



# Report of an inspection of a Designated Centre for Older People.

## Issued by the Chief Inspector

Name of designated centre:	Hillview Private Nursing & Retirement Residence
Name of provider:	Hillview Private Nursing & Retirement Residence Partnership
Address of centre:	Rathfeigh, Tara, Meath
Type of inspection:	Unannounced
Date of inspection:	22 October 2025
Centre ID:	OSV-0000141
Fieldwork ID:	MON-0048582

## About the designated centre

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

The designated centre provides care for both women and men over the age of 18 from low to maximum dependency needs. It can provide twenty four hour nursing care to meet a range of care needs including for residents with intellectual and physical disability, dementia, acquired brain injury, convalescence, palliative, long term care and short term stay. The centre is located in a rural area. The centre is all located on one floor with an additional activity area located in a basement area accessed by residents via the garden. Accommodation is provided in 25 single bedrooms some of which have en-suite facilities. The aim of the centre is to provide a wide range of nursing and care services to meet the individual needs of residents while actively encouraging residents to fulfil their own potential.

**The following information outlines some additional data on this centre.**

Number of residents on the date of inspection:	23
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (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 22 October 2025	08:20hrs to 15:45hrs	Geraldine Flannery	Lead
Friday 7 November 2025	08:00hrs to 13:30hrs	Geraldine Flannery	Lead
Wednesday 22 October 2025	08:20hrs to 15:45hrs	Sheila McKeivitt	Support
Friday 7 November 2025	08:00hrs to 13:30hrs	Sheila McKeivitt	Support

## What residents told us and what inspectors observed

The inspectors met with many residents and visitors during the inspection to gain insight into their experience of Hillview Private Nursing & Retirement Residence, and spoke more in-depth with 13 residents and four visitors.

All of the residents and visitors who were spoken with were complimentary of the staff. One resident told the inspectors that they were 'well cared for by staff' and another stated that the 'staff were grand'. Another resident gave high praise to the activity staff while another said the laundry staff was 'wonderful'. Visitors spoke positively about the great efforts that were made by staff to ensure the residents had everything they needed.

During the inspection many positive meaningful interactions were observed between staff and residents. Both parties were seen chatting and laughing together, as residents went about their daily routines. Care delivery was observed to be unhurried and staff were seen to be patient and kind.

Inspectors found that although the residents were well cared for by staff, there were significant concerns in respect of the governance and systems of management oversight. Significant action was required by the registered provider to ensure a safe and high-quality service was consistently provided to the residents living in the designated centre, which will be discussed further in the report.

This inspection took place over two days by two inspectors of social services. On the first day of inspection, the atmosphere in the centre was relaxed and calm. Some residents were in bed asleep; some had already started their morning routine in the privacy of their bedroom, while others were in the dining room having breakfast.

The inspectors noted that some residents were sitting at the dining table wearing extra layers. One resident said 'it can be cool at times', while another resident said they 'had to keep my coat on to keep warm'. The inspectors saw that there was no heating on and were informed that the heating was not working properly. Management stated they had already engaged with a professional to fix same in the coming days. In the absence of the maintenance staff who was on leave, staff did not know how to turn the heating on. However, the person-in-charge who arrived later in the morning, manually started the boiler and the heating resumed for the rest of the inspection. On the second day of inspection, the heating problem had been rectified; inspectors observed that the heating was working and residents confirmed they were warm.

While inspectors were viewing the hot-press where the hot water tank was housed, they sighted a live infestation of vermin and later observed evidence of vermin presence in one storage cupboard. Inspectors observed that the cement flooring in the hot press had several visible holes in it. The floor was not sealed around the

perimeter walls where they met with the floor and under the hot water tank.

Inspectors were shown evidence that pest control had been in the centre twice within the month of October, the most recent date was 12 days prior to day one of the inspection, and on both occasions found no evidence of live activity. Written assurances were received following day one of the inspection that pest control had re-visited the centre and again found no evidence of activity. On day two of the inspection, inspectors did not see any evidence of vermin activity.

The lived-in environment appeared homely throughout. There was sufficient private and communal space for residents to relax in. Residents' bedrooms were nicely decorated and were furnished with personal belongings. Fire exits and escape pathways were noted to be clear from obstruction. Inspectors observed that there was no clear signage to identify the hazard where oxygen was being used by residents, however signage was erected immediately.

Inspectors observed that some areas of the centre were not well-maintained. For example, the carpet on all corridors appeared heavily stained in areas and one communal toilet did not have a privacy lock in place. This posed a risk to the privacy and dignity of the residents who may be using that toilet.

