Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Hillview Convalescence & Nursing Home
Name of provider:	Hillview Convalescence & Nursing Home Limited
Address of centre:	Tullow Road, Carlow
Type of inspection:	Unannounced
Date of inspection:	13 May 2026
Centre ID:	OSV-0000238
Fieldwork ID:	MON-0050709

About the designated centre

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

Hillview Nursing Home is a family owned centre which opened in 2003. The registered provider is Hillview Convalescence and Nursing Home Limited. It is a purpose-built centre located on the outskirts of Carlow town, within walking distance of many amenities such as shops and churches. The centre is surrounded by spacious landscaped gardens with access to a secure garden for residents. There is ample parking available to the front and side of the centre. The centre can accommodate up to 54 residents, both male and female over the age of 18 in its 32 single and 11 twin bedrooms. Bedroom and communal spaces are divided over two floors with access to the first floor via a passenger lift and stairs. Communal space includes a dining room, day room, sun room, activity room, quiet room, reminiscence room and seating areas in the reception and landings on the first floor. Services provided include 24 hour nursing care, visiting general practitioners (GPs), pharmacy, chiropody, occupational therapy, physiotherapy, dietetics, speech and language, optician, dental and audiology. A range of social activities are offered to meet the needs of all residents over six days each week. Religious and advocacy services are also available. The centre caters for residents with varying levels of dependency for long term, convalescence and respite care.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	48

How we inspect

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 13 May 2026	08:50hrs to 18:20hrs	Niamh Moore	Lead
Wednesday 13 May 2026	08:50hrs to 18:20hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

Inspectors observed numerous kind and courteous interactions between staff and residents throughout the day in Hillview Convalescence and Nursing Home. Staff were observed supporting residents when required or requested. The overall feedback from residents was that they were happy living in the centre. Notwithstanding the overall positive feedback, an urgent action was issued to the provider following the inspection in respect of infection control measures and the management of an outbreak within the centre. This will be further discussed within this report.

This was an unannounced risk inspection which took place over one day by two inspectors of social services, including one inspector who focused on the provider's compliance with infection prevention and control (IPC) oversight, practices and processes.

Inspectors walked through the centre to review the premises and then completed an introductory meeting with the person in charge and a clinical nurse manager.

The designated centre is registered to accommodate up to 54 residents in 32 single and 11 twin bedrooms over two floors. There was 48 residents living in the centre on the day of the inspection. Residents were supported to personalise their bedrooms, with items such as photographs and artwork to help them feel comfortable and at ease in the home.

There was a warm and welcoming atmosphere in the centre and this was reflected in the feedback from residents, relatives and staff spoken with. The majority of residents were positive about their lived experience in the centre and were full of praise for the staff. However, a small number of residents reported that the care was not always consistent or in line with their preferences, particularly relating to their choice of when to go to bed. Some residents said they were requested to go to bed at approximately 5.30 or 6pm and that "its been that way since I came to the nursing home", one resident said that they could request to stay up a bit later to approximately 7.15pm noting that they had to be in bed before 8pm when night staff came on duty. This was brought to the attention of management on the day of the inspection.

Throughout the day staff were observed engaging with residents in a respectful and friendly manner and being kind and courteous to residents at all times. Some residents were living with dementia and were unable to detail their experience of the service. However they were also observed by the inspectors to be content, relaxed in their environment and in the company of other residents and staff.

Residents were generally complimentary of the home cooked food and the dining experience in the centre. On the morning of the inspection, breakfast was being

served and residents had a choice of cereals, porridge, toast and fruit. Inspectors observed the lunch-time service on the day of the inspection. There were two servings, one at 12pm and one at 1pm, inspectors were told this was to allow for residents dependency levels, with those requiring additional support received their lunch at 12pm. Some residents attended the dining rooms for their meals while the others choose to have lunch in their bedrooms. Menus were available on tables in the dining rooms and also on display on notice boards. Residents had a choice of three options for the main serving, residents told inspectors they were asked their choice in the morning time and it was no problem if they changed their mind. Residents were complimentary of the food with comments such as "I love the food here", and "I am very happy with the food".

Residents confirmed that there was a wide range of activities taking place, seven days a week, and residents were encouraged to engage in meaningful activities throughout the day of the inspection. Residents were observed moving freely around the centre, and were observed to be socially engaged with each other and staff.

There were no visiting restrictions in place and visitors were observed coming and going to the centre on the day of inspection. Visitors confirmed that visits were encouraged and facilitated in the centre. Residents were able to meet with visitors in private or in the communal spaces and visiting rooms throughout the centre. Visitors were observed to be welcomed by staff and it was evident that staff knew visitors by name and actively engaged with them. Visitors also complimented the quality of care provided to their relatives by staff, who they described as kind and respectful.

While the centre generally provided a homely environment for residents, some of the décor and finishes were showing signs of wear and tear. In addition, there was poor storage observed throughout the centre, including storage of discharged residents belongings stored under stairwells, which impacted on fire safety concerns. Inspectors required the registered provider to address this risk on the day of the inspection.

There were a variety of communal spaces available to residents. Communal areas were seen to be supervised at all times and call bells were answered promptly. However, inspectors observed that during this inspection, the quiet/prayer room was used as an office and as a result was not available for residents to use, as they wished.

