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:	Louth
Type of inspection:	Unannounced
Date of inspection:	05 December 2025
Centre ID:	OSV-0002671
Fieldwork ID:	MON-0048501

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
Tuesday 20 January 2026	11:35hrs to 20:00hrs	Karena Butler	Lead
Friday 5 December 2025	10:35hrs to 13:20hrs	Karena Butler	Lead

What residents told us and what inspectors observed

Over the two days of this unannounced monitoring inspection, the inspector found a warm and positive atmosphere where the residents were receiving a good standard of person-centred care. However, the inspector found that improvements were required in relation to the premises, specifically regarding the suitability of a bathroom for all residents. Furthermore, a review of staffing levels was required to ensure the centre could maintain suitable supports for residents' increasing needs. Improvements were needed in how records were maintained to ensure they fully guided staff. These points are discussed in detail later in this report.

The inspector met and observed three of the five residents that were living in the centre. On the first day of this inspection, one resident attended an appointment. On return they said that they enjoyed going out for a hot chocolate after the appointment. On day two, the inspector met again with that resident and in addition spoke with two other residents. All three chose to speak jointly with the inspector. They told the inspector that they got on well with their housemates and felt they had choice in their day-to-day lives regarding food and activities. They stated they had no concerns, felt supported by staff, and that the staff were nice.

The inspector did not meet the remaining two residents. On day one they were at their day service programme and on day two, one was away on a family visit, and the other was self-isolating due to illness. However, the inspector observed staff being attentive to the resident who was unwell, regularly checking in on them and bringing them snacks and drinks.

Staff were observed to be calm and friendly in their interactions. On the second day, two staff members were seen watching a comedy show on television with three residents, and everyone appeared comfortable in the presence of each other. The inspector spoke with three staff on duty over the two days, the team leader, and the newly appointed person in charge. The person in charge had previously managed this service and was familiar with the residents and their support needs.

Feedback received when speaking on the phone with two residents' family representatives on day two of this inspection 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. They both felt that their family members were happy living in the centre and that it would be easy to know if they weren't. Both felt that the staff team knew their family members well. One stated that they felt staff had great respect for their family member. That staff listened and had great patience with their family member. They said they had no concerns at present and that if they were to have a concern they would feel comfortable raising it with staff or the person in charge. They both believed that they would be listened to.

Notwithstanding the issue regarding the bathroom which will be discussed later in the report, the inspector observed the house to be tidy and it appeared homely on both days. There were some mature plants and decorative hanging baskets at the front of the house. The front garden was mainly used for parking. The back garden contained a garden bench that residents could use in times of good weather.

Each resident had their own bedroom. The inspector had the opportunity to see two bedrooms. They had adequate storage facilities for any personal belongings and were individually decorated.

While some additional cleaning was required on day one of the inspection, this was completed that day.

At the time of this inspection there were no visiting restrictions in place and there were no vacancies or recent admissions to the centre. There was one complaint due to a resident not happy with an interaction with another resident they lived with. The person in charge and a staff member communicated that the staff team were trialling changes in the house to help minimise negative interactions between the two individuals. For example, staggering their breakfast times.

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 unannounced and was undertaken as part of on-going 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 in May 2023.

The findings of this inspection indicated that the provider had the capacity to operate the service within substantial compliance which ensured a safe service was provided.

From a review of a sample of rosters across four months, the inspector found that there was adequate staffing in place to meet the assessed needs of the residents. However, due to the changing needs of the residents, there were increased intimate care needs that required staff support. This had the potential to limit the current staff team's ability to spend quality time with the residents and promote community inclusion.

Some improvement was required to how records were maintained in the centre to ensure accurate and sufficient information was provided to guide staff when supporting the residents.

The inspector reviewed the provider's governance and management arrangements and found that there were adequate systems in place.

Staff were found to be in receipt of training that would facilitate them to effectively support the residents, for example fire safety.

Regulation 14: Persons in charge

The person in charge was employed in a full-time capacity and had the necessary experience and qualifications to fulfil the role. For example, they held a qualification in social care along with a qualification in management. They demonstrated a good understanding of the residents and their needs, such as what healthcare support needs the residents required.

They were also found to be aware of their legal remit to the regulations and were responsive to the inspection process. For instance, they were aware that it was their responsibility to ensure the reporting of any adverse incidents that occurred to the Chief Inspector.