Activities were made available to residents; staff were on site and were observed to be very interactive with the residents. On the morning of inspection, a group of residents attended rosary in the sitting room and those spoken with said they 'enjoyed it very much'.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

## Capacity and capability

Overall, notwithstanding the positive feedback from residents and visitors, the inspectors found concerning practices in respect of staff recruitment and oversight which posed a safety risk to the residents living at the centre. The findings from this inspection were that renewed focus and action was required in the areas of governance and management, written policies and procedures, staffing, records, notification of incidents, safeguarding, managing behaviours that may be challenging, premises and individual assessment and care planning, to support the provision of a safe and quality service to residents.

This was an unannounced inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 -2025 (as amended). The inspectors followed up on unsolicited information from the public,

received in relation to the care and welfare of residents living in the designated centre including the safeguarding of residents, which was substantiated.

The registered provider is Hillview Private Nursing & Retirement Residence Partnership. The person in charge had responsibility for the day-to-day operations of the centre and was supported in their role by an assistant director of nursing (ADON) and a team of healthcare, catering, housekeeping and maintenance staff.

The inspectors followed up on the compliance plans from the previous inspection and found that the registered provider had made several positive changes, specifically relating to fire precautions. For example, a fire proof door was installed in the hot press and there was no inappropriate storage observed.

However, this inspection found that the registered provider did not take all reasonable measures to protect residents from abuse. The management were aware of a potential safeguarding concern, however there was no evidence of said concern being investigated.

Also, notwithstanding that there were sufficient staffing levels in place on the day of inspection, a random review of a sample of staff files found that a staff member had been employed and was working in a nursing role capacity despite not being registered with the Nursing and Midwifery Board of Ireland (NMBI). Records showed that this person was the only nurse on duty on at least three separate dates and had administered medication to residents on these three dates.

An immediate action was issued on day one of the inspection to remove this staff from the roster, pending their NMBI registration and ensure that there would be one registered nurse at a minimum on duty at all times in the centre. Appropriate assurances were received on the day.

In addition, an urgent compliance plan was issued to the provider following the inspection in respect of a potential safeguarding concern, and relating to the evidence that the person in charge did not ensure that the staff of the designated centre included at all time at least one registered nurse.

The provider's response to the urgent compliance plan did not provide adequate assurances and was not accepted by the Chief Inspector of Social Services. A second day of inspection was completed to ensure that the residents were being cared for in a safe and secure environment by appropriately trained staff.

On day two inspection, inspectors were assured that adequate measures had been put in place to safeguard vulnerable residents and there was no unregistered staff nurses on the duty roster or administering medication.

## Regulation 15: Staffing

The person in charge did not ensure that the staff of the designated centre included

at all times, at least one registered nurse. The inspectors found that on three dates in October there was no registered nurse on duty in the centre. The person identified as a registered nurse on the roster was not registered as a nurse with the Nursing and Midwifery Board of Ireland (NMBI) and therefore were not registered to work as a nurse in Ireland. There was no other registered nurse on duty on the three days that this person worked in the centre. An immediate action plan was issued to the provider in relation to this issue.

Judgment: Not compliant

### Regulation 21: Records

Management of records was not fully in line with regulatory requirements, as follows;

- Not all records in relation to staff employment as outlined in Schedule 4 were readily available for inspection. For example, not all staff files included a contract of employment, therefore inspectors were unable to establish the date of role commencement.
- A review of the actually-worked duty roster did not fully account for the presence of the person-in-charge in the centre.
- Staff files reviewed showed that the registered provider had failed to ensure that appropriate documentation was obtained for each staff member in advance of commencing employment as per Schedule 2 requirements. For example, one staff file showed that:
  - there was no record of current registration details of professional staff subject to registration.
  - two written references, including a reference from a person's most recent employer were not in place.

Judgment: Not compliant

### Regulation 22: Insurance

There was an appropriate contract of insurance in place that protected residents against injury and against other risks, including loss or damage to their property.

Judgment: Compliant

### Regulation 23: Governance and management

The governance and management systems in place did not ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by the following:

- The registered provider had failed to implement recruitment procedures in-line with the legislative requirements.
- The registered provider had failed to ensure there were adequate resources in place at all times to meet the needs of the residents as evidenced by the absence of a registered nurse on duty in the centre for three separate days in October 2025.
- The registered provider had failed to take all reasonable measures to protect all residents from abuse. A safeguarding incident involving residents had not been investigated, although it had been documented and reported to the person-in-charge.
- Information provided to the Chief Inspector on the day and following the inspection was incorrect and inaccurate.
- Management systems in place did not identify that statutory notifiable incidents had not been notified to the Office of the Chief Inspector.
- Not all policies in place were in line with legislative requirements, as further detailed under Regulation 4: Written policies and procedures. Other policies such as the use of restraints, were found not to be implemented in practice.
- Notwithstanding the provider's systems in place to provide a safe environment, on the day of inspection there was evidence of live vermin in the hot press and droppings in a storage cupboard that included residents' supplies.