Ancillary facilities generally supported effective infection prevention and control. For example, staff had access to a dedicated housekeeping room on both floors for the storage and preparation of cleaning trolleys and equipment. Each unit also had a sluice room for the reprocessing of bedpans, urinals and commodes. However, the laundry facility was not managed in a way that supported effective infection prevention and control.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impact on the quality and safety of the service being delivered.

Capacity and capability

This inspection found there was ineffective oversight of the management systems and infection prevention and control within the centre. In addition, inspectors found there was a remarkable decline in the overall regulatory compliance when compared with the November 2025 inspection and that of the provider's regulatory history. In light of these potential risks posed to residents, an urgent compliance was issued to the provider. Inspectors also contacted the Health Service Executive (HSE) through the HSE Public Health team in order to ensure that relevant parties were aware of the concerns of inspectors regarding the management and oversight of a prolonged and recurrent scabies outbreak.

This was an unannounced inspection to review compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 (as amended). In preparing for this inspection, the inspectors reviewed the compliance plan for the inspection of November 2025, solicited information provided by the provider and the person in charge as well as unsolicited information received by the Chief Inspector of Social Services.

Inspectors reviewed the detail of unsolicited information received by the Chief Inspector which included information concerning repeated scabies outbreaks and poor communication in relation to the outbreak. This information was substantiated on this inspection. The provider was required to take urgent action following this inspection to ensure there was local oversight systems, supervision and assurance mechanisms in place to ensure that the outbreak was effectively managed. The plan submitted was accepted by the Chief Inspector.

There has been a notable increase in reported scabies outbreaks nationally in recent years. Hillview Convalescence and Care Home has experienced recurrent and prolonged outbreaks of scabies infestation during this period. Despite a range of control measures, a scabies outbreak remained ongoing at the time of the inspection, with a significant number of residents and staff requiring repeated courses of treatment, suggesting challenges in achieving full eradication. A review of the management of the ongoing outbreak by inspectors, identified that the response was fragmented and lacked co-ordination which likely contributed to the persistence of the issue.

Inspectors also identified deficits in the systems used to communicate relevant and up-to-date information to staff, residents and visitors. Many staff members, residents and visitors were unaware of the status of the current outbreak. This increased the risk of onward transmission within the designated centre and the wider local community. Details of issues identified are reported under Regulation 23: Governance and Management.

The registered provider of Hillview Convalescence and Nursing Home is Hillview Convalescence and Nursing Home Limited. This company comprised of two company directors, with one present during this inspection.

The person in charge (PIC) was supported in their role by an assistant director of nursing, clinical nurse manager and a team of nurses, healthcare assistants, activity coordinators, housekeeping, catering, maintenance and administration staff.

Inspectors observed there were sufficient numbers of clinical and housekeeping staff to support the provision of care and services within the centre on the day of the inspection. Overall staff were knowledgeable of the needs of the residents and residents were seen to receive support in a timely manner, such as providing assistance at meal times and responding to requests for support. Cleaning records viewed confirmed that all areas were cleaned each day. However, there was no routine deep cleaning schedule, and records of periodic deep cleans were not maintained.

Inspectors reviewed the training matrix for the designated centre and saw a suite of training was available to staff on areas such as human rights and advocacy. However, significant gaps were seen in attendance at mandatory training in line with the provider's policy on safeguarding, infection control, manual handling, first aid and fire safety. Some staff had not yet received training, and for others training had expired. Management told inspectors that training dates were booked for the coming weeks following the inspection. However, inspectors found that issues identified during this inspection likely contributed to continued scabies transmission and highlighted the need for additional staff supervision and training, standardised procedures and improved oversight of infection prevention and control procedures.

Inspectors found that there was inconsistent oversight of staff meetings and auditing occurring within the centre. For example, staff meetings had last occurred in November 2025 and while regular auditing was taken place, there was a noticeable reduction in the frequency of audits since March, and no audits carried out in April and no evidence of audits having been completed during the first two weeks in May. In addition, the findings of audits which had been carried out, recorded high levels of compliance achieved and this was not reflected on the day of the inspection.

Regulation 15: Staffing

There was sufficient staff on duty to meet the needs of the current residents, having regard to current occupancy of the centre, for the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to mandatory and other relevant training to support them in their roles, and the registered provider had planned upcoming training dates to ensure staff were up-to-date with relevant training. However, on the day of the inspection the training matrix provided to inspectors highlighted gaps in training in the areas of fire safety, infection prevention and control, safeguarding and managing behaviours that is challenging. For example:

- 46 staff were due refresher training in infection prevention and control
- 8 staff did not have any training in infection prevention and control
- 42 staff were due refresher training in safeguarding
- 5 staff did not have any training in safeguarding
- 16 staff were due refresher training in fire safety
- 3 staff did not have any training in fire safety
- 40 staff were due refresher training in managing behaviour that is challenging
- 8 staff did not have any training in managing behaviour that is challenging

Judgment: Not compliant

Regulation 21: Records

Incomplete information was identified in the documentation of Schedule 2 staff files. For example, a full employment history together with satisfactory history of any gaps in employment was not available for two out of the four staff files reviewed. This is a repeat finding.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management systems to ensure that the service provided was safe, appropriate, consistent and effectively monitored were not sufficiently robust. This was evidenced by the following:

- A local outbreak control team, chaired by management, held regular outbreak meetings. However, minutes from the most recent meeting held on 04 May 2026 indicated that management did not have access to accurate and up-to-date information regarding the status and management of the outbreak. This indicated inadequate oversight, monitoring and escalation arrangements in relation to the management of the outbreak.