They were responsible for the management of this designated centre along with one other. They had only re-commenced managing this centre in the weeks prior to day two of this inspection. Their plan was to attend the centre regularly to provide oversight and informal supervision for staff. They were supported in this role by a team leader.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that while the staffing arrangements in the centre were effective in meeting residents' assessed needs, the increasing support needs of the residents was putting a strain on the current staff team resources. Therefore, this regulation was found to be substantially compliant.

The inspector reviewed a sample of rosters over a four-month period from October 2025 to January 2026. The review demonstrated that planned and actual rosters were being maintained. The centre had a full staffing complement. Cover for planned or unexpected leave was undertaken by familiar consistent agency staff when available.

However, due to the changing needs of the residents, there was an increase in intimate care needs requiring staff support. The provider had recently approved additional staffing hours in the morning to help with the increased support needs. The team leader was undertaking the majority of the additional morning shifts to support with medication administration and intimate care. However, this was taking time away from their ability to complete their administration work and was impacting on how the documentation in the centre was being maintained. Therefore, that arrangement was not sustainable.

Three staff communicated that increased support needs were resulting in occasions when residents may have to wait to be supported with their personal care if staff were already supporting another resident. It was also communicated that the increased support needs were on occasion impacting on residents' ability to participate in external activities.

In addition, only four of the seven staff were drivers, two of whom worked part-time. This also had the potential to negatively impact on residents' ability to leave their home for recreational interests as some residents were not in a position to use public transport.

The staff on duty on the day of the inspection were observed to be caring towards the residents. One family representative stated that their family member 'had a lot of medical issues, that the staff were well on top of it and the appointments and keeping them aware of it.'

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of two staff members' Garda Síochána (police) vetting (GV) certificates as well as their police clearance certificates. Both staff members' GV were completed within the last year. This demonstrated that the provider had arrangements for safe recruitment practices.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with access to a suite of training and were being appropriately supervised in line with the provider's guidance.

A review of certification of five training courses for a sample of staff demonstrated to the inspector that staff received training in areas determined by the provider to be mandatory as well as refresher training. Staff had also received training in additional areas specific to residents' assessed needs.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- Children First safeguarding

- medication management
- epilepsy management
- hand hygiene
- Autism and sensory processing
- human rights
- fire safety.

From a review of three staff members' files, this confirmed to the inspector that formal supervision was occurring for staff and that it was an opportunity to raise concerns if any.

Judgment: Compliant

Regulation 21: Records

This inspection found that although the majority of records were accessible, improvements were required to ensure records were always accurate and up to date.

For example, there was no information to guide staff as to a resident's normal blood pressure range as they were diagnosed with high blood pressure. There was no information to guide staff on how to recognise if the resident may be experiencing an episode of higher than normal blood pressure or when to seek medical attention. In addition, another resident suffered from high cholesterol and other than noting this in their file, there was no support plan in place. While the above information was known to staff and both conditions were under control at the time of this inspection, this had the potential for staff, particularly temporary staff, to not be familiar with how to support the residents appropriately and consistently in those areas.

Review of fire safety documentation highlighted gaps in information. For instance, fire drill records indicated that some residents declined to leave during practice drills. However, the records did not identify who had refused, which made it difficult to track and trend the information. Furthermore, residents' personal emergency evacuation plans (PEEPs) had not been updated to reflect this non-participation or to guide staff on how to encourage evacuation in such scenarios. Although some updates were made during the inspection, gaps remained. One PEEP did not reflect that a resident used a mobility aid, and another lacked clear guidance on how to support a resident should they refuse to leave in the future. This presented a risk that staff, particularly those less familiar with the residents, would not know how to support them effectively in a fire.

While a risk assessment mentioned that a resident used a rollator while out in the community, the risk management plan did not mention the rollator as a control

measure. This had the potential for staff not to be familiar with all applicable information which may increase the risk of falls for that resident.

One resident was recommended not to eat or drink after 8pm due to stomach issues. While this information was known to the staff on duty, it was only documented in the professional notes from the general practitioner (GP) appointment and not in a support plan. That information had the potential of being missed by staff and not known, particularly to new staff or part-time staff, which could result in inconsistent care and impacting negatively on the resident's health.

