Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Hillview A
Name of provider:	Peter Bradley Foundation CLG
Address of centre:	Clare
Type of inspection:	Unannounced
Date of inspection:	12 March 2026
Centre ID:	OSV-0001515
Fieldwork ID:	MON-0044612

About the designated centre

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

Hillview A consists of a detached one-storey house located in a housing estate in a town. This designated centre provides a residential neuro-rehabilitation service for up to four residents with an acquired brain injury. Both male and females over the age of 18 can avail of the centre. Each resident has their own bedroom and other rooms in the centre include bathrooms, a kitchen-dining area, a living room and staff rooms. Residents are supported by the person in charge and rehabilitation assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 12 March 2026	08:20hrs to 17:05hrs	Conor Dennehy	Lead

What residents told us and what inspectors observed

This inspection was carried out as a monitoring inspection with the centre having previously been inspected in April 2024. Two members of centre management, two members of staff and the three residents living in this centre were spoken with during this inspection. Good compliance was found during this inspection in key areas regarding the quality and safety of care and support provided to residents. This included areas such as safeguarding and the provision of healthcare. Some regulatory actions, including areas of non-compliance, were identified regarding the timeliness of notifications submitted, the recording of complaints and external painting of the centre.

Hillview A has a capacity for four residents but at the time of this inspection just three residents were living in the centre. It was indicated to the inspector that filling the one vacancy in the centre was currently under consideration. Of the three residents that were living in the centre, the inspector met one of these shortly after the inspection commenced. This resident greeted the inspector with the resident then heard to be wished a happy birthday by management of the centre. The resident later told the inspector that it had been their birthday the day before the inspection and that they had gone out for a dinner with a relative to mark the occasion.

This resident also spoke about going to different day services during the week and liking both. It was further indicated by the resident that they liked living in Hillview A because of the "nice staff" and because the centre was "homely". When asked, the resident said that they felt safe in Hillview A because of the staff in the centre. Some of the things that the resident did included movie nights, making mosaics and quizzes with the resident showing the inspector some planting that they did in the centre's back garden. The resident had an exit door directly off their bedroom which led to this garden with the resident happy with this.

As the morning of the inspection progressed this resident and another resident both left the centre to attend different day services. Before the latter resident had left, the inspector had an opportunity to speak with them. This resident also went to two separate day services during the week where they did things like cooking and computers. The resident informed the inspector that they enjoyed both day services. The resident indicated that they liked living in the centre as they got to meet people. However, the resident also informed the inspector that they would like to live on their own.

The inspector was introduced to the third resident living in this centre later in the morning with the inspector then having a chat with this resident in the centre's living room. This resident told the inspector that they got on with the other residents living in the centre and that the staff were good. The resident indicated that they could have a bit of craic with the other people in the centre. The resident talked about

their life before moving into the centre and said that they "couldn't fault" the centre. It was also mentioned by the resident that they would be going to a medical appointment on the day of inspection. The resident was later supported by a staff member to leave the centre to go to this appointment.

The two residents that had left the centre to attend day services returned to Hillview A before the end of the inspection. Given that both of these residents had been gone for much of the inspection, the overall atmosphere in the centre on the day of inspection was quiet. Staff members and management on duty were found to interact with residents warmly and pleasantly. For example, one resident was brought a cup of tea by a staff member with the staff member then telling the resident when they would next see resident again as the staff member was just going off shift. As the inspector was leaving the centre, he was informed that another staff member would be supporting a resident to go on an outing later that evening to further mark the resident's recent birthday.

In summary, while one resident did indicate that they wanted to live on their own, the feedback from residents living in his centre was positive. Staff and management interacted with residents warmly. Two residents attended day services on the day of inspection while the third was supported to attend a medical appointment with the support of staff. Regulatory actions identified during this inspection will be discussed elsewhere in this report.

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 impacted on the quality and safety of the service being delivered.

Capacity and capability

This inspection found good compliance in areas such as staff training and development. Some regulatory actions were identified though relating to the submission of required notifications and the annual review for the centre.

Registered until August 2027, this designated centre was last inspected by the Chief Inspector of Social Service in April 2024 during which an overall good level of compliance with the regulations was found. The current inspection was conducted to monitor compliance with the regulations in more recent times. Overall, this inspection found residents to be well supported which was reflected in good compliance in areas relevant to the quality and safety of support received by residents as discussed further elsewhere in this report. The provider was monitoring the quality and safety of care and support provided to residents via unannounced visits to the centre and annual reviews. It was noted though that the two most recent annual reviews for the centre did not include contemporary feedback from residents' representatives. It was also found during this inspection that some

required notifications had not being submitted from this centre in a timely manner. For example, two safeguarding matters had not been notified within three working days as required. While these notification matters did not pose a high risk to residents, timely submission of such notification is specifically required by the regulations with such matters impacting overall regulatory compliance on this inspection.

