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:	Dundalk Supported Accommodation
Name of provider:	The Rehab Group
Address of centre:	Louth
Type of inspection:	Announced
Date of inspection:	13 May 2026
Centre ID:	OSV-0003405
Fieldwork ID:	MON-0041857

About the designated centre

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

The designated centre is a two storey detached house with five bedrooms in close proximity to a large town in County Louth. The service can accommodate up to five adults with disabilities. Each resident has their own bedroom (one en-suite) and communal facilities include a kitchen cum dining room, a sitting room, a sun room, a utility facility and communal bathrooms. There is a garden to the rear of the property and adequate on-street and private parking is available. Transport is also available to residents if required. The staffing arrangements consist of a person in charge, a team leader and a team of support workers. Staff are available to provide support in the evenings and morning times with a sleepover staffing arrangement provided at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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 13 May 2026	10:30hrs to 18:40hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Overall, on this announced inspection, the inspector found a caring staff team was delivering good quality care to the residents.

However, the inspector identified that some areas of governance oversight required improvement. While residents received good care, there were gaps in the oversight of staff training, cleaning practices, Garda vetting, and notification of incidents. Additionally, some minor improvements were required to how records were maintained in the centre and the contents of the contracts of care required more information. These points are discussed in detail later in this report.

The inspector had the opportunity to meet and observe the four residents that were living in the centre. There was one vacancy. On the day of this inspection, three residents attended day service programmes and one attended their paid employment. Three residents stated that they had a good day when they returned and that they planned to relax in for the night. The fourth resident had soccer training. Although they were able to independently walk to their training, a staff member offered to walk with them to keep them company for the journey, which they accepted.

The four residents who spoke with the inspector all said they felt safe living in the centre and would tell a staff member if they were worried or concerned. They said that the staff that supported them were nice. One resident stated that you 'can't get people like them, they are amazing'. They all said that they got on well with their housemates. They felt they got choice regarding their meals and daily activities.

Residents appeared content and comfortable in the centre. Interactions between staff and residents were seen to be respectful and engaging. Residents were supported in a gentle manner.

The inspector had the opportunity to speak with the person in charge as well as the team leader and two staff members on duty. They appeared knowledgeable regarding the residents' support needs and preferences when speaking with the inspector.

One staff member explained how they had put that training into everyday practice. They explained that they were more conscious about the potential power imbalance between staff and residents. They said they did not want to impose their views on the resident. They explained that a resident has the right to refuse. They noted that the role of staff was to gently remind the resident of the potential consequences or outcomes of their decisions. They explained the training had helped them realise that their role was to help the resident make an informed decision. One staff

member commented that the most recent admission to the centre from 2024, was a 'blessing to have living in the centre'.

The inspector had the opportunity to speak with two residents' family representatives on the phone on the day of this inspection and feedback received was positive. The family representatives communicated that they felt their family members were safe. Both felt welcome to visit the centre. They both felt that their family members got on well with their housemates. Both felt their family members were safe living in the centre. They added that if they were to have a concern they would feel comfortable raising it with staff or management.

As part of this inspection process residents' views were sought through questionnaires provided by the office of The Chief Inspector of Social Services (The Chief Inspector). Staff members helped the residents to complete their questionnaires. Feedback was positive and the questions were ticked 'yes' for happy when asked about the service and care provided. One resident wrote that 'the house was very safe and the staff were kind' and that 'they had lots of privacy'. Another stated that 'they loved living in this house and loved living with their friends'. They said that 'the staff were so wonderful and supportive to them'. Another said that they were 'happy out' and 'everything was good'.

The premises was found to be clean and tidy. One resident had recently had their en-suite bathroom renovated and they said they loved it. They informed the inspector that they were in the process of picking paint colours for their bedroom to get re-painted.

At the time of this inspection, there had been no complaints received since the last inspection.

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 following the provider's application to renew the registration of the centre. This centre was last inspected in December 2024.

The findings of this inspection indicated that while some areas for improvement were identified, the provider had the capacity to operate the service within substantial 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). The person in charge was operating

the service in a manner which ensured the delivery of care was meeting the residents' needs.

While there was evidence of regular quality assurance audits taking place, the provider's governance and management arrangements were found to require a number of improvements in order to ensure appropriate oversight of the quality and safety of the service.

There were sufficient staffing levels in place to support the assessed needs of the residents. The inspector also found that there was a programme of training and refresher training in place for all staff.

Some minor improvements were required as to how some records were maintained in the centre, for example aspects of residents' personal inventories were vague. In addition, some improvements were required to the information provided to residents in their contracts of care.

The provider had ensured that the centre was adequately insured against risks to residents and property.