An urgent compliance plan was issued following day one of inspection and provider's response did not provide adequate assurances that appropriate measures were taken to protect the residents. That compliance plan was not accepted.

Judgment: Not compliant

### Regulation 31: Notification of incidents

The person in charge did not inform the Chief Inspector of all incidents as set out in paragraphs 7 (1)(a) to (i) of Schedule 4, which occurred in the designated centre and within the required time frame. In particular, allegations of abuse of a resident had not been appropriately reported. Retrospective notifications were submitted following the inspection, however the inspectors found inaccuracies in the information provided within the notification.

Judgment: Not compliant

## Regulation 4: Written policies and procedures

The registered provider had prepared in writing the policies and procedures as set out in Schedule 5 of the regulations, however the recruitment policy was not reflective of Schedule 2 requirements. For example, it did not specify that the following documents were to be held in respect for each member of staff:

- A record of current registration details of professional staff subject to registration.
- References should include a reference from a person's most recent employer (if any).

In addition, the centre's safeguarding policy had not been updated to reflect the legislative changes implemented at the end of March 2025.

Judgment: Not compliant

## Quality and safety

The inspectors found that aspects of the quality and safety of care provided to residents were impacted by weaknesses in the governance and management arrangements, and oversight described under the Capacity and Capability section of this report.

This inspection identified that the delivery of care required further improvement, particularly in relation to assessments and care planning, management of responsive behaviours, safeguarding of residents and up-keep of the premises in a timely manner.

While there was evidence that residents' needs had been assessed using validated assessment tools, the care plans reviewed were not always informed by these assessments, and did not reflect person-centred guidance on the current care needs of the residents.

The inspectors saw that residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) did not have appropriate assessments and care plans in place.

The registered provider had a policy on the use of restraint, however, the inspectors found that the policy was not being consistently implemented in practice. As a result

the use of restraints was not being managed in line with national guidance.

The policies in place to ensure residents were safeguarded from all forms of abuse, did not meet the legislative requirements. There was evidence of alleged abuse having been reported to the person-in-charge and not investigated or reported to the Chief Inspector. A strengthening of oversight of the practices outlined above was required to ensure residents continued to be safeguarded from all forms of abuse.

The social care needs of residents were met. The residents had access to wide variety of activities that met the needs of all residents and their rights were upheld.

The premises were of suitable size to support the numbers and needs of residents living in the designated centre. However, further improvements were needed, as further detailed under Regulation 17: Premises.

### Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors. Visits were not restricted and there was adequate space for residents to meet their visitors in areas other than their bedrooms, if they wished.

Judgment: Compliant

### Regulation 17: Premises

Improvement was required of the registered provider, having regard to the needs of the residents at the centre, to provide premises which conform to the matters set out in Schedule 6 of the regulations. For example;

- The flooring in two rooms was not sealed; damaged flooring was observed under the hot water tank in the hot press and at the floor to wall junctions in the hot press and in the sluice room.
- The carpet on the corridor floors appeared heavily soiled in some areas.
- The sealing at the bottom of one toilet appeared unclean with a rust colour noted where toilet met with the floor.
- There was no privacy lock on one communal toilet door.

Judgment: Substantially compliant

### Regulation 28: Fire precautions

Inspectors followed up on fire safety actions that were outstanding since the last inspection, and found they had been completed to comply with the regulations. For example:

- The hot-press that housed a gas boiler was no longer used to inappropriately store clothing materials and towels. A new fire-door was installed in this hot-press.
- The provider had submitted a fire risk assessment relating to the attic, providing assurances that there was fire protection measures in place along compartment lines in the attic above bedrooms.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

The designated centre's policies on managing behaviour that is challenging and on the use of restraint were available for review, however the practices outlined in these policies were not seen reflected in practice.

Residents who were identified as displaying responsive behaviour at times did not have their individual needs, known triggers or de-escalation techniques that worked for them outlined in their care plan. This meant that staff were not effectively guided in respect of specific individualised interventions to support the resident.

The provider was making attempts to promote a restraint-free environment, in line with national policy by educating residents on the use of restraint prior to admission. However, for those residents with bed-rails in use, their risk assessments did not reflect what, if any alternatives to restraint were trialled, tested and failed prior to restraint being used. There were no care plans in place for some residents with bed-rails in place.

Judgment: Not compliant

## Regulation 8: Protection

The registered provider had not taken all reasonable measures to protect the residents from abuse. The safeguarding policy updated in February 2025, did not include legislative changes which came into effect at the end of March 2025 and therefore was not appropriate to guide staff.

