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:	Drogheda Supported Accommodation
Name of provider:	The Rehab Group
Address of centre:	Meath
Type of inspection:	Announced
Date of inspection:	06 May 2026
Centre ID:	OSV-0002671
Fieldwork ID:	MON-0041714

About the designated centre

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

Drogheda supported accommodation is a designated centre operated by Rehab Group which provides 24 hour residential support to five male and female adults. The centre is a large detached six bedroom house with a large garden to the back of the property. The residents' home is spacious and comprises of a large kitchen dining area, a large sitting room and a large conservatory. It is in close proximity to the nearest town and is within walking distance to a large shopping centre.
Residents attend a day service during the week with the option to stay in the centre certain days of the week if they want. A vehicle is also provided for residents. There are two staff on duty in the evening times and for some hours at the weekend. One sleepover staff is also on duty to support residents at night and in the morning time. The person in charge is also responsible for other service provision in the wider organisation. In order to assure effective oversight of the centre, a team leader is also in place.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 May 2026	10:15hrs to 18:30hrs	Karena Butler	Lead

What residents told us and what inspectors observed

From what residents told us and from what inspectors observed, it was clear that residents were enjoying a good quality of life. Their views were listened to and they were supported by a kind and dedicated staff team.

However, improvements were needed in relation to residents' support plans to ensure all applicable information was known, that plans fully guided staff, and to ensure that information contained was still relevant.

The inspector also found that some improvements were required in relation to the premises to ensure all areas could be effectively cleaned, were maintained in a hygienic manner, and that an identified potential leak was repaired. Further oversight over residents' finances, specifically related to their banking, was required alongside improved monitoring of incoming medicines. These points are discussed in detail later in this report.

The inspector met and observed the five residents that were living in the centre. One resident was supported to attend a medical appointment and the other four residents attended their day service programmes. In the evening, two residents attended a specific weekly club they go to. The other three residents said that their plan was to relax at home for the evening.

One resident spoke with the inspector in private when giving a tour of their bedroom. The other four chose to speak jointly with the inspector. They each told the inspector that they got on well with their housemates. One resident said that on occasion they didn't get on with another housemate and when that happened they could go to their room as they felt comfortable there and they liked their privacy. Each resident felt they had choice in their daily lives with regard to food and activities. They communicated that they had no concerns, that staff were nice and that they felt supported by the staff team.

Staff were observed to be calm and friendly in their interactions and everyone appeared relaxed in each others presence. The inspector spoke with the person in charge, the team leader, and four staff on duty over the course of the inspection.

The provider had arranged for staff to have training in human rights. One staff member explained how they had put that training into everyday practice. They felt that in the past when supporting residents with intimate care they always ensured they protected the residents' dignity and explained the steps to them. Since having the training, they confirmed that they were now more conscious to check in and ask if the resident was comfortable with each step of the support provided.

Feedback received when speaking on the phone with two residents' family representatives was very positive. They told the inspector that they felt their family

members were safe and had their assessed needs met by the staff team. One representative communicated that on occasion their family member and another housemate could have negative verbal interactions with one another. However, they felt that without a doubt their family member wanted to live in this centre and that their family member mostly got on fine with their housemates. They went on to say that 'staff members have residents' best interests at heart, that they are a lovely group and are respectful'.

The house was observed to be homely, for example there were potted flowers at the front of the house. While the house was found to be clean and tidy, as mentioned above, some improvements were required which will be discussed under Regulation 17: Premises. There was an accessible front and back garden with the front garden mainly used for parking.

Each resident had their own bedroom and the inspector had the opportunity to see all bedrooms. They had adequate storage facilities for any personal belongings and were individually decorated. One resident had recently had their room painted in their chosen colour and had purchased a new bed. They said that they next wanted to pick out new curtains.

At the time of this inspection there were no visiting restrictions in place, no volunteers were used, and there were no vacancies or recent admissions to the centre. There was one recent complaint since the last inspection. A resident was not happy with another housemate interrupting their conversation one day. The person in charge explained that they had reminded the staff team to ensure doors were closed if a resident wished to have a private conversation, or to support them to move to another room if required. The person in charge discussed this with the resident, who appeared happy with the suggested solutions.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

Capacity and capability

This inspection was announced and was undertaken as part of the provider's application to renew the registration of the centre as well as part of ongoing monitoring of compliance with the S.I. No. 367/2013 - Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (the regulations). This centre was last inspected over two days in December 2025 and January 2026.