Regulation 14: Persons in charge

The registered provider had appointed a full-time, suitably qualified and experienced person in charge to the centre. They managed two designated centres and split their time evenly.

They were supported in each centre by a dedicated team leader for each centre in order to support the person in charge to maintain appropriate oversight and support.

While the person in charge had only recently taken back over the running of this centre, they were familiar with the residents' needs and could clearly articulate individual health and social care needs on the day of the inspection.

They were also found to be aware of their legal remit in line with the regulations, such as to notify the Chief Inspector when adverse incidents occurred in the centre. They were also found to be very responsive to the inspection process.

Judgment: Compliant

Regulation 15: Staffing

On the day of this inspection, the registered provider ensured there were sufficient staffing levels with the appropriate skills and experience to meet the assessed needs of the residents.

The inspector reviewed a sample of the planned and actual staff rosters across February to May 2026 and found that regular, familiar staff were employed, which ensured continuity of care for all residents. Additionally, the rosters reviewed accurately reflected the staffing arrangements in the centre, including the full names of staff on duty during both day and night shifts.

Throughout the inspection residents were observed to be very comfortable in the presence of staff and they were complimentary of the staff team.

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of two core staff members' and one relief staff member's Garda vetting certificates. While one had received Garda vetting within the last three years as per best practice, it had been a number of years since the other two had received re-vetting. This was addressed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 16: Training and staff development

There were adequate systems in place for the training and development of the staff team.

The inspector reviewed the training oversight records and a sample of certification and attendance records for nine different training courses. This review demonstrated that staff had completed a range of training courses, ensuring they possessed the necessary knowledge and skills to effectively support residents. This included mandatory training in critical areas such as fire safety, safeguarding vulnerable adults, epilepsy awareness and emergency medication usage, and training related to positive behaviour support.

From speaking with one staff member, they confirmed that they received formal supervision four times a year and that was an opportunity for them to raise concerns should they have any.

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.

While some improvements were required to the oversight of training, this was addressed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 21: Records

All required records were for the most part adequately maintained and available for inspection, including records of staff meetings and training records. There was a residents' guide available for residents, as well as a statement of purpose.

The provider had ensured that residents had inventories of their belongings recorded in order to facilitate safeguarding of their belongings as well as oversight of ownership. However, the inventories were found to be vague in some of the description of items recorded. This meant that if a resident's item went missing, it would be difficult to identify or replace it. For example, a resident's inventory described that they had a mobile phone and other than to say what company made the phone, it had no further description which would make it difficult to recognise it if required, particularly as another resident also had the same brand phone with no other descriptions recorded in their inventory.

While the person in charge and a resident confirmed that all money was accounted for, some of the weekly expenditure checks were not clearly recorded. Improvements were required to ensure financial checks provided a thorough and accurate account of residents' spending.

The inspector reviewed the residents' personal emergency evacuation plans (PEEPs) and found them for the most part to be generic. They contained inaccurate information saying that the residents required verbal prompts when this was not the case. While regular staff knew the correct supports, this posed a risk of unfamiliar relief staff providing unnecessary supports during evacuation.

In addition, while the residents and the staff on duty confirmed that the residents all got on with one another, a formal compatibility assessment had not been completed for the last admission to this centre. Compatibility assessments are important as they help to ensure any potential compatibility issues would be highlighted and considered in a timely manner. This was self-identified on the provider's own audits.

Judgment: Substantially 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 the property. Evidence of the insurance was submitted to the Chief Inspector.

Judgment: Compliant

Regulation 23: Governance and management

While there were some governance systems in place, they did not always ensure adequate oversight and accountability. A number of improvements were required regarding staff vetting, training, cleaning, and submission of notifications.

The provider was monitoring the quality of care and support for residents through their audits and reviews. For instance, the provider had carried out an annual review of the quality and safety of the centre which included positive resident and family representative consultation. There were arrangements for unannounced visits to be carried out on the provider's behalf every six months. The inspector reviewed the two most recent reports from November 2025 and May 2026. Improvements were required regarding the provider's unannounced visits; the inspector observed that some recorded actions could not be easily linked to a specific resident. When asked by the inspector, the person in charge and the team leader could not identify which resident the actions related to, which hindered the tracking and trending of information.

There were regular team meetings occurring in the centre and learning from any incidents that occurred was discussed to ensure staff awareness and consistency of approach.

There were other regular weekly and monthly audits completed in the centre on a variety of topics, for example complaints, IPC, medication, health and safety, safeguarding, and restrictive practices.