The person-in-charge had not investigated an incident of alleged abuse that had been reported to them. This did not provide assurance that the residents living in the centre were protected and effectively safeguarded against any potential or

confirmed abuse.

Judgment: Not compliant

### Regulation 9: Residents' rights

Residents' rights were upheld in the centre and all interactions observed during the two day inspection were person-centred and courteous.

Residents had access to meaningful activities. The activity schedule was on display and residents were involved in person-centred activities throughout the day.

Residents' right to vote was respected and some spoken with said they had exercised that right during the recent presidential election.

Judgment: Compliant

### Regulation 5: Individual assessment and care plan

Notwithstanding the comprehensive assessments completed on admission, significant improvements in nursing documentation were required to ensure residents' needs were met. For example:

- The safeguarding care plans reviewed were not person-centred and did not clearly outline the care practices in place to safeguard the residents in question. For example, the safeguarding care plan for one resident stated check the resident regularly but there was no records of any checks being completed on this resident.
- Two residents with bed-rails in use had no bed-rail assessment in place and there was no record of what if any alternatives to bed-rails that had been trialled prior to bed-rails being used. There was no evidence of a multi-disciplinary approach to the use of bed-rails.
- One resident with bed-rails in use had no care plan to direct staff regarding the use of the bed-rails.

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 Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 15: Staffing	Not compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 4: Written policies and procedures	Not compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant

# Compliance Plan for Hillview Private Nursing & Retirement Residence OSV-0000141

Inspection ID: MON-0048582

Date of inspection: 22/10/2025

## 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 Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

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	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:            The provider representative acknowledges the finding of non-compliance with Regulation 15: We have thoroughly reviewed and addressed our systems and the necessary controls have been put in place. The measures outlined below have been copper-fastened to ensure this will not reoccur.</p> <p>The specific measures to achieve compliance have included, the immediate Removal of Non-Registered Staff, the individual identified as not being registered with NMBI was removed from nursing duties on the day of insepection, 22nd October and is no longer rostered in any nursing role.This action eliminated the immediate risk to residents. The verification of All Nursing Registrations, a full audit of nursing staff registration status was completed by the Person in Charge on 23rd October. Written evidence of all other nursing staff’s current NMBI registration continues to be held in each nurse’s personnel file.</p> <p>From 23rd October all nursing rosters ensure that at least one NMBI-registered nurse is on duty at all times.The Person in Charge reviews and signs off on rosters weekly to confirm compliance.</p> <p>No nurse may commence employment or agency work unless:</p> <ul style="list-style-type: none"> <li>• Active NMBI registration is verified on the NMBI register</li> <li>• Copies of registration evidence are physically on file</li> </ul> <p>This check is now embedded in the recruitment checklist and personnel file audit process.</p> <p>A contingency plan is in place to cover unplanned absences, ensuring immediate access to NMBI-registered agency or relief nurses.</p> <p>The centre maintains an approved panel of registered nurses verified by management. The Person in Charge and Provider Representative have reflected on this matter and are committed to continous learning and improvement and have completed inhouse refresher training on staffing legislaton and regulatory compliance. Going forward staffing compliance will be reviewed as a standing agenda item at governance monthly meetings.</p> <p>At all times there will be a minimum of one registered nurse on duty and the Person in Charge will review and sign off rosters weekly to confirm compliance.</p>	

Compliance with Regulation 15 will be monitored through:  
 (a) Monthly audits of rosters and NMBI registration and (b) Quarterly governance review of staffing compliance.

These actions ensure robust staffing governance, promote a culture of regulatory awareness, and provide ongoing training and support to the Person in Charge, ensuring continuous compliance with Regulation 15 and safe care delivery for residents.

Regulation 21: Records	Not Compliant
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Outline how you are going to come into compliance with Regulation 21: Records:  
 The provider representative has strengthened governance arrangements to ensure ongoing compliance with Regulation 21. The person in charge has received additional guidance on regulatory requirements relating to records and staff management and will be supported in this on an ongoing basis. Policies on recruitment, record keeping, and roster management have been updated and shared with management staff.

Ongoing Action will include :

- Annual internal audits will be conducted against HIQA regulations and schedules.
- Findings from audits will be documented, and corrective actions tracked.

The registered provider assures HIQA that robust systems are now in place to ensure:

- All staff records meet the requirements of Schedules 2 and 4.
- Duty rosters accurately reflect staffing and management presence.
- Only appropriately vetted and registered staff are employed.

The provider representative is committed to continuous improvement, ongoing management training, regulatory compliance, and ensuring safe, high-quality care for all residents.