Some minor gaps were observed in the centre's cleaning checklists making it difficult to know if the cleaning was completed on those dates.

Furthermore, it was not always evident from the documentation provided for review, if some residents were being supported to progress their goals. While goals were identified, the documentation did not always record how staff supported residents to achieve them. The team leader communicated that this was a documentation issue and was able to verbally communicate at what stage the residents were working towards their goals.

Overall, while residents had not been negatively impacted by the identified issues to some of the documentation in the centre, if documents were not maintained properly it could increase the risk of impact to residents receiving inappropriate support and therefore required improvement.

Judgment: Substantially compliant

Regulation 23: Governance and management

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

There were many audits being completed on different aspects of the service to facilitate a safe and effective service. For example, the provider had arrangements in place for an annual review, of which the inspector reviewed the version that was up to and including June 2025 period.

There were arrangements for unannounced provider led visits every six months and the inspector found that they were taking place as required, evidenced by a review of the reports from January and July 2025. In addition, there were weekly reviews completed by the team leader and monthly reviews completed by the person in charge. The inspector reviewed the last two of each and topics included safeguarding, behaviour support, incidents, medication management, finances, and complaints.

The inspector observed from a review of the records of the team meeting minutes that they were occurring regularly. The inspector reviewed the minutes of three

team meetings held in August, October, and December 2025. The review demonstrated to the inspector that any incidents that occurred within the centre were reviewed for shared learning with the staff team. Topics discussed at the meetings included a discussion on the residents, safeguarding, restrictive practices, and Infection Prevention and Control (IPC).

All four staff 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, this inspection found that the residents living in this service were supported in line with their assessed needs. However, some improvements were required in relation to the premises.

The inspector observed the house to be tidy. In addition to the staff cleaning, an external cleaner was employed twice a week for three hours which facilitated the arrangements for good IPC. However, significant improvements were required to the downstairs bathroom facilities to ensure they met the accessibility needs of all residents.

Residents were supported in line with the assessed needs and access to healthcare professionals was arranged as required.

There were adequate arrangements in place to safeguard the residents from the risk of abuse. For instance, there was a safeguarding policy in place to guide staff should they have any safeguarding concerns.

The inspector found that the residents were facilitated to engage in recreational activities in line with their preferences.

Staff were familiar with how residents communicated which supported effective communication in the centre.

There were suitable fire safety management systems in place. For example, the fire extinguishers were serviced annually having last been serviced in November 2025.

Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences.

The residents in this centre communicated verbally. From a review of two residents' files they had documented guidance on how best to communicate with the individuals. For example, the inspector observed information to guide staff as to how to know when a resident was not in good form. It explained to the reader that the resident could become very quiet and twiddle their fingers. It went on to say that if the resident did talk about what was worrying them, that they could repeat it over and over. This information could support staff to act as effective communication partners and support residents to communicate their needs effectively.

The inspector observed there was a visual roster on the notice board in the dining area to inform the residents what staff would be supporting them each day.

The inspector also observed that residents had access to phones, televisions and the Internet while in the centre which would further support their communication and facilitate compliance with this regulation.

Judgment: Compliant

Regulation 13: General welfare and development

This inspection found that the residents were supported to engage recreational activities in their home and in the community based on their preferences.

Residents were supported to maintain relationships with family. Both family representatives spoken with said they felt welcome to visit the centre.

The inspector reviewed two residents' files over a four-week period from 27 December 2025 to 20 January 2026, and spoke with staff on duty and three residents. That review demonstrated that residents were being offered activities that interested them. Activities included Zumba classes, trips to the cinema, attending a panto, shopping, and going for coffee or dinner out.

Residents were supported to undertake personal goals to enhance their quality of life. For instance, from a review of a sample of two residents' goals, they were undertaking goals. Some goals related to planning individual holidays, attending a specific concert, and learning to independently walk to the nearby shopping centre.

While it was not evident through a review of the two residents' documents if they were being supported to progress all of their goals, this was actioned under Regulation 21: Records as from speaking with the team leader this appeared to be a documentation issue.