However, further oversight was required with regard to staff training. The inspector found that a staff member commenced employment in September 2025 and while they had completed an online fire safety course, they had not completed their in-person training. Both trainings were required by the provider. The inspector brought to the attention of the person in charge and they arranged for the staff member to be scheduled to complete the training on 3 June 2026. While this was a positive step, training was reviewed monthly as part of governance oversight and this issue had not been identified. Therefore, improvements were required.

The person in charge had ensured that all of the staff team had recently re-applied for re-vetting of their Garda vetting which was a positive step. However, from the sample of Garda vetting reviewed, some staff members had not been re-vetted in a number of years. For instance, one staff member had not completed Garda vetting since 2005. This was not within best practice and had the potential for pertinent information not to be known to the provider. Additionally, the provider's policy was very vague on when a staff member should be re-vetted, stating only that they reserve the right to re-vet every three years. This meant the provider could not assure themselves that all staff were fully vetted in line with best practice to safeguard the residents living in the centre.

While the provider submitted most notifications as required, one three-day notification had not been submitted. This was only completed on the day of the

inspection after the inspector brought it to management's attention. Furthermore, the provider failed to notify the Chief Inspector within the 28 day time frame for a person participating in management (PPIM) ending their employment with the provider. The PPIM ceased their role in January 2025 and the Chief Inspector was not notified until September 2025. Therefore, improvement was required so that the systems in place would always ensure the provider would fulfil their regulatory responsibilities.

Furthermore, oversight of infection prevention and control (IPC) required improvement. The inspector observed dirty washing machine seals, cleaning equipment that was not used in line with the provider's own colour-coded guidance, and observed gaps in periodic cleaning schedules. While oversight of cleaning was included as part of the weekly governance audits, the review was not of a thorough nature and only reviewed the same day of the week, each week.

The washing machine seals were a repeat finding from the previous inspection. The person in charge was responsive and arranged on the day of the inspection for a new washing machine to be purchased and cleaning equipment to be available in line with the provider's guidance. However, this issue was only rectified once brought to management's attention.

While those identified issues were not causing a negative impact to the residents at the time of this inspection, there was a potential for risk if improvements were not implemented.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

While residents were supported well during the admissions process, some improvements were required to the written contracts of care to ensure residents were fully informed of the services provided.

The inspector reviewed the most recent admission to the centre and found that they were supported in moving to the centre through an individual transition plan. They were provided with several opportunities to visit the premises in advance of admission.

From speaking with the resident’s family representative, they confirmed their family member had the opportunity to visit the centre prior to moving in and met the other people that lived in the centre. They said their family member has settled well. They confirmed that an assessment of need was completed prior to the move and their family member’s support needs were known. They confirmed that their family member had received a contract of care and the contents were explained by the person in charge.

Residents were provided with a contract of care to review and sign; however, the documents did not fully outline all of the services residents could expect to receive. For example, it did not explain if they would have access to allied healthcare professionals and if that access would incur a cost to the resident. It was not evident if residents would have access to transport or if any furniture would be provided for them.

Judgment: Substantially compliant

Quality and safety

The inspector found that the quality and safety of care provided for residents was to a good standard. The centre presented as a comfortable home and the staff team provided person-centred care to the residents.

An assessment of need was completed for residents and a support plan was in place for any identified needs.

There were appropriate arrangements in place to recognise and respond to any potential safeguarding risks to residents, in order to protect them from the risk of abuse. For example, there was an organisational policy to guide staff and staff were found to be appropriately trained to understand their roles and responsibilities in relation to safeguarding vulnerable adults.

Residents were supported to maintain control over their personal possessions.

The centre was found to be tidy and homely. Visits were facilitated with no visiting restrictions in place in the centre. Different private areas for entertaining visitors were available depending on residents' preferences.

There was a residents' guide that contained the required information as set out in the regulations.

The inspector reviewed the fire management arrangements and found the provider ensured that adequate fire precautions were in place and that the fire detection and alert as well as firefighting equipment were well maintained.

Regulation 11: Visits

The provider facilitated residents to receive visitors in accordance with residents' wishes. There were no restrictions to visiting at the time of the inspection and there were suitable facilities available in order to receive visitors in private. For example,

residents could entertain their visitors in the sitting room or visits could be facilitated in the garden room that was located in the back garden.

From the two family representatives spoken with, they both felt welcome to visit.

Judgment: Compliant

Regulation 12: Personal possessions

The provider had ensured that residents retained control of their personal property; residents had their own items in their home, and these were recorded in a log of personal possessions.

While the log was vague at times in the description of the items, this was addressed under Regulation 21: Records.

The inspector confirmed, through speaking with a resident and the person in charge, as well as reviewing two financial files, that residents had accounts in their own names and retained control over their own money. Staff members supported the residents weekly to review the residents' banking transactions to verify their expenditures.