#### Staff Employment Records (Schedule 4)

The following Action has been taken to ensure compliance with Regulation 21:

- Contracts of employment to all staff members, signed, and hardcopies will be placed on file available for inspection.
- Each staff file now clearly identifies the date of role commencement, role title, and conditions of employment.
- A standardized staff file checklist aligned with Schedule 4 requirement has been enhanced and is now in use to ensure ongoing compliance.

Ongoing Action will include:

- Staff files will be reviewed quarterly by the provider/person in charge to ensure documentation remains complete and up to date.

Duty Rosters and Person-in-Charge Presence

Action Taken:

- Duty roster templates have been revised to clearly record the actual hours worked by the person in charge.
- All rosters now accurately reflect staffing presence in the centre and are retained on site for inspection purposes.
- The person in charge now signs off weekly on completed rosters to confirm accuracy.

Ongoing Action:

- Rosters will be maintained in real time and reviewed weekly.
- A full audit of all staff files quarterly

3. Pre-Employment Documentation (Schedule 2)

Action Taken:

- The person in charge and provider representative have reviewed legislative and regulatory requirements to identify and address any gaps in knowledge.
- All current staff files have been reviewed to ensure compliance with Schedule 2 requirements.
- Copies of current professional registration have been obtained and verified.
- Two written references, including one from the most recent employer, are on file for all staff.
- A pre-employment checklist has been enhanced ensuring no staff member commence employment without all required documentation in place.
- No staff member will be permitted to commence employment without full completion of the pre-employment checklist being authorised.

Regulation 23: Governance and management

Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

The provider representative will strengthen governance arrangements by establishing an enhanced governance structure with clearly defined roles and accountability. The provider representative has identified the need to further support the Person in Charge through additional training and professional development. To begin, a relevant management and governance training course has been identified and will be completed by the Person in Charge to enhance knowledge and understanding of regulatory requirements, including Regulation 23. This course will commence during January 2026. The Person in Charge will receive ongoing support, guidance and supervision from the provider representative and external agencies, alongside continued access to refresher training. The overall aim of the training is to equip with the knowledge and competencies in line with national and best practice and the relevant regulations as identified in the Health Act 2007.

Professionally up to date courses will be identified by the Provider representative and undertaken by their person in charge to ensure they remain informed of new developments and best practices and they will receive training to develop and strengthen

communication and interpersonal skills.

These measures will support and maintain our historical culture of openness, transparency, and regulatory awareness, strengthening oversight, accountability and sustained compliance.

Monthly governance meetings will be held between the provider representative and the Person in Charge to review quality, risk, staffing, incidents, safeguarding concerns, and legislative and regulatory compliance. Minutes of these meetings will be documented and actioned.

Our safeguarding risk register will be enhanced and reviewed monthly to ensure risks to residents are identified, escalated, and mitigated in a timely manner.

A full audit of all staff recruitment files to ensure compliance with legislative requirements, including Garda vetting, references, professional registration, and contracts has been completed no further gaps identified.

A modified recruitment checklist will be implemented and must be completed and signed by the Person in Charge prior to staff commencing employment.

A staffing contingency plan has been implemented to ensure a registered nurse is on duty at all times. This will include agreed escalation procedures and confirmed agency arrangements.

#### Safeguarding and Protection from Abuse

The provider representative will ensure all safeguarding concerns are investigated in line with national safeguarding procedures. The safeguarding incident identified during inspection has been investigated and outcomes recorded.

All staff will receive refresher training in safeguarding, recognition of abuse, and reporting procedures. A staff meeting was held on 2/12/25 to discuss this new training.

A question and answer session took place at this meeting to enhance staff awareness of safeguarding definitions, who and what to report and various potential scenarios staff may experience. Staff have been requested to provide feedback on training, any gaps identified and ongoing training will include dedicated training programs devised internally and with external trainer consultation. At the meeting of 2/12/2025 staff were asked to take a 'staff grievance form' for the purpose of highlighting/including any gaps they feel are present in care, training, refresher courses, or support. The Person in Charge will undertake the Safeguarding Adults: Designated Officer blended training programme over the course of the next three months. It is intended that the additional training will support and assist the Person in Charge in developing a tailored in house training/workshop programme for all staff to receive.

A safeguarding log will be maintained and reviewed weekly by the Person in Charge to ensure appropriate follow-up and escalation and reviewed monthly by the Provider Representative.