As previously stated, a bathroom used by a particular resident was not suitable for their present and emerging needs. This was impacting on their general welfare as

their ability to thoroughly and appropriately clean themselves was affected by not being able to use the shower facilities. The person in charge was exploring with the staff team ways in which the resident may be able to avail of a shower external to the centre; however, there were no set plans for enactment of proposed ideas. This identified issue was actioned under Regulation 17: Premises.

Judgment: Compliant

Regulation 17: Premises

For the most part, the layout and design of the premises was appropriate in meeting the residents' needs. The premises was found to be in a state of good repair and was observed to be tidy. The facilities of Schedule 6 of the regulations were available for residents' use. For example, there was access to cooking and laundry facilities. However, a shared bathroom used by two residents was no longer suitable for use by one of the residents. Therefore, this regulation was found to be not compliant.

Due to the changing needs of one resident and from an occupational therapist (OT) assessment in October 2025, it was deemed that the downstairs bathroom was no longer suitable for one resident as they were at an increased risk of falling. It was recommended that the bathroom be renovated to be a wet room which would then suit the resident's needs. However, the inspector was informed that due to funding the bathroom was unlikely to be renovated. This meant that the resident may have to find an alternative home. In the meantime, the resident was being supported by staff to have bed baths, and a special shampoo that didn't require rinsing out was being used to support them with their intimate care needs. Therefore, this issue required action as the current situation was not sustainable for the resident. From communication with two staff members, it was difficult to ensure that the resident was being thoroughly cleaned, which was a potential risk to the resident's skin integrity. In the absence of a fully accessible bathroom, this had the potential to affect other residents that live in the centre, due to their changing needs as they age.

In addition to the structural constraints of the downstairs bathroom, the inspector noted on day one that the day-to-day monitoring of the kitchen and utility areas required improvement. Although the centre was visually clean, a review of the storage areas highlighted that stock rotation and food storage practices required review. The inspector observed instances of undated food in the freezer, unsealed food bags, and expired sauces. Furthermore, the washing machine detergent drawer required cleaning as slight mildew was observed. The provider addressed these matters prior to the second day of this inspection. The team leader and person in charge used the team meetings as an opportunity to remind staff of the need for vigilance in those areas.

There were facilities in place to support hand hygiene, such as hand wash and disposable towels. 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.

Each resident had their own bedroom individually decorated with sufficient space for their belongings.

One family representative felt that while issues were going on in relation to their family member's increasing support needs and that aspects of the premises weren't currently suiting their family member, they felt that the person in charge was keeping them fully informed. They confirmed that a meeting was arranged for the day after this inspection to discuss their family member's support needs and options available.

Judgment: Not compliant

Regulation 28: Fire precautions

There were suitable fire safety practices in place which included staff having received training in fire safety.

From a review of six fire practice drills, the inspector found that regular fire evacuation drills were being completed to ensure that staff and residents would be familiar with how to undertake a safe evacuation in the event of an emergency.

During particular drills some residents refused to leave the centre. The inspector found that the residents' PEEPs were not updated to include this information or to guide staff on how to respond should the residents refuse again. However, while the plans were amended prior to day two of this inspection to include the majority of pertinent information, further information was required. Therefore, this was actioned under Regulation 21: Records.

There were fire containment doors in place fitted with self-closing devices. The fire containment doors were tested to see if they closed properly and all closed effectively which would support fire containment in the event of an emergency.

The inspector found that there were detection and alert systems, emergency lighting and firefighting equipment in place, each of which was regularly serviced. For instance, the fire alarm was last serviced in January 2026.

Judgment: Compliant

Regulation 6: Health care

Residents were supported in line with their healthcare needs and had access to allied health professionals when required.

Three staff spoken with were knowledgeable with regard to required healthcare supports for residents.

Where applicable, there were healthcare plans in place to help guide staff as to what supports residents required, for example epilepsy care plans. While certain pertinent information was known to staff, the inspector found that it was not recorded in a care plan. For example, in relation to how to support a resident with high blood pressure. This was important in order to assure the provider that all staff including part-time staff would be familiar with the information. Due to the information known by the staff on duty, this was actioned under Regulation 21: Records.

Based on a review of two residents' files, they were found to have access to a range of allied healthcare services, such as a GP, neurologist, a dentist, a chiropodist, and an OT when required.

Judgment: Compliant

Regulation 8: Protection

There were suitable arrangements in place to protect the residents from the risk of abuse.