- An accurate log to track new cases, including symptom onset, GP diagnosis and treatment dates, was not maintained. This resulted in uncertainty among staff and management regarding the number of residents identified with scabies to date and the current status of the outbreak.
- Appropriate infection prevention and control signage was not displayed at the entrance to notify visitors of the ongoing scabies outbreak within the centre. Several visitors spoken with were unaware of the status of the current outbreak. This increased the risk of onward transmission within the designated centre and in the local community.
- Staff meetings had not been held in 2026 to date. This lack of formal communication and oversight contributed to ambiguity among staff about the status of the outbreak and may have impacted the effectiveness and consistency of the centres outbreak response.
- There were insufficient local oversight, supervision, training and assurance mechanisms in place to ensure that the environment and equipment was effectively cleaned and decontaminated. Deep cleaning records were not maintained.
- Disparities between the findings of local infection prevention and control audits and the observations on the day of the inspection indicated that there were insufficient assurance mechanisms in place to ensure compliance with the National Standards for infection prevention and control in community services.
- Ineffective systems were in place to monitor fire safety in the centre, for example daily, weekly and monthly audits did not outline storage concerns which impacted on fire safety. In addition, it was documented since March that there were issues with gaps in fire doors, however, there was no time bound action plan in place to address this.
- Previous commitments given by the registered provider in their compliance plan from the inspection in November 2025 had not been addressed and therefore repeat findings were identified on this inspection.
- There was insufficient oversight to ensure residents care was provided in line with their assessed needs, as discussed under Regulation 5: Individual assessment and care plan and Regulation 18: Food and Nutrition.

Judgment: Not compliant

Quality and safety

Overall, this inspection found that residents generally reported a good quality of life in the centre, with caring staff and good access to activities. Notwithstanding the positive feedback from residents and visitors, the findings of this inspection are that significant improvements were required in the management of the premises and infection control and prevention. Other areas that required improvements included

residents' assessment and care planning, residents' rights, food and nutrition, temporary absence or discharge of residents and fire safety.

Inspectors observed that staff were familiar with residents' medical history, needs and preferences. Residents had timely access to general practitioners (GPs), allied health professionals, specialist medical and nursing services including community palliative care specialists as necessary.

A sample of care plans and assessments for residents were reviewed. Care plans based on assessments were completed no later than 48 hours after the resident's admission to the centre and reviewed at intervals not exceeding four months. Overall, the standard of care planning was good and described person centred and evidenced based interventions to meet the assessed needs of residents. However, some care plans were lengthy having not been updated appropriately and some included conflicting information.This reduced clarity regarding residents overall care needs.This is detailed under Regulation 5; individual assessment and care plan.

While the centre generally provided a homely environment for residents, improvements were required in respect of premises and infection prevention and control, which are interdependent. For example, inspectors observed that the décor in the centre was showing signs of wear and tear. Surfaces and finishes including wall paintwork, wood finishes and flooring in some areas including the onsite laundry were worn and poorly maintained and as such did not facilitate effective cleaning.

Efforts had been made to de-clutter the centre. However, there was a lack of storage space in the centre resulting in the inappropriate storage of equipment and supplies. Clinical supplies were stored on the floor in the dining room, store rooms and in a clinical room, which could lead to floors not being cleaned adequately and contamination of supplies.

Menus were displayed for residents, and residents had a choice for their meals. Residents spoken with were all very complimentary of the mealtime experience and confirmed that they enjoyed the meals provided. Nutritional screening was in place for residents and where risk was identified residents were referred to the appropriate services such as dietitians and speech and language therapy. However, inspectors found that residents did not always receive nutritional care and support in line with their nutritional care plans, or as per the provider's policy.

A local transfer document was used when residents were transferred to acute care. This document contained details of health-care associated infections and colonisation to support sharing of and access to information within and between services. However, a review of files found that details of the ongoing scabies outbreak in the centre was not included on transfer documentation. As a result, there was no information provided to the receiving hospital to alert them to the need for appropriate infection prevention and control measures, increasing the risk of transmission. These findings are set out under Regulation 25; temporary absence or discharge of residents.

The recurrent and prolonged nature of the scabies outbreaks, including the occurrence of sporadic cases, suggested an intermittent source of contamination, likely exacerbated by a number of infection prevention and control deficiencies. These included;

- Unclear guidance among staff
- Lack of timely resident isolation when symptomatic
- Inadequate contact tracing procedures
- Poor equipment and environmental hygiene practices
- Inadequate management of laundry and non-washable items.

Collectively, these gaps contributed to continued transmission and highlighted the need for further staff training, standardised procedures and improved oversight of infection prevention and control procedures. Details of issues identified are set out under Regulation 27: infection control.

There were some systems in place to monitor fire safety procedures within the centre. For example, there was service records for the fire alarm, emergency lighting and fire extinguishers. However, there were gaps in the oversight of fire safety which was seen in the areas of staff training, fire drills and containment. This is further discussed under Regulation 28: Fire precautions.

