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:	Cavan Supported Accommodation
Name of provider:	The Rehab Group
Address of centre:	Cavan
Type of inspection:	Unannounced
Date of inspection:	29 September 2025
Centre ID:	OSV-0002676
Fieldwork ID:	MON-0048245

About the designated centre

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

Cavan Supported Accommodation provides a community-based residential service for up to seven adults with mild to moderate intellectual disabilities. The centre is located in a busy town in Co Cavan. Residents have access to amenities such as shops, cafes and restaurants. Cavan Accommodation comprises three self-contained apartments. Apartment one has three bedrooms, two bathrooms, a shared kitchen and living area and a staffroom. Apartment two and three both have two bedrooms, each with a shared bathroom, kitchen and living room area. Residents attend local day services Monday to Friday. If a resident is unwell or chooses not to attend day service they can independently stay in their apartments and arrangements are made based on risk assessments for support. During the week there are extra staff supports provided in the evenings and hours may vary depending on activities planned. Residents are supported on a 24-hour basis at weekends by a team of support workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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
Monday 29 September 2025	10:30hrs to 18:30hrs	Karena Butler	Lead

What residents told us and what inspectors observed

On the day of this unannounced monitoring inspection, the inspection findings were positive. The residents were receiving a good standard of person-centred care from a staff team who were aware of and ensured their assessed needs were being met. Staff were encouraging residents to be as independent as possible. Some minor improvements were identified under three regulations. The regulations related to healthcare, protection, and premises were found to be substantially compliant. These regulations and identified areas for improvement will be further discussed later in this report.

The inspector had the opportunity to meet all seven residents that were living in the centre. Two residents chose not to talk to the inspector and their wishes were respected. From the residents spoken with they felt supported by staff and felt that staff would listen to them if they had a concern. They communicated that they felt safe and happy living in their apartments, they got on well with their housemates, they had choice each day in the food they ate and choice in the activities they participated in.

On the day of the inspection, residents attended a day service programme. The majority of residents communicated that they wanted to relax in for the evening. One resident went out independently for a walk, while another attended an appointment with staff support.

Residents participated in activities depending on their interests. For example, attending the library, family visits, movie nights, and special Olympics.

In addition to the person in charge, there were two staff members on duty during the day of the inspection and one staff member was finishing their shift when the inspector arrived. The inspector had the opportunity to speak with each staff member. The person in charge and staff members spoken with demonstrated that they were familiar with the residents' support needs and preferences. They were observed to interact with residents in a patient and respectful manner.

The inspector had the opportunity to speak with one family representative on the phone. When asked if they had any concerns about the care and welfare in the centre they responded by saying 'no and that if they had any concerns they would be comfortable raising them'. They said that 'the staff have been great'. They said that their family member 'was reluctant to go to the family home which was a testament to how good the service was'. They said that they ''couldn't have hoped for anywhere better.''

The inspector conducted a walk around of the centre. The centre was made up of three apartments and they generally appeared tidy and clean. This facilitated in the arrangements for good infection prevention and control (IPC). One apartment

required some minor improvements and this will be discussed under the regulation for premises.

Each resident had their own bedroom and bathroom facilities were shared. There was sufficient storage facilities for their personal belongings in each room. Residents' rooms had personal pictures and achievements, for example certificates or medals displayed that they had earned.

The centre had a small shared garden space on the ground floor through the apartment complex's car park that was available for use.

At the time of this inspection there were no visiting restrictions in place and there were no vacancies or recent admissions to the centre. While there were some complaints raised in the centre, they were found to be dealt with. They will be discussed in more detail under that specific regulation.

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 an ongoing monitoring with 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 August 2023.

From a review of the governance arrangements in place, the inspector found they were effective in ensuring the centre was appropriately monitored. For example, the provider had completed audits of the centre as required, such as an annual review of the quality and safety of the service and six-monthly unannounced provider-led visits. Complaints were also found to have been reviewed and dealt with appropriately.