For example:

- there was an organisational safeguarding policy in place last reviewed May 2023
- staff had received training in safeguarding vulnerable adults
- there was a reporting system in place with a designated officer (DO) nominated for the organisation
- two staff spoken with were able to identify who the DO was to the inspector, and the identity of the DO was displayed in the dining area.

The inspector reviewed safeguarding incidents for the last year and 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.

From speaking with three residents, they communicated that they felt safe living in the centre. Of the three residents, two family representatives, and the four staff spoken with, they all felt comfortable raising concerns. At the time of this inspection nobody spoken with had any concerns.

A staff member spoken with was familiar with the steps to take should a safeguarding concern arise including a witnessed peer-to-peer incident or an unwitnessed disclosure. For example, the staff member explained that they would not promise confidentiality and would explain they have a duty to report safeguarding concerns. They would record what was communicated to them and try to gather the facts without leading the resident, and then they would report to their manager and the designated officer.

From a review of the two residents' files, the inspector observed that there were care plans in place that outlined residents' support needs and preferences with regard to the provision of intimate care. These plans promoted dignified care practices and reflected residents' preferences. For instance, it described how one resident preferred to have a shower daily, however, if they were worried about something they may not pay as much attention to their appearance and may need staff to remind them.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Drogheda Supported Accommodation OSV-0002671

Inspection ID: MON-0048501

Date of inspection: 20/01/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The Regional Manager and Person in Charge (PIC) met with the external funder on 17th February 2026 to discuss a business case that has been submitted to address the changing and increasing needs within Drogheda Supported Accommodation. The business case seeks approval for additional staffing resources. The submission is currently under review by the external funder, Rehabcare will ensure the service maintains safe staffing levels that will support the service users to have a safe service that will ensure they have and can participate in a meaningful day. This will be completed by 6th March 2026. • In the interim, the PIC is actively recruiting relief care staff, with particular emphasis on candidates who hold a full driving licence. The PIC is also reviewing current transport arrangements, including the feasibility of securing an automatic vehicle to better meet operational needs. This will be completed by 30th March 2026.	
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • A comprehensive blood pressure care plan will be developed and implemented for the resident who requires monitoring and management. Staff training in blood pressure monitoring will be provided to ensure safe and effective oversight. This will be completed by 21st March 2026.	

• A cholesterol management care plan will also be implemented for the relevant resident to ensure appropriate clinical oversight and adherence to medical guidance. This will be completed by 21st March 2026.

• The PIC and Team Leader are currently reviewing and updating all Personal Emergency Evacuation Plans (PEEPs). Updates include:
• Inclusion of mobility equipment, such as rollator's, within individual PEEPs.
• Documentation of instances where a resident declined to exit the building during a fire drill.
• Clear guidance on staff support strategies in such situations. This will be completed by 28th February 2026.

• The use of a rollator will be added to the Risk Management Plan as a current control measure for one resident. This will be completed by 28th February 2026.

• A resident's support plan has been updated to reflect that the resident does not eat after 8:00pm, in line with GP guidance. Completed 16th February 2026.

• The PIC and Team Leader are reviewing how residents' goals are documented to ensure clarity, measurability, and alignment with each individual's current objectives. This will be completed by 28th February 2026.

• The cleaning schedule is currently under review by the PIC to ensure it remains robust and reflective of the service's requirements. This will be completed by 28th February 2026.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• In light of a resident's changing needs, a meeting was held with the external funder on the 17th February 2026 to discuss proposed bathroom adaptations within the residence. Quotes are currently being obtained, and works will be carried out as soon as the contractor is available

• A business case submitted to the external funder is also requesting provision for additional staffing to support these evolving needs. The alterations to the bathroom will be actioned to ensure the provider maintains a safe and effective service. This is in line with the assessed needs of the residents.

• The PIC and Team Leader will meet with the staff team to reinforce procedures regarding food rotation and the dating of opened food items to ensure compliance with food safety standards. This will be completed by 28th February 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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	06/03/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/04/2026
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as	Substantially Compliant	Yellow	28/02/2026

	specified in Schedule 3 are maintained and are available for inspection by the chief inspector.			
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in Schedule 4 are maintained and are available for inspection by the chief inspector.	Substantially Compliant	Yellow	21/03/2026