The inspector reviewed the provider's governance and management arrangements and found that they were effective.

From a review of a sample of rosters across four months, the inspector found that there was sufficient staffing in place to meet the assessed needs of the residents. The provider had ensured that there were adequate systems in place to monitor staff training and development.

In addition, the provider had ensured that the centre was adequately insured against risks to residents.

Regulation 15: Staffing

The inspector found that the staffing arrangements in the centre were effective in meeting residents' assessed needs.

The inspector reviewed a sample of rosters over a four-month period from February to May 2026. The review demonstrated that planned and actual rosters were being maintained and that required staffing levels were met.

There was some use of agency staff to fill the need for the recent increased staffing requirements. The person in charge was monitoring this and there was a plan underway to recruit the required staff vacancies. The team leader had ensured that any agency staff working in the centre received an induction in order to ensure they were familiar with residents and their support needs.

The person in charge assured the inspector that as part of the current recruitment drive for the centre, preference was being given to staff members who could drive. In the meantime, they confirmed that taxis could be used where needed in order to ensure that residents were never impacted by the lack of staff drivers.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of two agency staff members' Garda Síochána vetting (GV) certificates. Both staff members' GV were completed within the last year, demonstrating safe recruitment practices in line with best practice.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge ensured that staff had access to necessary training and development opportunities. The provider had identified some areas of training to be mandatory, such as fire safety management and safeguarding. The inspector reviewed the certification of three training courses for a sample of staff including agency staff, as well as a review of the training oversight documents. This review

demonstrated to the inspector that staff members had each received training in these key areas as well as additional training specific to residents' assessed needs.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- first aid
- medication management
- epilepsy management
- training related to infection, prevention and control (IPC), for example hand hygiene
- fire safety.

Staff had received additional training to support residents. For example, staff had received training in human rights. Further details on this have been included in the 'what residents told us and what inspectors observed' section of the report.

Judgment: Compliant

Regulation 22: Insurance

As per the requirements of the regulations, the provider had ensured that the centre was adequately insured against risks to residents and evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider had adequate governance and management arrangements in place.

There were arrangements for unannounced provider led visits every six months and the inspector found that they were taking place as required by the regulations, evidenced by a review of the reports from July 2025 and January 2026. In addition, there were weekly reviews completed by the team leader and monthly reviews completed by the person in charge.

The provider had arrangements in place for an annual review. The inspector reviewed the most recent version that was up to and including June 2025 with the next being due in June 2026.

A review of the records of the team meeting minutes from January to April 2026 showed that incidents that occurred within the centre were reviewed for shared

learning with the staff team to promote consistency of approach to facilitate better care for residents.

All staff members on duty spoken with communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns and would feel listened to.

Judgment: Compliant

Quality and safety

Overall, the inspection found that the residents were receiving a good standard of care. However, improvements were needed in relation to the residents' support plans and to aspects of staff knowledge. Some improvements were required in relation to the premises, oversight of finances, and the systems in place for the intake of medicines.

For the most part, residents were supported in line with their assessed needs. However, a number of improvements were required as not all support plans in place to guide staff with regard to residents' support needs were thorough or reviewed within the last year. Additionally, there were gaps in some staff member's knowledge in relation to support requirements for residents.

There were many adequate arrangements in place to safeguard the residents from the risk of abuse. For example, staff were appropriately trained to recognise and respond to signs of abuse. However, further improvements were required to the oversight of residents' finances, other than the day-to-day cash expenses.

While the inspector found the house to be clean and tidy, some improvements were necessary. For instance, a potential leak was identified.

The risk management arrangements in place were ensuring that residents were protected from any identified or emerging risk.

For the most part, there were adequate arrangements in place for medicines management. However, some improvements were required in order to ensure the systems in place for receiving medicines into the centre worked effectively and were robust.

Regulation 17: Premises

For the most part, the premises was found to be in a state of good repair. It was observed to be tidy and clean. The facilities of Schedule 6 of the regulations were available for residents' use, for example residents had access to cooking and laundry facilities. However, some improvement was required to ensure all IPC measures were appropriate and facilitated effective cleaning. Additionally, a potential leak needed to be addressed.

Areas identified requiring improvement were:

- an area of an upstairs bathroom shower enclosure was discoloured and another area was not fully sealed which would allow water to pass through increasing the risk of a leak
- there was staining on the sitting room ceiling and utility room ceiling indicating that a leak may be present
- residents' pillows did not have protectors fitted and stains were observed on several pillows which could put residents at risk of bacterial growth
- some limescale was observed on the sink and tap of the downstairs water closet as well as the silicone between the sink and the wall was discoloured in parts and breaking.