The provider representative has identified the need to further support the Person in Charge through additional training and professional development. To commence, a HSeLanD for Adult Safeguarding Designated Officer programme course will be undertaken to enhance knowledge and understanding. The HSEland Safeguarding Adults: Designated Officer blended training programme will be completed in the next three months. The Person in Charge has enrolled in stage one and two, when these stages are completed, the Person in Charge is permitted to enrol in the third stage of the training program. Management is committed to maintaining a positive culture that Hillview has been proud to uphold, where quality, accountability, and respect are embedded in everyday practice. This culture of continuous improvement and effective

governance will be led from the Provider representative and Person in charge and reflected throughout all staff levels of the centre.

Each resident presenting with responsive behaviours has been identified, behaviour, mood and cognition care plans have been updated, and ABC charts have been commenced to identify times, triggers and positive redirection techniques, these will be reviewed and feed back to the care plan for correct and up to date identification of issues and solutions. This will provide practical support to staff in how to manage any type of responsive behaviour without inhibiting the life of the resident.

Referrals have been made to appropriate allied health professionals (e.g. SAGE and Safeguarding Ireland and Psychiatry of Old Age) where required.

Staff have received targeted training on understanding and responding to responsive behaviours via HSEland training and face to face inhouse assessment (6monthly) with certificates of completion being added to their staff file.

The registered provider and Person in charge will enhance the quality assurance programme incorporating audits of staffing, safeguarding, incident management, infection control, and policy compliance. Audit outcomes will be reviewed at monthly governance meetings and used to enhance continuous improvement.

Quality assurance review shall be undertaken in line with legislation and regulations in the form of the annual service report. The PIC will issue the questionnaire in December for collection and data extraction in January. This will then inform the care review plan for 2026.

The audit schedule has been reviewed and implemented to include staff training PIC audit of care plans and how they reflect the current condition of the residents and increase the occurrence of safeguarding, medication management and infection prevention and control.

Management meetings will incorporate all audits undertaken and include policy and procedures. These meetings will also review any changes to legislation and inform changes to policy, procedure and audits.

These measures will ensure effective governance and our management systems are in place to protect residents, ensure regulatory compliance, and support the delivery of safe and consistent care.

Regulation 31: Notification of incidents	Not Compliant
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Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

The provider representative has reviewed incident management systems to ensure statutory notifiable events are identified and reported to the Chief Inspector within required timeframes. A statutory notification register will be introduced and reviewed weekly by the Person in Charge and monthly by the registered provider.

Management training will be provided to ensure accurate and timely information is shared with the Chief Inspector.

Timeframe:

- Retrospective incident review completed
- Notification register implemented within 1 month

Management training within 6 weeks and ongoing

Regulation 4: Written policies and procedures	Not Compliant
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Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

All required policies and procedures will be reviewed and updated to ensure alignment with legislative requirements. Policies not implemented in practice, including the use of restraint policy, will be revised and embedded through staff training and supervision.

Timeframe:

- Policy review completed within 8 weeks
- Staff training completed within 8 weeks and ongoing

Quarterly audits ongoing

Regulation 17: Premises	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 17: Premises:

The provider representative has addressed the identified environmental concerns and had the licensed pest control contractor visit the centre immediately and a more robust monitoring programme with the contractor has been planned and will continue to be executed. A deep clean has been completed of the hotpress and storage practices reviewed.

Weekly environmental hygiene checks will be completed and monitored by the Person in Charge.

A new support maintenance staff member has been recruited to assist with daily maintenance requirements, this individual had previously worked in this position who will attend/replace the flooring in the two rooms concerned.

The Person in Charge will ensure the carpet cleaning routine is increased for the autumn and winter months to cope with the increased foot fall and potential increase in staining. Housekeeping staff will note and report any areas that carpets appear additionally stained and attend to spot cleaning as needed if spills occur.

The Person in Charge has undertaken a review of all privacy locks and ensured the privacy and dignity of residents is maintained. All locks are now installed, and this item has been added to the monthly household audit for continued monitoring.

Staff have been reminded to note all identified maintenance issues are noted on the maintenance action list for immediate attention and to inform the Person in Charge if the issue is not rectified in an appropriate timeline.

Regulation 7: Managing behaviour that is challenging	Not Compliant
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Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

The provider representative acknowledges the findings and is committed to achieving full compliance by strengthening governance, care planning, staff guidance, and the use of restrictive practices in line with national policy and best practice.

The provider representative is committed to ensuring residents are supported in a dignified, person-centred, and restraint-free environment wherever possible and to embedding Regulation 7 requirements into everyday practice. This includes, individualised care planning, all residents identified as displaying responsive behaviour will have fully individualised care plans developed and/ or updated. Each care plan will clearly outline:

- o Known triggers.
- o Early warning signs
- o Effective de-escalation strategies
- o Preferred communication methods
- o Person-centred interventions

Care plans will be developed and upgraded following a multidisciplinary assessment, with input from the resident and/or their representative and all identified residents will have an up-to-date responsive behaviour care plan completed within 4 weeks of this report.