Regulation 17: Premises

The use of two rooms in the designated centre were not in accordance with the registered statement of purpose. For example:

- the quiet room on the ground floor was seen to be used as an office.
- the staff changing room on the first floor was also used as a staff break room.

Improvements were required from 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:

- Poor organisation and a failure to separate clean and dirty activities in the on-site laundry posed a risk of contamination, particularly in the context of the ongoing scabies outbreak.
- Not all areas of the premises were kept in a good state of repair. For example damage to flooring and surfaces was observed in some areas of the centre. In addition, many of the chairs in communal areas were damaged and had chips to varnish on the chair legs which required maintenance.
- Poor storage practices were observed throughout the centre, including boxes of supplies stored on floors, cluttered and untidy storage rooms, supplies stored in communal areas and resident moving and handling slings stored on hooks in the dining room. The poor storage practices adversely impacted the overall standard of environmental hygiene. The provider was endeavouring to

improve existing storage facilities through the provision of an additional external storage facility. However, this was a repeat finding.

Judgment: Not compliant

Regulation 18: Food and nutrition

Many bedrooms viewed by inspectors did not have water jugs or glasses provided on the day, this did not meet the criteria of the regulations which outlined that each resident should have access to a safe supply of fresh drinking water at all times. It was also not in line with the registered provider's policy which outlined that water is available adjacent to each resident's bed. Inspectors were told by management that drinks were available in day rooms, and when residents returned to their bedrooms, these items would be made available to them. However, one resident who was in their bedroom did not have a jug of water available to them. In addition, a visitor was seen having to access a drink for the resident from the day room to bring to the resident's bedroom.

There was limited evidence that food and drink which was properly and safely prepared and served to residents who required a modified diet, 14 percent of clinical staff had not received IDDSI training. This training equips staff with the knowledge and skills to safely prepare and serve texture-modified foods and thickened liquids for individuals with dysphagia. As a result of this lack of training, residents were at a higher risk of choking if their food was not prepared and served appropriately.

Inspectors found that there were gaps in the provision of the dietary needs of residents as prescribed by health care or dietetic staff in accordance with the resident's care plan. For example:

- There was a lack of supervision to ensure all residents were given the correct nutritional requirements of food as prescribed. For example, two residents did not receive a high calorie or high protein diet as per their care plan, as staff who prepared their meals were not aware of the requirement to fortify the meals.
- A resident who was recorded as requiring one-to-one supervision due to a risk of choking did not have the same supervision while having snacks as they did having their lunch-time meal.
- There was a delay of 5 weeks for a resident to receive their nutritional supplement when prescribed.

Judgment: Not compliant

Regulation 25: Temporary absence or discharge of residents

Nursing documentation for residents transferred to hospital did not include details of the ongoing scabies outbreak. As a result, the receiving hospital did not have any information to ensure appropriate infection prevention and control measures were put in place when these residents were admitted to hospital.

Judgment: Substantially compliant

Regulation 27: Infection control

The provider did not met the requirements of Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018). Inspectors identified a number of practices which may have contributed to the persistence and recurrence of scabies infestation within the designated centre. For example;

- A review of documentation indicated that residents showing signs of infestation were not immediately isolated pending clinical diagnosis, and for 24 hours after initial treatment. This may have increased the risk of the infestation spreading between residents, staff and possibly visitors.
- Active monitoring of residents at day 7, 14 and 21 following scabies treatment, in line with Public Health guidance issued to the provider, was not carried out or documented to determine whether treatment had been effective.
- There was no evidence that contact tracing procedures were implemented following the identification and treatment of suspected cases. This increases the risk of ongoing transmission of scabies due to unidentified and untreated close contacts.
- A shared bedroom was not effectively deep cleaned when a resident was treated for scabies. The curtains had not been changed. This contributes to the risk of re-infection post treatment.
- Items that could not be laundered, such as slippers, were not appropriately managed when residents were treated. This poses a risk of mites being reintroduced into the environment or to other residents.
- The provider had introduced a tagging system to identify equipment and areas that had been cleaned. However, this system had not been consistently implemented at the time of inspection. For example, several items of shared equipment had not been tagged after cleaning and the old tag was not removed after using some equipment.

Judgment: Not compliant

Regulation 28: Fire precautions

While there was evidence that the registered provider had taken some precautions against the risk of fire. However, the arrangements for preventing, containing and responding to a fire required review. For example:

- There was inappropriate storage of items such as wheelchairs, mobility aids, residents' belongings and televisions under two stair wells which created a fire risk. The registered provider was required to address this risk on the day of the inspection and it is acknowledged this was completed.
- A number of fire doors were observed to have gaps. While the provider acknowledged they were aware of this, there was insufficient oversight of a full review of fire doors with a time bound action plan. This created a risk that not all doors were capable of restricting the spread of smoke and fire.
- Three fire doors were held open, two were with door stoppers and one was propped open by a chair scales.
- Poor attendance at fire safety training was outlined earlier in this report. In addition, not all staff spoken with were confident in the fire evacuation procedures on the day of the inspection.
- Inspectors reviewed records of routine fire drills which outlined there was evidence of learning being identified. However, these drills did not reflect the staffing levels and there was also inaccuracies in the records for what compartment was evacuated. Therefore, these records did not provide assurances that high risk scenarios such as a full compartment with night-time conditions, when staffing levels are at their minimum, particularly in the case of residents with complex mobility and evacuation needs, had been trialled.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Overall, the standard of care planning was good and described person centred and evidenced based interventions to meet the assessed needs of residents. However, further oversight was required to ensure compliance with the regulations.