In addition, those issues detracted from the overall homeliness and presentation of the house for the residents living there.

The person in charge arranged for someone to call out to the premises in the days after this inspection to review the leak.

The layout and design of the premises were appropriate to meet the residents' needs. Each resident had their own bedroom with sufficient space for their belongings. The downstairs bathroom had been redesigned into a wet room, making it fully suitable for residents' showering needs.

A review of the storage areas found that there were improvements in the system for stock rotation and food storage practices since the last inspection. For example, food that staff had frozen from fresh was clearly labelled with freezing and defrosting dates.

There was a colour-coded system in place for the cleaning of the centre to minimise the chances of residents receiving a healthcare-related illness. For example, there were colour-coded cloths, mops and buckets in place. Additionally, there were facilities in place to support hand hygiene, such as hand wash and disposable towels.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

There were systems in place to manage and mitigate risk and keep residents safe in the centre. For example, there was a policy on risk management available.

Each resident had a number of individual risk assessments on file so as to support their overall safety and wellbeing. For example, where a resident may be at risk of falling, they were assessed by an occupational therapist and mobility aids were available in the centre.

The inspector reviewed incidents that occurred in the centre since the last inspection and found that they were recorded, reviewed and where possible learning was taken to minimise recurrence.

Equipment used for the residents, such as a height-adjustable bed was recently serviced, as well as the centre's boiler to ensure they were safe for use.

The inspector observed that the centre's vehicle was recently serviced, insured, taxed, and had a valid national car test (NCT).

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

While there were many appropriate arrangements in place with regard to medicines management, the inspector observed that the internal checks designed to catch mistakes, prior to administration of medication, required improvement to ensure the system for checking and verifying incoming medicines was robust.

For example, from a review of two residents' files, the medication stock count form for medicines received from a pharmacy, did not allow for staff to ensure that medicines came with pharmacy labels, compare pharmacy labels to the prescription, or check for expiry dates.

In addition, the inspector found that there were some descriptions available for staff to recognise medication. This was to ensure staff could easily identify medications that arrived in blister packs rather than their original packaging. However, not all pictures available were clear, and some medications did not have any description or picture available. This meant that staff were unable to independently verify that the specific medications contained in the blister packs matched those prescribed. While a sample of three daily stock counts demonstrated that accounts were accurate and no known medication error had occurred, this gap reduced the robustness of the checking system and made it harder for staff to identify potential pharmacy errors prior to administration.

The inspector was satisfied that the arrangements for storage of out of date or medicines to be returned to the pharmacy ensured that they were segregated from

other medicinal products and a record was kept of returned medications that were signed as received by the pharmacy.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The provider had ensured that assessments of residents' health and social care needs had been completed and care plans developed for any identified needs. However, some support plans required further information and one plan required a formal review. Additionally, some enhancement of staff knowledge was required.

There were personal care plans in place to guide staff as to the support required for any identified needs. For example, there were plans in place in relation to osteopenia, epilepsy, and high cholesterol.

The inspector found that one resident's mental health support care plan required more elaboration and guidance for staff to follow in order to ensure they were appropriately supporting the resident. For instance, it did not describe the resident's anxiety symptoms or provide guidance on how staff should respond. This lack of clear guidance meant that if the resident experienced a period of anxiety, staff, particularly temporary staff, might not recognise the signs early or know how to comfort them effectively, which could lead to prolonged distress for the resident.

While care and support were, for the most part, provided in line with their care needs and any emerging needs and other healthcare needs were being met, the inspector found that one recommendation from a general practitioner (GP) was not being followed through on. It was recommended that a resident's blood pressure was to be checked twice weekly. This was not known to the person in charge or the staff member spoken with and it was not occurring in practice. While this was a recent recommendation, the inspector was not assured that all care plans, once reviewed by allied healthcare professionals, were discussed with the staff team. This meant that the resident's healthcare needs were not being adequately monitored in line with medical advice, potentially putting their health at risk.

One resident's positive behaviour support guidance had not received a review since September 2024. Therefore, it was difficult to ascertain if the information contained was still applicable. In addition, some recommendations contained were not clearly explained, for example guiding staff to use an approach called SDM, to support the resident to make decisions. This information was not known or understood by the person in charge or a staff member spoken with which meant the resident may not be receiving support in line with their assessed needs.