While such matters did need some improvement, the inspection did highlight how appropriate staffing arrangements were provided to support the needs of residents living in the centre. The staff spoken with during this inspection demonstrated a good awareness of residents' needs and were noted to interact appropriately with residents during the inspection. Relevant documentation was generally being maintained for such staff although the inspector did identify some minor areas in need of improvement related to this. Other records reviewed and discussions with two staff members confirmed that staff working in the centre were in receipt of supervision while a system was in operation for staff to seek out-of- hours support if required. Staff facilitated residents' meetings in the centre on a monthly basis where issues such as complaints were discussed while information about complaints was seen to be on display in the centre. Only two complaints had been logged for the centre since the start 2025 although it was noted that the recording of these complaints did not fully comply with regulatory requirements.

Regulation 15: Staffing

Documentation relating to all staff working in a centre must be obtained. This documentation includes written references, full employment histories and evidence of Garda Síochána (police) vetting. During this inspection, documentation relating to three staff members was reviewed with most of the required documentation found to be in place. For one staff member though it was noted that evidence of the staff's identification that included a recent photograph and evidence of a relevant qualification were not in place.

In addition to staff files, staff rotas for a centre must be maintained in planned and actual formats. The inspector was provided with rotas during this inspection which he was informed were maintained in such formats. The inspector reviewed these rotas from 1 November 2025 to 12 March 2026 with these indicating that a good consistency of staff support was provided to residents. These rotas also indicated that appropriate staffing levels were being maintained in the centre to meet the needs of residents. This was further indicated by discussions with staff in the centre and observations on the day of inspection. However, it was noted that the actual rotas provided did not accurately reflect the working hours of the person in charge (PIC) role for the centre throughout 2026. During the feedback meeting for the inspection, management of the centre insisted there was no other errors in the rotas provided.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Under this regulation, staff should be appropriately supervised. During the introduction meeting for this inspection, the inspector was informed that staff working in the centre were to be supervised on a quarterly basis. Both staff members spoken with during this inspection indicated that they had received recent supervision. Supervision records for these two staff along with two other staff members, confirmed that all four of these staff had been supervised during 2026. This provided assurances that staff were being appropriately supervised.

Judgment: Compliant

Regulation 23: Governance and management

An organisational structure was in place for this centre as outlined in its statement of purpose although it was noted that some notified persons participating in management for the centre did not form part of this structure. Staff spoken with during inspection commented positively on local management support for the centre. Such staff also indicated that there was an on-call system in operation to provide out-of-hours support if required with a rota for this on-call support seen to be on display in the staff office. Aside from support for staff, documentation provided confirmed that audits were conducted in specific areas such as medicines management and restrictive practices.

Further documentation reviewed indicated that provider unannounced visits (a key requirement of this regulation) had been conducted for this centre in June 2024, December 2024, June 2025 and November 2025. Such visits must be conducted every six months and must be reflected in written reports. The inspector viewed reports of the three must recent provider unannounced visits and noted that they considered matters related to residents' quality and safety of care and support such as fire safety and medicines management. It was noted though that the report of the December 2024 provider unannounced visit referenced matters from February 2025. This was queried with management of the centre with no explanation for this provided.

Aside from provider unannounced visits, reports were also provided of two annual reviews, another regulatory requirement, that had been conducted for 2024 and 2025. This regulation also requires that annual reviews provide for consultation with residents' representatives. While a section on family feedback was contained within both annual review reports seen, it was noted this was feedback taken from a survey across the provider's services that was conducted between December 2023 and January 2024. As such, neither the 2024 nor the 2025 annual reviews contained

any direct contemporary feedback from residents' representatives that was specific to this designated centre. The 2025 annual review also seemed to include some matters that were not relevant to Hillview A for that year. For example, a section of notifications submitted for 2024 was present that did not reflect notifications received from this centre.

While such matters did need improvement, no concerns were identified around the quality and safety and care and support provided to residents during this inspection. This was evidenced by the findings under key regulations, as discussed further elsewhere in this report. Such findings were contributed to by the resources provided for the centre. These resources included the provision of appropriate staffing and access to transport. Residents availed of this transport on the day of inspection to go to day services and to attend a medical appointment.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

To comply with this regulation, certain events must be notified to the Chief Inspector within specific time-frames. This includes any allegations of abuse, which must be notified within three working days, and any use of restrictive practices, which must be notified on a quarterly basis. Documentation received during this inspection confirmed that two matters of a safeguarding nature had been reported on 10 February 2026. However, neither of these were notified to the Chief Inspector until 19 February 2026. In addition, the centre's restrictions log listed a restrictive practice relating to a resident's finances. This was entered on the restrictions log in November 2025 and was still in use at the time of this inspection. Despite this, it had not been notified to the Chief Inspector as being in use during the fourth quarter of 2025 in a relevant quarterly notification that was submitted to the Chief Inspector on 30 January 2026.