A review of the rosters across three months demonstrated that there was sufficient staffing in place to meet the assessed needs of the residents. Additionally, the person in charge ensured that there were appropriate training and staff development arrangements in place. For example, formal staff supervision was occurring as per the frequency decided by the provider.

Regulation 14: Persons in charge

There was a suitably qualified and experienced person in charge employed to manage the centre. They held a qualification in health services management, in addition to a qualification in social care. They demonstrated a good understanding of the residents and their needs, such as what healthcare needs each resident required support with.

The person in charge was employed on a full-time basis and was supported in their role by a team leader.

They were also found to be aware of their legal remit to the regulations and were responsive to the inspection process. For example, they were aware that it was their responsibility to ensure the reporting of any adverse incidents that occurred in the centre to the Chief Inspector of Social Services (The Chief Inspector).

Judgment: Compliant

Regulation 15: Staffing

There were sufficient staff available to meet the assessed needs of residents.

As previously mentioned, the staff on duty on the day of the inspection were observed to be respectful and caring towards the residents.

The inspector reviewed a sample of rosters over a three month period from July to September 2025. The review demonstrated that there were planned and actual rosters maintained. Two staff spoken with communicated that they felt that there was adequate staffing levels now in place and that there was always a second staff on each day to facilitate residents to engage in the community or attend appointments.

As previously mentioned, the inspector had the opportunity to speak with a family representative on the phone. They believed the staff were "very accommodating" and that "they go above and beyond".

Staff personnel files were not reviewed at this inspection. However, the inspector reviewed a sample of four staff members' Garda Síochána (police) vetting (GV) certificates. The person in charge had arrangements for safe recruitment practices that were in line with best practice. Since commencing their role in February 2025, they had started the process of five staff applying for re-vetting due to the length of time since their last GV.

Judgment: Compliant

Regulation 16: Training and staff development

There were suitable arrangements in place to support training and staff development. The inspector reviewed the training oversight matrix for training completed. Additionally, a sample of the certification for eleven training courses completed by staff. This review confirmed that staff received a suite of training to help them carry out their roles safely and effectively.

Examples of the training staff had completed included:

- safeguarding vulnerable adults
- medication management both an online and in-person training
- Autism awareness
- fire safety
- first aid or cardiac first response
- human rights
- training related to IPC, such as hand hygiene, and standard and transmission based precautions.

The inspector also reviewed the supervision files for three staff members. From that review, it was found that there were formalised quarterly supervision arrangements in place. Supervision was found to be an opportunity for staff to raise any concerns they may have.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that there were appropriate governance and management systems in place at the time of this inspection.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by the person in charge and they were supported by a team leader.

The provider had completed an annual review of 2024 of the service and had carried out unannounced six-monthly provider-led visits in January and June 2025 as required by the regulations.

There were other local audits and reviews conducted in areas. For instance, there were monthly audits completed by the person in charge. Areas included in the audit were complaints, staff training, residents' supports, medication management, risk management, and health and safety. The person in charge or the team leader also completed weekly audits to ensure the staff team were completing their checks as required. Staff checks and tasks included vehicle checks, fridge and freezer temperature checks, and daily cleaning of the centre.

Team meetings were occurring monthly and the inspector reviewed the meeting minutes for August and September 2025. Topics included safeguarding, complaints, risk management, restrictive practices, health and safety, and staffing. The inspector observed that any incidents occurring within the centre were reviewed for shared learning with the staff team.

From all three staff spoken with, they communicated that they would feel comfortable going to the person in charge if they were to have any issues or concerns and they felt they would be listened to.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints policy, and associated procedures in place. An accessible version of the policy was available for residents, and a copy of the complaints policy was available in the centre. There was also a designated complaints officer nominated.

The person in charge had commenced weekly meetings for people to bring any complaints or compliments they may have. There was a complaints and compliments log in place for oversight of complaints or compliments made.