Furthermore, when spoken with, one staff member had gaps in their knowledge in relation to epilepsy care, despite recently completing training. This would put residents with epilepsy at increased risk from adverse effects were they to have a seizure while being cared for by this staff member. The person in charge confirmed

that they would ensure the staff member was familiar with epilepsy care plans within the centre, the staff would receive re-training, and that they would escalate this with their manager for review.

Overall, while residents' needs were assessed and care plans were in place to guide staff support, improvements were required to ensure all information contained in the plans thoroughly guided staff, was reviewed annually to ensure information was up to date and applicable, and that all applicable information was known to staff.

Judgment: Not compliant

Regulation 8: Protection

There were many suitable arrangements in place to protect the residents from the risk of abuse. However, improvements were required with regard to oversight of residents' finances.

From a review of two residents' finances, the inspector found that regular checks were being completed of residents' day-to-day cash expenditures. The team leader completed a check of one resident's cash expenditure in front of the inspector and the count was found to match that of the written record.

However, further oversight was required with regard to the system for when the residents used their banking cards and the checks to verify the expenditures shown on their bank statements. While management had started checking bank statements, the reconciliation process was incomplete, as not all withdrawals or expenditures had been cross-referenced. In addition, it had been several months since either resident's bank statements had been checked. Therefore, improvement was required to provide appropriate oversight of residents' finances in order to ensure that their money was safeguarded.

There was an organisational safeguarding policy in place. There was a reporting system in place with a designated officer (DO) nominated for the organisation and two staff spoken with were able to identify who the DO was to the inspector.

Staff had received training in safeguarding vulnerable adults. A staff member spoken with was familiar with their roles and responsibilities in safeguarding residents from the risk of abuse. For example, in the case of a peer-to-peer incident, the staff member would ensure the initial safety of the residents involved and assess if medical attention was required, and ensure the incident was reported as soon as possible.

From a review of the safeguarding incidents since the last inspection, the inspector found that any potential safeguarding risks were escalated, reviewed, and reported to the relevant statutory agencies. There were safeguarding plans in place to minimise the chances of recurrence of incidents.

All five residents communicated that they felt safe living in the centre. Furthermore, the residents, two family representatives, and the four staff spoken with all confirmed they would feel comfortable raising concerns if they had any.
Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Drogheda Supported Accommodation OSV-0002671

Inspection ID: MON-0041714

Date of inspection: 06/05/2026

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 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • Upstairs bathroom leak has been repaired. This was completed on 07/05/26. • Repainting of the ceiling has been booked with the painter. This will be completed by 30/06/26. • All residents have now got pillow protectors and any stained pillows have been replaced. This was completed on 02/06/26. • Downstairs bathroom tap and sink will be replaced by 30/06/26.	
Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services: • New Medication stock count form will be explained to staff and implemented after the next staff meeting. This will be completed by 30/06/26. • New medication pictures for each resident will be added to each medication file to make it easier for staff to recognize medication on intake. This will be completed by 30/06/26.	

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:

• Mental Health plan will be reviewed and additional support needs will be clearly identified on this plan to guide staff practice. This will be completed by 30/06/26.

• Blood Pressure monitoring sheet to be put in place for staff to monitor and record twice a week. This will be put in place following staff blood pressure training. This will be completed by 20/07/26. In the interim the resident will be supported to have their blood pressure twice weekly at a local pharmacy, records of these checks will be maintained locally.

• Going forward any recommendations for the support of residents from clinicians will be reviewed at staff meetings to ensure that all recommendations are implemented in a timely manner.

• Behaviour Support Guidance for one resident will be reviewed by the Behaviour Therapist, guidance will be clearly documented for staff to ensure they have the required knowledge to support the resident. This will be completed by: 30/06/26

• Staff member referred to above was taken off sleepovers/ lone working following this inspection. This staff member will be retrained in Epilepsy and emergency medication training. Once completed the staff member will be assessed on knowledge of Epilepsy in advance of their return to lone work or sleepovers in the service. This will be completed by 20/06/26.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• All residents finance will be cross checked and reconciliation to be done at the end of each week by staff and team leader. PIC will cross reference them on a monthly basis. This will be completed by 30/06/26.

• All residents will be supported get access to their own bank statements for cross checking to be completed more frequently. This will be completed by 30/06/26.

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 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	07/05/2026
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	30/06/2026
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that	Substantially Compliant	Yellow	30/06/2026

	medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.			
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	20/07/2026
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/06/2026
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	30/06/2026

Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/06/2026