. This arrangement was no longer in place, at the request of the resident.

The other resident's assessment determined they require support to manage their finances. The resident's preference for a named external person to manage and have oversight of their finances was documented. They had an opportunity to meet with a social worker to discuss their preferences. The resident had access to an agreed amount of cash from their income weekly to spend on day-to-day items. Receipts were not maintained for this spending. A set amount of money was also stored for them in the staff office for other spending such as appointments. Receipts were maintained by staff for this type of spending. The resident did not have access to the remainder of their income, unless requested from the named external party. The provider had requested oversight of the residents' statements of account in financial institutions to ensure that the residents' finances were safeguarded. This was in progress at the time of the inspection.

From a review of the staff training matrix, 100% of staff had completed adult safeguarding and protection training. The inspector spoke with the person in charge and staff on duty and found that they were all knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse.

The provider had a safeguarding policy which detailed each person's roles and responsibilities. A sample of documentation relating to six safeguarding concerns notified to the Chief Inspector were reviewed. This demonstrated that these were reported and followed up in line with the provider's and national policy.

Records reviewed in the centre indicated that there were risks relating to financial safeguarding for them both. This was also demonstrated in information notified to the Chief Inspector for one resident.

Both residents had detailed intimate care plans in place. They contained information on their preferences and support needs.

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Kare DC2 OSV-0001992

Inspection ID: MON-0051033

Date of inspection: 11/08/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Access to an electric car is available for the location each day after 4pm. This will be delivered each day after local service and available each weekend for the full weekend. This car meets the current needs of the location. The resident is satisfied with this arrangement. This is in place from the 26th of August 2026. There are 4 staff who work on the team who are indemnified to drive their own vehicles also during the day. The quality team will update the centre's audit schedule to ensure that financial safeguarding, transport arrangements and any associated risks are specifically reviewed through the six-monthly unannounced visit and annual review. Audit findings will continue to be recorded on the team plan, with named persons responsible, clear timeframes for completion, and evidence of follow-up reviewed by the person in charge and PPIM at monthly governance meetings. This action will be completed by the end of December 2026.	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The risk register for this location related to finances will be reviewed and any additional controls identified will be added to the residents' financial support plans and the centre risk register if required by the end of October 2026. Where a resident requires support to make or communicate decisions about their finances, the staff team will support the resident to access independent advocacy,	

financial information, social work input or other appropriate supports in line with their will and preferences. Any agreed referral or support request will be completed by 30 October 2026 and the outcome recorded in the resident's plan.

A biannual financial oversight audit will be implemented for this centre. This audit will review each resident's financial assessment, support plan, access to funds, account statements, cash balances, receipts, property records, and any restrictions or external arrangements relating to money management. Audit findings will be recorded on the centre team plan, with named persons responsible and clear timeframes for completion. This audit will commence by 31 October 2026.

The provider will provide refresher guidance to the staff team on supporting residents with financial management, promoting autonomy and choice, safeguarding residents' finances, maintaining accurate records, and escalating any concerns. This will be completed through a staff team discussion by 31 October 2026 and recorded in the staff meeting minutes.

A plan to review further details gathered related to financial statements, legal letters and other documents together to determine if concerns have been highlighted. This has been discussed with the Designated Officer for safeguarding in Kare. Once this information is reviewed by leader by the 15th of September 2026 next steps will be identified and implemented.

Co decision making for one resident will be considered and explored with the individual as a legal process following the outcome of the above review.

Financial management plan back in place for other resident following discussion since the 20th of August 2026.

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.	Substantially Compliant	Yellow	23/12/2026
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	23/12/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/10/2026