The excessive number and volume of care plans resulted in duplication of information and reduced clarity regarding residents overall care needs. Some care plans were not updated consistently to ensure that outdated information, which was no longer relevant, had been removed and that all aspects of the residents' care had been appropriately reviewed in order to provide clear information for staff caring for the residents. For example:

- A care plan on swallowing referred to the resident being assessed to have different texture levels of food depending on the mobility chair being used. However, inspectors were told that the resident only used one mobility chair. This inconsistency resulted in unclear information available for staff and

increased the risk of the resident receiving inappropriate care which could lead to choking or aspiration.
- One responsive behaviour care plan referenced a medicine that had been prescribed on an as-required basis. However, inspectors saw that this medicine was no longer prescribed and had been replaced with a different medicine on the resident's prescription.
- One nutritional care plan referred to two nutritional supplements they were prescribed, however only one of these was on the residents prescription.

Appropriate infection prevention and control instructions were not detailed in care plans to effectively guide and direct the care of residents that were colonised with an MDRO. For example, care plans directed that residents be routinely cared for using contact precautions. This is not aligned with national guidance, which states that standard infection control precautions are sufficient in residential care and community settings. This may lead to confusion.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a number of local general practitioners providing medical services to the centre and out-of-hours medical cover was also available. There was evidence of appropriate referral to and review by health and social care professionals where required, for example, dietitian, speech and language therapist and chiropodist. A physiotherapist was on-site weekly to assess and review resident's mobility as required.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were provided with opportunities to participate in activities in accordance with their interests and capabilities. Residents expressed their satisfaction with the variety of activities on offer and said they could choose whether or not to attend. However, three residents expressed that they could not exercise choice regarding when to retire to bed. Residents stated that they had to go to bed prior to the night shift commencing at 8pm.

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
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 25: Temporary absence or discharge of residents	Substantially compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Hillview Convalescence & Nursing Home OSV-0000238

Inspection ID: MON-0050709

Date of inspection: 13/05/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and 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 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

Onsite mandatory training had already been pre-booked prior to the inspection, with training dates scheduled for the weeks following the inspection. The training programme was organised in advance and had to be planned around staff annual leave commitments and trainer availability to ensure maximum attendance while maintaining safe staffing levels within the designated centre. While the training matrix available on the day of the inspection identified gaps in fire safety, infection prevention and control, safeguarding, and the management of behaviours that challenge arrangements had already been made before the inspection to deliver this training. The training matrix has been reviewed since inspection and future dates for more staff training booked in.

The registered provider will continue to monitor attendance, training compliance and update the training matrix following completion of each training session and maintain oversight to ensure all staff complete mandatory training within the required timeframes and remain compliant with regulatory requirements. There are two trained Infection Prevention and Control link practitioners onsite who give support and guidance to all staff in relation to IPC.

In addition to mandatory infection prevention and control training, employees are required to complete further IPC education as part of their continuous professional development. This includes for example training in outbreak management, IPC risk assessment and hand hygiene. These additional training modules support staff in maintaining current knowledge and implementing best practice in infection prevention and control within the designated centre.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
While employment histories were available, additional clarification regarding historical gaps in employment had not been fully documented within two staff files. Following the inspection, the personnel files have been reviewed and the outstanding information has been obtained and added to the relevant staff records

The registered provider has also strengthened its recruitment and file audit processes to including complete employment histories and satisfactory explanations for any gaps in employment, is verified and recorded prior to the commencement of employment and routinely monitored thereafter. This will help ensure ongoing compliance and prevent a recurrence of this finding.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Management acknowledges that the minutes from the outbreak control team meeting held on 04th May 2026 identified gaps in the availability of accurate and up-to-date information relating to the status and management of the outbreak. Immediate actions were taken by management to update the current line list, strengthen oversight and monitoring and escalation processes.
At the time of the inspection, a new main entrance door had recently been installed and the outbreak signage was inadvertently not transferred to the new door. This omission was identified during the inspection, and appropriate infection prevention and control outbreak signage was displayed immediately.
The designated centre had implemented its outbreak management procedure, and all resident representatives listed on the designated centre's contact register were informed of the scabies outbreak by email in February 2026. Guidance regarding scabies and infection prevention and control measures was circulated to staff and residents' representatives at the onset of the outbreak in February. Management had advised nominated residents' representatives to seek GP assessment if they suspected a rash and not to visit the home for 24 hours post treatment. Pictures of scabies rash from the HSE website have been attached to family and staff emails for heightened awareness. Scabies and the associated control measures were also discussed with residents during residents' meetings to promote awareness and understanding. Communication sent out by email provided an option for residents nominated representatives to contact the PIC if they had any queries. The registered provider recognizes that not all family / friends / visitors to

Hillview are included on this email communication list, in accordance with residents' wishes and data protection considerations.
The designated centre has also engaged with the Public Health Department and highlighted the value of providing general public information on the recognition, prevention and treatment of scabies to support wider community awareness and reducing the risk of onward transmission into our home. All staff have found scabies outbreaks a huge challenge to manage.