The inspector observed any complaints made had been suitably recorded, reviewed and attempts were made to resolve any identified issues. From a review of the complaints log and associated paperwork, the inspector observed that there were seven complaints in 2024 of which six related to one resident playing the music or television too loudly. Up to and including the day of this inspection, there were ten complaints in 2025. The majority of the complaints related to the same resident playing devices too loudly. Efforts were being made to support the resident not to disturb other residents. For example, behaviour support were reviewing related incidents and try to guide staff responses, and noise cancelling headphones had been purchased. The complainant understood efforts were being made to come up with a solution that suited everyone.

The centre also received many compliments from residents. For example, one resident complimented a staff member for being very supportive.

Judgment: Compliant

Quality and safety

This inspection found that the residents living in this service were supported in line with their assessed needs and were happy living in this centre. Some improvements were required in relation to healthcare plans, the accuracy of recording of a resident's finances, and some minor improvements were required to the premises to ensure it was thoroughly clean and could be cleaned effectively.

There were systems in place to meet residents' assessed needs with regard to positive behaviour support, communication, and general welfare and development.

For example, there were communication plans in place to promote effective communication. The residents had access to opportunities for recreation in line with their preferences. When required they had a positive behaviour support plan in place to guide staff as to how best to support them should they be experiencing periods of distress.

Excluding the previously mentioned resident's finances, there were suitable arrangements in place to ensure they were safeguarded in the centre and in the community. For example, there was safeguarding policy in place to guide staff to recognise and escalate any safeguarding concerns.

There were adequate risk management systems in place including a number of risk assessments in place to mitigate known risks from occurring.

In addition, there were suitable fire safety management systems in the centre. For example, there were detection and alert systems in place.

Regulation 10: Communication

Communication was facilitated for residents in accordance with their needs and preferences. Residents in this centre communicated verbally.

The person in charge and a staff member spoken with were familiar with how the residents communicate and how best to communicate with them.

A review of two residents' files showed that communication plans were in place to guide staff on how best to communicate with them. They were found to have been recently reviewed. One resident's plan explained that they preferred smaller groups and that they were a quiet person. If they wanted to confirm they were happy with something they normally smiled or gave a thumbs up.

On review of other arrangements in place to meet the requirements of this regulation, the inspector observed that residents had access to a radio, television, and a phone.

Judgment: Compliant

Regulation 13: General welfare and development

The person in charge had ensured that residents had access to opportunities for leisure and recreation. Residents engaged in activities in their home and community.

Different residents regularly visited family members. One resident chose to stay in their family home every weekend.

Residents were supported to set and achieve personal goals in order to enhance their quality of life. For example, one resident was supported to have an emergency medication discontinued for them. Staff worked with them to develop an action plan and to understand what this may mean for them. Staff supported them to attend the specialist appointment to explain their case to their consultant who agreed to discontinue the medication. Another resident was working on promoting healthy eating and exercise.

From a review of two residents' files over a two week period in September 2025, the inspector observed that residents were being offered and participating in activities of their preference. Ranging from going out for coffee, going out for lunch or dinner, visiting forests, going for walks, and going shopping.

Recently the person in charge had commenced different culture nights whereby residents would try food from different cultures. They communicated that it was going well.

Four residents had went on holiday to Donegal in the summer of 2025. Residents who didn't wish to attend the holiday were offered day trips instead with staff or family members.

Judgment: Compliant

Regulation 17: Premises

This regulation was found to be substantially compliant. At the time of the inspection each apartment was adequate in terms of layout and design for the assessed needs of the residents. However, some minor areas for improvement were identified.

While the apartments were generally found to be clean and in a good state of repair. In one apartment, the microwave was found to be dirty with some of the surface peeling and a small amount of rust. A small amount of rust was also observed on a bathroom radiator, as well as some slight mildew on the grouting at a shower which may pose a risk to residents' respiratory health. Rust would prevent the area from being able to be effectively cleaned.