Judgment: Not compliant

Regulation 32: Notification of periods when the person in charge is absent

Under this regulation, where a PIC is absent from a centre due to an emergency or unanticipated event for 28 days or more, the registered provider must notify the Chief Inspector of the absence. Such a notification must be submitted as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more. The provider had submitted a notification of such an absence on 22 January 2026 for the previously notified PIC for the centre. While this notification did appoint a replacement PIC, the notification also indicated that the absence was unexpected and that the absence started on 14 January 2026. However, during this inspection

the inspector was informed that the absence of the previously notified PIC for the centre commenced in mid-December 2025 and not 14 January 2026 as was indicated in the notification submitted. As such, the inspector was not assured that the notification had been submitted as soon as it became apparent that the absence concerned was for 28 days or more.

Judgment: Not compliant

Regulation 34: Complaints procedure

Under this regulation, a record of all complaints made including details of any investigation into such complaints, the outcome of complaints, any action taken on foot of complaints and whether or not the resident who complained was satisfied must be maintained. When reviewing the complaints register for the centre it was noted that two complaints had been logged since the beginning of 2025. For one of these complaints, follow up action taken in response to the complaint had been documented but it was not recorded in the complaints register if the resident who complained was satisfied or not with the outcome.

The second complaint had been made by another resident in May 2025. This related to the resident not being happy in their current placement and wanting to live independently. This complaint was indicated as not being resolved and it was not recorded in the complaints records provided what the outcome or current status of follow up action taken in response to the complaint had been. As such, the recording of these two complaints was not consistent with regulatory requirements with a similar finding having been made during the April 2024 inspection.

Regarding the May 2025 complaint, when queried, the currently appointed PIC for the centre informed the inspector that the resident was engaged with an independent advocate about this matter. It was also indicated that efforts were being made with the resident to improve their skills for managing a particular health issue to help them to live independently. Aside from this, complaints was indicated being discussed with residents in two residents' meetings that had taken place in January 2026 and February 2026. Information around the centre's complaints processes was seen to be on display in the centre.

Judgment: Substantially compliant

Quality and safety

The health needs of residents were found to be well supported. A risk register and risk assessments were in place. Appropriate responses had been taken in response to safeguarding matters that had been raised.

No safeguarding concerns were identified during this inspection with some safeguarding matters raised earlier in 2026 found to have been responded to appropriately. As part of this response, relevant safeguarding plans were put in place where required with follow up action taken in line with these plans. Staff had completed training in safeguarding and were aware of how to report any safeguarding concerns. Such staff had also completed training in fire safety and participated in fire drills for the centre with residents also involved in these. It was noted though that some recent recorded evacuation times for the centre were over a specific target time for these drills. The centre was equipped with fire safety systems such as a fire alarm and a fire extinguishers. The fire safety systems in the centre were subject to maintenance checks by external contractors

Fire safety was reflected in the centre's risk register while risk assessments were in place for identified risks relating to individual residents. This included matters related to residents' health needs. Guidance on supporting residents' health needs was contained within residents' personal plans with staff displaying a good knowledge of how to support residents with these. The personal plans reviewed also contained recently reviewed guidance on supporting residents' other needs. Goals were identified for residents through the personal planning process but there was variance noted in the review and recording of these goals. Aside from this, limited restrictions were present in the centre which was positively noted. The premises of the centre was generally seen to be well presented internally but the external of the premises needed some painting.

Regulation 11: Visits

Based on the space and rooms available in the centre, sufficient communal and private space was present within the centre for residents to receive visitors. One resident told the inspector that they received visits from a family member while staff also referenced how another resident received visits from their relatives. Some documentation reviewed related to a recent notification received from the centre referenced that one resident was to be supported to create a list related to visitors that they wanted to receive in the centre. This list was not created at the time of the inspection but it was acknowledged that the due date for this was the day after this inspection occurred.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises provided for residents to live in was seen to be well-furnished and homelike on the day of inspection. For example, the centre's living room was provided with a fireplace, a television and couches while each resident had their own individual bedrooms. Such bedrooms were personalised to the residents. Records provided indicated that facilities and equipment present in the centre had been serviced to ensure that they were working as intended. For example, the centre's boiler had been serviced in February 2026 while the electrical installations in the centre had been serviced in August 2025. Given the needs of one resident with regards to their diagnosis of diabetes, there was some clinical waste in the centre but the arrangements for the disposal of this waste were outlined to the inspector.