To notify visitors of outbreaks the person in charge has introduced additional checks to ensure that appropriate outbreak signage is displayed and maintained at all entrances for the duration of any outbreak. This will form part of the outbreak management checklist and be verified through regular environmental and infection prevention and control audits to ensure visitors are appropriately informed on arrival. Management have always remained in regular liaison with the Public Health team throughout outbreaks and sought excellent onsite supportive guidance and advice in relation to outbreak management and control measures. Public Health advised that the South East region was experiencing a significant increase in scabies cases and Hillview Nursing Home will remain fully open and highly receptive to any further guidance, support or recommendations from Public Health to strengthen outbreak prevention and management measures.

Although formal staff meetings had not taken place during the period referenced, there were extensive and ongoing communication processes were in place to ensure staff were informed throughout the outbreak. Numerous emails, written memos and updates were circulated to all staff regarding the scabies outbreak, outbreak management plans and any changes to infection prevention and control measures. In addition, the PIC and the designated centre's Infection Prevention and Control Link Practitioners provided ongoing verbal guidance and support to staff, including updates on newly identified resident and staff cases and the actions required to minimise the risk of transmission.
The registered provider recognises the importance of formal staff meetings in supporting consistent communication and oversight. A planned schedule of regular staff meetings has now been implemented to complement existing communication methods. Outbreak management and infection prevention and control will continue to be standing agenda items during any outbreak, ensuring staff have the opportunity to discuss concerns, seek clarification and receive consistent updates.

Deep cleaning was undertaken as part of the designated centre's enhanced infection prevention and control measures; however, the completion of this cleaning was not consistently documented on a dedicated deep cleaning record. Following the inspection, a specific new deep cleaning record has been developed and implemented to ensure all deep cleaning activities are clearly documented, monitored and auditable.
In addition, domestic staff have attended staff meeting with mnagament and also attended onsite deep cleaning training since the inspection to further strengthen their knowledge and competency in enhanced environmental cleaning practices. Ongoing oversight will be maintained through regular audits of cleaning records and supervisory checks to ensure deep cleaning is completed and documented in line with the designated centre's infection prevention and control procedures. Domestic staff had completed AMRIC routine management of physical environment training.
The registered provider recognizes that there was a discrepancy between the findings of

local infection prevention and control (IPC) audits and the observations made on the day of the inspection. Following the inspection, the IPC audit process has been reviewed and strengthened. Audit tools have been revised where required, and greater management oversight has been introduced to validate audit findings, monitor the implementation of corrective actions and ensure identified issues are addressed in a timely manner. Audit outcomes and action plans will be reviewed regularly.
Following the inspection, additional storage areas have been installed within the designated centre to ensure equipment and supplies are stored appropriately and do not impact on fire safety or means of escape. The registered provider has also reinforced the requirement for daily, weekly and monthly fire safety checks to specifically include the identification of storage concerns, with any issues identified recorded and escalated promptly for action. In relation to the gaps identified in fire doors, the registered provider acknowledges that, although these issues had been identified through internal monitoring, a time-bound action plan had not been implemented. Since the inspection, a formal action plan has been established, with clear responsibilities and completion dates assigned to all fire safety maintenance issues. All staff have been spoken to regarding the inappropriate storage of items and again this should no longer be an issue with the new reorganisation of storage within the home.
The matters identified in relation to residents' care being provided in line with their assessed needs will be addressed in detail under Regulation 5: Individual Assessment and Care Plan and Regulation 18: Food and Nutrition. The registered provider will ensure that the actions identified under these regulations are implemented, monitored and reviewed through the centre's governance and oversight systems to ensure residents receive care and support that is reflective of their assessed needs and preferences.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
Staff have been reminded to change in and out of uniforms in the designated staff bathroom. This arrangement supports appropriate use of available space while ensuring staff changing requirements are facilitated. The registered provider has also reinforced that the staff break room is to be used solely for the purpose intended, ensuring this space remains available as a designated area for staff breaks and wellbeing. Additional staff lockers have also been ordered. On the day of inspection, the quiet room was not in use by residents and was occupied by CNM for a short period of time only for some staff consultations. This is not a regular occurrence and the quiet room is still available for use by residents/families when/if required as detailed in statement of purpose. The registered provider has reviewed the use of designated rooms within the centre and has reinforced expectations with staff regarding the appropriate use of each area to ensure all rooms are utilised in line with the Statement of Purpose.
Following the inspection, laundry audit was carried out and processes and available space within the designated centre were reviewed. There is designated areas within the laundry for clean and dirty laundry however, this process was not appropriately

maintained at the time of inspection. Management acknowledges that poor organisation within the laundry environment may increase the risk of cross-contamination, particularly during an outbreak situation. Storage area for clean laundry is planned to be maximised to ensure that clean linen is stored consistently separately from any dirty laundry activities. This additional space will support a clearer separation between clean and contaminated items and reduces the risk of cross-contamination, particularly during periods of increased infection prevention and control measures. Laundry staff have been reminded of the importance of maintaining clear separation between clean and dirty laundry processes, and ongoing monitoring will be completed to ensure laundry practices remain in line with infection prevention and control requirements Flooring in the laundry is currently under review and due to be renewed in the coming weeks, the laundry has since been painted, tidied and deep cleaning carried out. Effective daily cleaning will take place on a daily basis.