Bi-monthly audits by the Person in Charge will confirm compliance and ensure individualised plans remain current and up to date. This will take place to ensure the legislative quarterly updates/on change in ability is being reviewed by a person not witnessing the day-to-day ability of the resident, as this is when slow declines may be missed.

In respect of Staff Guidance and Training, the Provider representative and Person in Charge have acted and planned for all staff to receive mandatory training in, managing responsive behaviour, de-escalation techniques, human-rights-based, person-centred approaches. All staff training recorded on the training matrix. Key interventions for each resident will be discussed during daily handover and supervision; staff supervision records will evidence discussion of behaviour supports. Additionally, quick-reference behaviour support guides will be placed in residents' care records.

The estimated timeframe for staff inhouse training to be fully completed is March 1, 2026, and ongoing, with refresher training provided annually.

Regarding the Use of Restrictive Practices (Bed Rails)

A full audit of all residents using bed rails has been undertaken 23/11/25.

For each resident:

- A new risk assessment has been developed and added to the care plan. Including list of alternatives trialled and dates from and to this trial was undertaken.
- The form will include family review date and comment.
- A specific restrictive practice care plan will be developed where any practice is utilised, e.g. bed rails to be cited as 15. Special circumstances.
- Consent will be obtained and documented.

Restrictive practices will be reviewed regularly with the aim of using any form of restriction for the shortest period, and the provision of reasonable alternatives as able.

All residents with bed rails will have, specific care plans, completed risk assessment, documented alternatives trialled (those already admitted have missed the opportunity to date these trials). Therefore, the idea of alternatives shall be documented at the point of discussion on implementation of updated assessment.

In addition , monthly restraint audits completed and reviewed by management.

Audit and care plans completed within 1 month and reviews conducted at least every 3 months or sooner if risk changes.

Policies on responsive behaviour and restraint will be reviewed and updated in line with national and HIQA guidance and communicated to all staff through team meetings and supervision. The Person in Charge will monitor implementation through:

- o Bi-monthly audits to reduce gap between quarterly care plan review by nurses.
- o Monthly restraint analysis via the restraint register
- o SMART audit review and evaluation of service

Regulation 7 compliance will be a standing item at management and quality meetings. Outcomes will be included in the Annual Review of Quality and Safety to be complied once questionnaires are returned and data extracted. January 2026 and learning from incidents will inform continuous improvement.

Regulation 8: Protection	Not Compliant
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Outline how you are going to come into compliance with Regulation 8: Protection:  
The provider representative is committed to ensuring all reasonable measures are taken

to protect residents and in achieving full compliance with Regulation 8, by strengthening governance, care planning, staff guidance, training and supervision, in line with national policy and best practice. The provider representative will strengthen governance arrangements by establishing an enhanced governance structure with clearly defined roles and accountability and this will be achieved through the following;

The provider representative has identified the need to further support the Person in Charge through additional training and professional development in safeguarding. To begin a HSeLanD for Adult Safeguarding Designated Officer programme course will be undertaken to enhance knowledge and understanding .

The Person in Charge will receive ongoing support, guidance and supervision from the provider representative and relevant external training agencies, alongside continued access to refresher training. The overall aim of the training is to equip with the knowledge and competencies in line with national and best practice and the relevant regulations as identified in the Health Act 2007.

Monthly governance meetings will be held between the provider representative and the Person in Charge to review quality, risk, staffing, training requirements, incidents, safeguarding concerns, and legislative and regulatory compliance. Minutes of these meetings will be documented and actioned.

These measures will support the maintenance of a culture of openness, transparency, and regulatory awareness, strengthening oversight and sustained compliance.

In addition corrective actions regarding safeguarding policy and governance have been implemented to ensure residents are safeguarded from abuse and that systems now provide robust assurance of protection. These actions include;

- The safeguarding policy has been fully reviewed and updated to incorporate all relevant legislative changes that came into effect at the end of March 2025.
- External guidance and national safeguarding standards were referenced to ensure the policy is current, comprehensive, and suitable to guide staff practice.
- The revised policy has been approved by governance and disseminated to all staff, with clear guidance on roles, responsibilities, reporting pathways, and timeframes.
- Ongoing policy review dates have been embedded into the governance calendar to prevent future lapses and ensure timely alignment with legislative changes.