Each resident had their own room decorated to their own preference. One resident told the inspector that they had chosen their bedroom's paint colour and were happy with the colour.

There were colour coded equipment used for cleaning the centre and preparing food. There were appropriate facilities in place to facilitate good hand hygiene, for example the inspector observed that hand wash and disposable hand towels were available. This helped to prevent residents from contracting healthcare-related illnesses.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management arrangements ensured that risks were identified, monitored and regularly reviewed. There was a risk management policy in place to provide guidance to staff on how to manage and escalate risks. The policy was last reviewed December 2023. In addition, there was a local health and safety statement in place that was last reviewed April 2025.

There were centre specific risk, for example fire safety with control measures that included fire practice drills, staff and residents receiving fire safety training, as well as residents having documented personal emergency evacuation plans (PEEPs). Risks specific to individuals, such as falls risks, had also been assessed to inform care practices. For example, magnetic door holders were installed for the resident's bedroom, and they wore a falls alert bracelet.

The inspector reviewed incidents that occurred in the centre since August 2025. They were found to have been reviewed by the person in charge and incidents were discussed at team meetings for shared learning. For example, a resident, who self-administered their own medication, had dropped their medication on a couple of occasions. In response, the person in charge had purchased and encouraged the resident to use a non-slip mat on a tray to administer their medication on. The inspector observed that control measure in place and the resident confirmed its usage as a result of the medication errors.

On review of other arrangements in place to meet the requirements of this regulation, the inspector observed that the oil boiler had received an annual service.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable fire safety management systems in place, including detection and alert systems, emergency lighting and firefighting equipment, each of which was regularly serviced. Staff and residents had also received training in fire safety.

The inspector's review of four residents' PEEPs, confirmed that they gave staff clear guidance on how to support residents in an emergency evacuation. One plan identified that the resident has refused to evacuate during some practice drills and it provided staff with a number of suggestive actions to use in the event of a real fire. For instance, there was a picture ready to show to the resident to demonstrate that it was a real fire and not a drill. There was a box of incentives with items they liked stored in the staff office in order to encourage them to leave in the event of a fire.

Periodic fire drills were completed in order to assure the provider that residents could be safely evacuated from the building at all times including with minimum staffing levels and maximum residents participating. From a review of five fire drill records, the inspector found that alternative doors were being used for evacuation as part of the practice drills. This was in order to assure the provider that residents could be evacuated from all areas of the building if required.

There were fire containment doors in place where required and they were fitted with self-closing devices. All fire containment doors, which would facilitate containing a fire in the case of an emergency, closed as required except for one. The identified door was fixed and evidence of it closing was submitted the day after the inspection.

Therefore, based on the information above, the inspector was assured that there were appropriate fire precautions systems in place which would facilitate residents' safety in an emergency situation.

Judgment: Compliant

Regulation 6: Health care

This regulation was found to be substantially compliant. Residents were supported with their healthcare needs and had access to allied health professionals when required. However, some healthcare plans and documents required review and improvement to ensure accuracy and that all applicable information was contained.

For instance, one resident's hospital passport, that would be used to guide hospital staff should the resident require a hospital stay, did not guide the reader that the resident was prone to falls or that they wore a falls bracelet. Another resident's hospital passport also did not contain all pertinent information. such as that they were on blood pressure medication or they had a specific condition.

One resident's type two diabetes care plan did not contain information to guide as to the signs and symptoms to monitor for when the person was experiencing high or low blood sugars. Their records did not clearly document the frequency of chiropody

appointments or confirm each attendance at those appointments, which were important appointments due to their health diagnosis.

Three staff spoken with were knowledgeable in the majority of areas related to resident's healthcare needs and supports required. However, enhanced knowledge was required with regards to diabetes and signs and symptoms to monitor for.

These identified areas had the potential to put the residents at risk if important information was not known to the staff supporting them.