Damaged chairs have been identified and segregated while they await reupholstering to comply with IPC regulations. The process for maintenance and revarnishing legs of chairs has begun, this will be an ongoing process due to nature of hoist use etc.

Storage has been reviewed and reorganized in the building since inspection to prevent reoccurrence of inappropriate storage and facilitate adequate cleaning. All staff have been made aware not to store any items on the floors. More appropriate storage has been made available for these items. We are working towards a clutter free environment across all storage rooms, management are following this up with maintenance and spot checking to ensure compliance.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
Management acknowledge that a small percentage of residents did not have direct access to fresh drinking water on the day of inspection. This issue has been addressed immediately with all nursing and healthcare assistant staff through meetings, where the regulatory requirement that all residents must have access to a safe supply of fresh drinking water at all times was reinforced. Hillview Nursing Home has implemented measures to ensure compliance with Regulation 18(1)(a). Fresh drinking water will be available and accessible to all residents at all times while residents are in their bedrooms and throughout the centre. Nursing staff are responsible for ensuring that each resident has an adequate supply of fresh drinking water within easy reach, taking into account individual needs, preferences and any assessed risks. Water jugs / drink vessels will be replenished regularly throughout the day by care staff and replaced with fresh water as required. The nurse in charge on each shift will monitor compliance through regular environmental checks and daily oversight to ensure this practice is consistently maintained. This requirement has also been incorporated into the centre's Nutrition /

Hydration Policy and clinical staff inductions and ongoing supervision processes to support sustained compliance. In addition, fresh water dispensers are available on each floor to facilitate the prompt replenishment of residents' drinking water.

Dysphagia and IDDSI training has previously been provided onsite for staff and staff are required to take online hseland training on IDDSI guidelines and the safe management of people with dysphagia in order to support them in safely preparing and serving texture-modified diets and thickened fluids for residents with dysphagia. Following review of the training records, it was identified that a small number of clinical staff required updated IDDSI training. Additional onsite dysphagia/IDDSI training has therefore been scheduled for this month to ensure all relevant staff have the required knowledge and competencies. The registered provider will continue to monitor staff training compliance through the training matrix and ensure that staff involved in the preparation and provision of modified diets maintain up-to-date knowledge and skills in line with residents' assessed needs and best practice guidance

New documentation for kitchen staff has been generated to ensure the information from all dietician reviews are relayed to kitchen staff to ensure they are made aware of the need to fortify meals if directed by dietician, this was addressed at the recent nursing meetings.

The resident who was recorded as requiring one to one supervision with all oral intake has since been reviewed by SLT, care plan amended and staff informed to reflect most up to date information.

Evidence was made available to the inspector demonstrating that the dietitian's recommendations had been forwarded promptly by nursing staff and communicated to the GP for review. The registered provider acknowledges that nursing staff should ensure appropriate follow-up and escalation where required to support the timely completion of the prescribing nutritional supplements. This matter has been reviewed at a recent nurses' meeting and the importance of follow up and repeated follow-up with GP and escalation has been reinforced to minimize the risk of recurrence.

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
The transfer letter has been amended to include any current outbreaks within the nursing home on day of transfer to be documented. This was discussed with nursing staff at recent meeting.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Since the inspection current guidance has been reinforced again with clinical staff regarding the immediate isolation of residents displaying signs or symptoms of possible infestation pending clinical assessment and for 24 hours following initial treatment, in line with infection prevention and control guidance. Upon investigation by management of the resident identified by inspectors as not isolated , a treatment plan, isolation plan as per the residents' care plan had been discussed and handed over verbally to oncoming staff shift by nursing staff but instructions were not followed or information escalated , in response to this management have spoken with staff since the inspection to ensure that infection prevention and control instructions are clearly understood and implemented immediately when directed.

Staff have been reminded of the importance of timely initiation of precautionary measures, including isolation procedures, to reduce the risk of onward transmission. Management and the IPC link practitioners have reviewed current procedures with staff to ensure timely implementation of isolation precautions and appropriate documentation. ongoing supervision and monitoring will be carried out to ensure full compliance with infection prevention and control measures and to minimise the risk of onward transmission between residents, staff and visitors. Link practitioners will carry out more regular onsite IPC guidance and training with staff going forward. Infection control guidance resources are onsite for staff to refer to and have been simplified in a quick synopsis to avoid confusion or uncertainty going forward.

The resident's care plan detailed instructions for staff to monitor for recurrence of symptoms at day 7, 14 and 21 following scabies treatment, in line with Public Health guidance. Informal monitoring and discussion regarding residents' skin integrity and any recurrence of symptoms were occurring during nursing handovers between staff nurses; however, this was not formally documented. Since the inspection, a monitoring document has been introduced to ensure that all observations and reviews undertaken at day 7, 14 and 21 are formally recorded and maintained within the resident's documentation, this will provide improved oversight and assurance that monitoring following treatment is completed and documented appropriately.

The registered provider acknowledges that contact tracing procedures were not formally documented following the identification and treatment of the suspected case. Going forward, staff will ensure that contact tracing procedures are completed and reviewed for all suspected or confirmed cases to provide clear evidence of assessment, decision-making and follow-up actions. Contact tracing record / risk of potential transmission has been updated on the outbreak management document to support this process and ensure consistent implementation during any future outbreaks.