For the purposes of Incident Management and Investigation, a clear safeguarding escalation and investigation process has been implemented to ensure all allegations, disclosures, or suspicions of abuse are immediately assessed, responded to, and investigated. Meaning that all safeguarding concerns to be risk-assessed, documented, reviewed without delay and appropriate protective measures put in place to safeguard residents while investigations are ongoing. Notifications and reporting to relevant authorities will be completed in line with internal process, regulatory requirements and within required timeframes in accordance

Regarding staff training and culture, the Person-in-Charge will undertake additional safeguarding and incident management training to strengthen oversight, decision-making, and accountability. The planned training will ensure both management and staff, are supported in consistent practice, professional development, and strong leadership.

All staff have completed updated safeguarding training, with a specific focus on recognising abuse, managing disclosures, reporting concerns, and understanding legislative duties. Safeguarding is now a standing agenda item at staff meetings, governance meetings, and supervision sessions, reinforcing a culture of openness, responsibility, and zero tolerance of abuse. Staff are encouraged and supported to

escalate concerns without fear of reprisal, and this is reinforced through weekly staff meetings, supervision and audits.

Safeguarding audits are now conducted quarterly with a 6 monthly review of staff knowledge and understanding to identify learning, and ensure continuous improvement. Trends, incidents, and learning outcomes are reviewed at governance level to provide assurance that safeguarding systems are effective and residents are protected.

The safeguarding of our residents is of the utmost importance and underpins all aspects of our practice and the ongoing measures now in place will protect our residents and ensure Regulation 8 is fully complied with on an ongoing basis.

Regulation 5: Individual assessment and care plan

Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

The provider acknowledges the gaps identified in care planning and risk assessment documentation and has implemented targeted actions to strengthen compliance with Regulation 5. Safeguarding, care Planning and recording, all safeguarding care plans have been reviewed to ensure they are person-centred, clearly outline identified risks, protective measures, and the specific frequency of checks required.

A standardised safeguarding care plan template has been introduced to ensure consistency and clarity. Where checks are required, these are now clearly documented and recorded on daily care records.

All safeguarding care plans have been reviewed and updated. Monitoring check forms are audited on a weekly basis by the Person in Charge.

Monthly analysis of findings will identify trend in times of the day, trigger points, or agitators. The findings will then be reviewed with the nursing team to create a more communicative strategy to alleviate issues.

Bed-Rail Use and Risk Assessment, a full review of bed-rail use has been undertaken. Each resident using bedrails now has a completed bed-rail risk assessment, including documented consideration of alternatives and a clear rationale for compliance with bed-rail risk assessments. This will be subject to with ongoing quarterly reviews by the nursing staff as part of care plan reviews. This is also to be reviewed with the GP 3 monthly on routine visits. Bed-rail decisions are now supported by a multidisciplinary approach, with documented input from nursing staff, GP and allied health professionals where appropriate. Residents and/or their representatives are actively involved in decision-making, and their preferences are clearly recorded.

Care plan updates and family/resident comments to be conducted within one month. GP input early 2026 on next routine visit in January.

Care Plans to guide staff practice, all residents using bedrails now have an individualised

care plan that clearly directs staff on safe use, monitoring requirements and review dates.

Care plans have been aligned with risk assessments to ensure clear guidance for staff. The internal controls to ensure best practice include that , the Person in Charge will conduct monthly audits of the restraint register. Person centred care plans will be reviewed on a quarterly basis by the allocated staff nurse.

The Person in Charge will strengthen governance oversight of clinical documentation through regular audits, staff supervision and refresher education on person-centred care planning and risk assessment.

Findings from audits inform ongoing quality improvement and audit outcomes will be reviewed bimonthly and action plans implemented where gaps identified through audit.

These actions have/ and will continue to result in improved clarity, consistency, and person-centred care planning, ensuring that residents' individual needs are assessed, documented, and met in accordance with Regulation 5.

## 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 and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Red	14/11/2025
Regulation 15(2)	The person in charge shall ensure that the staff of a designated centre includes, at all times, at least one registered nurse.	Not Compliant	Red	23/10/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out	Substantially Compliant	Yellow	23/01/2026

	in Schedule 6.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	16/12/2025
Regulation 21(4)	Records kept in accordance with this section and set out in paragraphs (6), (9), (10), (11) and (12) of Schedule 4, shall be retained for a period of not less than 4 years from the date of their making.	Substantially Compliant	Yellow	16/12/2025
Regulation 21(5)	Records kept in accordance with this section and set out in paragraphs (7) and (8) of Schedule 4, shall be retained for a period of not less than 7 years from the date of their making.	Substantially Compliant	Yellow	16/12/2025
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	16/12/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Red	23/12/2025

	appropriate, consistent and effectively monitored.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	23/10/2025
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Not Compliant	Orange	01/02/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/01/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and	Substantially Compliant	Yellow	20/01/2026

	where appropriate that resident's family.			
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	02/12/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Not Compliant	Orange	30/01/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	02/12/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Red	02/12/2025