Residents were supported to avail of national screening tests when they were deemed eligible. For example, one resident had attended a retinal scan in August 2025.

Residents were found to have access to a range of allied health care services, such as a general practitioner (G.P), urologist, chiropodist, and dietitian when required.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to experience best possible mental health and when required had access to the support of allied health professionals. For example, they had access to a behaviour therapist, and mental health team as required.

From a review of two residents' files, the inspector found that where required, residents had a positive behavioural support plan in place which was reviewed by a behaviour therapist. They were observed to have been reviewed since February 2025. This facilitated staff being provided accurate information and ensured that the residents were receiving up-to-date appropriate supports.

Behaviour Support plans were found to outline potential triggers of behaviours as well as both proactive and reactive strategies that staff needed to follow to support the residents in times of distress.

For instance, one plan guide staff to utilise a 'daily diary' programme to support the resident to reflect on their day.

Restrictive practices were found to be logged and reviewed six monthly by the person in charge, the behaviour therapist and team leader. Residents were found to have consented to the practices in place, for example not using the hob for cooking without staff supervision.

Therefore, based on the above information, the inspector was satisfied that the provider had appropriate systems in place to meet the requirements of this regulation.

Judgment: Compliant

Regulation 8: Protection

This regulation was found to be substantially compliant. For the most part, there were suitable arrangements in place to protect the residents from the risk of abuse.

The inspector reviewed the finance balance recording sheets for three months for one resident and found that the residents' money was being checked periodically by staff to facilitate safeguarding of their money. However, the inspector counted the money balance belonging to the resident in the presence of the person in charge, and the amount was found not to match that recorded on the finance recording sheet. Minor inconsistencies were also observed in the finance recording sheet across July to September 2025. The person in charge felt assured that the errors were related to documentation and communicated that they understood that more robust recording was required for going forward. This area required improvement as the current systems in place were not effectively working. This would put the resident's finances at potential risk if the money was not being tracked and recorded accurately.

Examples of some of the suitable arrangements in place included:

- staff were suitably trained to recognise and escalate any safeguarding concerns
- the person in charge had completed a safeguarding self-assessment tool in April 2025 with no actions arising
- there was a reporting system in place with a designated safeguarding officer (DO) nominated for the organisation
- a staff spoken with was able to identify who the DO was to the inspector, and the identity of the DO was displayed in the centre.

It was found that concerns or allegations of potential abuse were reviewed, reported to relevant agencies, and to determine if any learning arose from the incident that could be adopted by staff.

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.

From a review of three residents' files, the inspector observed that there were intimate care plans in place that clearly guided staff as to supports residents required.

Overall, while the monitoring of one resident's finances required improvement, other systems in place promoted a culture of safeguarding.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Cavan Supported Accommodation OSV-0002676

Inspection ID: MON-0048245

Date of inspection: 29/09/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • The area of rust on bathroom radiator will be filed smooth and repainted. • The small area of mildew in grout will be deep cleaned and added to the monthly cleaning tasks to prevent occurrence. • Microwave was replaced 01/10/2025	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • Hospital passports will be reviewed for all residents to include risk of falls, health conditions, diagnosis and medication • Diabetes care plan for one resident to be reviewed to include the signs and symptoms regarding high or low blood sugar levels. • All staff will complete the Smart training with Diabetes Ireland for awareness around type 2 diabetes and management of same. • Chiropodist appointments for the resident with diabetes will be recorded on one health visit sheet per year to reduce the risk of staff failing to record the appointments every 6-8 weeks.	
Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • The resident's financial transaction sheet will be checked weekly by PIC or Team Leader and recorded on the weekly audit. Staff team meeting 14/10/2025 discussed that any money which comes into the service for resident must be recorded at that time into resident's financial transaction sheet. This will be repeated in November staff team meeting.	

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)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Substantially Compliant	Yellow	20/11/2025
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	20/12/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	20/11/2025