The registered provider recognises that isolation measures can be challenging for some residents, particularly those who experience behaviours that may place additional barriers on their ability to understand, tolerate or comply with restrictions. Staff will continue to use a person-centred approach, providing reassurance, support and appropriate infection prevention and control measures while respecting residents' assessed needs.

Since the inspection, a meeting has been held with domestic staff to highlight the non-compliance identified in relation to curtain changing and strict deep cleaning procedures following treatment for scabies. The importance of completing all aspects of terminal and deep cleaning, including the changing of curtains in shared rooms has been reinforced with staff to minimise the risk of re-infestation. In addition as mentioned above , new deep cleaning documentation has been developed, shared and circulated with domestic staff to support improved recording, oversight and compliance with infection prevention and control cleaning procedures going forward.
Instructions regarding appropriate management of items that could not be laundered, had been communicated to staff at handover; however, staff failed to complete this task as directed. Since the inspection, this matter has been discussed with staff members and the importance of adhering to all infection prevention and control instructions has been reinforced to minimise the risk of re-infestation or onward transmission. Management will continue to monitor compliance with these procedures through increased oversight and supervision.

Following the inspection, the importance of consistent implementation of the cleaning identification system has been reinforced with all staff. Clear guidance has been provided regarding the requirement to remove existing tags after equipment use and to ensure a new cleaning tag is applied following each cleaning episode.
The effectiveness of this process will be monitored through regular infection prevention and control audits and environmental checks by the management team.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All staff have been spoken to regarding the inappropriate storage of items and again this should no longer be an issue with the reorganisation of storage within the home
A number of fire doors were noted to have gaps, which posed an issue with containment of a fire. This has again been brought to the attention of the registered owner who has ensured that these issues will be rectified.
It was noted that there were an increased number of residents requesting their bedroom doors to be kept open while they were in the room 2 days prior to inspection, noise activated door stoppers had been ordered and a list kept of room numbers for these

stoppers. They have since been installed and wooden door stoppers are no longer in use to comply with safety regulations. We acknowledge the risk these pose and spoke with all staff re their use and to inform maintenance/management if any further are required for other residents
Since inspection, outstanding newly employed members of staff have had a fire drill/ evacuation and now feel more competent in knowing what to do in case of fire. Fire safety training will take place on August 6th for pending staff.
Management have amended the fire drill checklist document to reflect the relevant changes such as high-risk scenarios (full compartment evacuation with night time conditions) and more detailed records.

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:
An excessive number and volume of care plans was highlighted and a plan has been made to clarify of information in these care plans. Reducing the number and volume of care plans is a huge task and requires planning, coordination among all nurses and hours of work. We have long term plans to consolidate care plans and reduce the number of steps in care plans to clarify the information within them. These new consolidated care plans will be implanted with new residents when they are created.

The swallow care plan with outdated information has been amended and the importance of only keeping up to date information has been discussed with nursing staff.
It was noted on inspection that out-of-date information in one response behaviour care plan was outdated and incorrect. This was amended to reflect the most up to date information. When care plans are streamlined, it may help ensure accurate information in care plans when they are not duplicated and or lengthy
Nutritional care plans were reviewed and only the most up to date information was retained.
All MDRO care plans were and reviewed and the wording was changed in these care plans and the frameworks to reflect national guidelines.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Following the inspection feedback on the day of inspection, management requested nursing staff to carry out an observational audit of residents who went to bed early to establish the reasons for this and to ensure that residents' choices and preferences were being appropriately supported.
The observational audit identified that some residents chose to go to bed earlier at times due to increased fatigue, while others expressed a preference to retire at different times based on their individual routines and wishes. The findings reinforced the importance of recognising and supporting residents' personal choices while ensuring that any changes in routines are monitored and reflective of their assessed needs and wellbeing.
Residents' choice should always be respected and this has been reinforced with nursing and HCA staff at recent meetings. Residents who have verbally asked to go to bed earlier this has been documented in their care plan.
The registered provider will continue to monitor residents' routines through ongoing review and ensure that residents are supported to make choices regarding their daily lives in line with their preferences and rights.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	01/09/2026
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Substantially Compliant	Yellow	01/09/2026
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 in Schedule 6.	Not Compliant	Orange	08/09/2026

Regulation 18(1)(a)	The person in charge shall ensure that each resident has access to a safe supply of fresh drinking water at all times.	Substantially Compliant	Yellow	22/07/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	22/07/2026
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Not Compliant	Orange	01/09/2026
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	Substantially Compliant	Yellow	01/09/2026

	for inspection by the Chief Inspector.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	20/05/2026
Regulation 25(1)	When a resident is temporarily absent from a designated centre for treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.	Substantially Compliant	Yellow	22/07/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Not Compliant	Red	20/05/2026

Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is implemented in the designated centre, as required.	Not Compliant	Red	20/05/2026
Regulation 27(c)	The registered provider shall ensure that staff receive suitable training on infection prevention and control.	Not Compliant	Red	20/05/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Not Compliant	Orange	28/08/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire	Substantially Compliant	Yellow	01/09/2026

	fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	01/09/2026
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	15/09/2026
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	Substantially Compliant	Yellow	15/09/2026

	the resident concerned and where appropriate that resident's family.			
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	22/07/2026