Judgment: Compliant

Regulation 17: Premises

The inspector completed a walk around of the premises and found that there was adequate communal and private space for residents. The centre had been decorated to ensure it was homely in presentation and it was found to be tidy.

Each resident had their own bedrooms, which were decorated to reflect their individual tastes. One resident had recently had their en-suite bathroom renovated and they were delighted with how it had turned out.

The centre was found to meet the requirements of Schedule 6 of the regulations. For example, the residents had access to cooking and laundry facilities. Residents confirmed that they were supported to buy their own food shopping and cook their own meals.

While additional oversight of certain aspects of cleaning and the cleaning logs required improvement, this was addressed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide that contained the required information as set out in the regulations. For example, it contained information on how residents can access inspection reports.

Judgment: Compliant

Regulation 28: Fire precautions

There were effective fire safety management systems in place in the centre. The inspector observed fire fighting equipment, detection systems, and emergency lighting all in working order around the centre and they were serviced as required.

There were fire containment doors in place that were fitted with self-closing devices, fire seal strips and cold smoke seals. Each door was tested and all were found to close effectively which demonstrated that they would facilitate in protecting residents from the spread of smoke and fire.

A review of a sample of seven practice fire evacuation drills showed that staff and residents were completing them periodically to ensure they were familiar with how to safely evacuate in the event of an emergency. Drills included two during hours of darkness, one with minimum staffing levels and maximum residents participating, and drills undertaken used alternative evacuation routes in order to ensure that residents could be evacuated from all areas of the house and under different conditions.

In addition, each resident had a PEEP in place which guided staff on the supports they required if an evacuation was necessary. Some minor reviews were required to the PEEPs and this was addressed under Regulation 21: Records.

Judgment: 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. These assessments, along with residents' support plans, were under periodic review and

demonstrated that multidisciplinary professionals were involved in the development of care being provided.

For example, from a review of aspects of three residents' files, the inspector found that there were support plans in place for identified needs, such as epilepsy, stoma care, and high cholesterol. The information contained guided staff as to what supports were required. Care and support was provided in line with their care needs and from speaking with a staff member, residents' support needs were known.

Judgment: Compliant

Regulation 8: Protection

There were arrangements in place to protect residents from the risk of abuse. For example, staff had completed training in relation to safeguarding vulnerable adults.

From speaking with one staff member, they were found to be knowledgeable in relation to their responsibilities should there be a suspicion or allegation of abuse. For example, they explained in the case of a peer-to-peer negative interaction, they would separate the individuals, ensure the safety of both, check for injuries, seek medical attention if necessary, provide appropriate supervision, report, and document the incident.

Two staff members spoken with could confirm who the designated safeguarding officer (DO) for the organisation was and the identity of the DO was displayed in the dining room.

There had only been one safeguarding concern since the last inspection. It was found to be reported to the relevant statutory agencies and a safeguarding plan was implemented to mitigate the chances of recurrence.

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

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Dundalk Supported Accommodation OSV-0003405

Inspection ID: MON-0041857

Date of inspection: 13/05/2026

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • PIC addressed level of detail required in resident's inventories at a staff meeting on the 29/05/26. All inventories have been updated with additional detail. This was completed 29/05/2026. • PIC addressed the need to record in detail weekly expenditure checks at the staff meeting on the 29/05/2026. Going forward the Team Leader and PIC will ensure all checks are documented as required. This was completed 29/05/2026. • PEEPs will be updated to reflect each resident's individual needs. This will be completed by 30/06/2026. • Formal Compatibility Assessment will be carried out for potential new resident by the Behaviour Therapist on the 18/06/26. This will be completed by the 30/06/2026.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Team leader is now doing cleaning spot checks and is documenting them on an audit tool naming area checked, date checked etc. This was implemented on 30/05/2026. • The provider's Head of Regulation emailed all Internal Auditors on 03/06/2026 to remind auditors that the names of residents linked to audit actions should be shared verbally on the day of audit or in email post audit with the PIC and Team Leader of the service to enable improved action tracking. • Going forward the PIC will ensure all notifications to the Regulator are submitted within	

the required timeframes.
• The PIC will ensure that training is effectively reviewed on a monthly basis as part of the service level monthly audit and training will be booked as required.
• The Provider will review its current National Vetting Bureau Policy with a view to determining if there additional legal requirements that need to be incorporated into the policy. The review of these requirements will completed by 31/08/2026.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
• Contracts of Care were updated on the 15/05/2026, they now outline all potential costs to the residents and detail all supports available in the service. This was completed on 15/06/2026.

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 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	30/06/2026
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.	Not Compliant	Orange	31/08/2026
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the	Substantially Compliant	Yellow	15/06/2026

	designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			