However, while the premises that made up Hillview A was generally seen to be reasonably maintained, some areas were noted which needed improvement. These included:

- A tap in a resident's en suite bathroom was in need of replacing as it was visibly worn, marked and grimy.
- The external parts of the premises needed painting. This was evidenced by some parts of the external walls being chipped, weathered or worn while moss was evident on some window sills.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

A risk register was in place for this centre that had been reviewed in March 2026 and contained risk assessments relating to identified risks for the centre overall. Each assessment described the potential impact from the individual risks identified, outlined existing controls in place to mitigate the risks and highlighted any additional actions that were required. When reviewing the risk register, it was noted that it included risks such as slips, trips and falls, fire safety and adverse weather. Identified risks for individual residents were outlined in risk assessments for these residents that were contained within the residents' personal plans. During the inspection, the inspector reviewed the personal plans of two residents and found that the risk assessments contained within them reflected the outlined needs of residents and notifications that had been received from the centre since the April 2024 inspection.

Judgment: Compliant

Regulation 28: Fire precautions

The fire evacuation procedures to be followed in the centre were seen to be on display just inside the centre's front door. Based on records provided during this inspection, fire drills had taken place regularly in the centre during 2025 and 2026. It was noted that some of the fire drill records for 2025 recorded higher evacuation times. When the inspector queried this, he was informed that this was due to one resident with increased mobility needs who no longer lived in the centre. Two fire drills had been conducted for 2026 that involved the current three residents of the centre. One of these fire drill records indicated that the target evacuation time was 2:45minutes.

However, for both 2026 fire drills the recorded evacuation time was higher than this with the most fire drill in February 2026 indicating an evacuation time of 5:15minutes. The record of this drill indicated that one resident had some difficulty in opening a fire exit but that following the drill staff demonstrated to the resident how to open the door correctly. The same resident also had a January 2026 personal emergency evacuation plan in place (PEEP) which outlined the supports they needed to evacuate the centre. It was noted though that this PEEP made no reference to a particular mobility aid used by the resident nor had it had been updated to reflected the outcome of the two 2026 drills.

All staff working in the centre had completed fire safety training based on a training matrix provided. Such staff also completed daily checks on the fire safety systems in place throughout 2026 based on logs reviewed by the inspector. The fire safety systems that were present in the centre included emergency lighting, a fire blanket, fire extinguishers and a fire alarm. Further records provided during this inspection confirmed that these fire systems were receiving maintenance checks by external to ensure that they were in proper working order. For example, the fire extinguishers and fire blanket had received an annual maintenance check in October 2025.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

A designated centre's residents must have individualised personal plans which are explicitly required under this regulation. These personal plans are intended to outline guidance for staff in how to meet the health, personal and social needs of residents. During this inspection, the inspector reviewed two residents' personal plans. It was noted that both personal plans had been recently reviewed and contained various guidance on supporting the needs of residents in areas such as their intimate personal care and health. These personal plans were also subject to an annual review and as part of the personal planning process, goals were identified for residents to help with their rehabilitation from an acquired brain injury. However, for one resident it was noted that the goals identified for them had a due date of 1 September 2025 but no actions were listed for supporting the resident with their goals while it was not recorded if these goals had been achieved or not. When queried, the inspector was informed that these goals had been reviewed since 1

September 2025 but that there may have been some issues in how this had been recorded.

Judgment: Substantially compliant

Regulation 6: Health care

When reviewing two residents' personal plans, it was seen that they contained recently reviewed guidance on how to support these residents' assessed health needs in areas such as diabetes and epilepsy. One of these residents required particular support with their diabetes and it was seen that the resident's diabetes care plan contained detailed information on the supports that the resident needed on a daily basis for this. A staff member spoken with about the resident's diabetes, displayed a very strong knowledge of the supports this resident needed in this area. The information provided by this staff member was consistent with the resident's diabetes care plan. Further records reviewed also confirmed that the same resident had been supported to avail of a national screening service related to their diabetes during 2025 and 2026. Another resident was supported by staff to attend a physiotherapist appointment on the day of inspection.

It was noted though when reviewing risk assessments for the centre, that a high/red rated risk had been identified for the centre relating to access to clinical services. When queried with management of the centre, it was indicated that this primarily related to the centre not having direct access to a psychologist for the region where the centre was located. The inspector was further informed that this had been escalated internally within the provider and that recruitment efforts were ongoing. When queried if the absence of a psychologist for the region where the centre was located had any impact on the residents currently living in Hillview A, the inspector was informed that it had not. It was also highlighted that the centre could access support from another psychologist in a different region.

Judgment: Compliant

Regulation 7: Positive behavioural support

There was clear indications that the provider was promoting a restraint free environment in this centre. Two restrictive practices were listed on the centre's restrictions log. Both of these had been reviewed by a behaviour support specialist in February 2026 which resulted in one of these restrictive practices being recently discontinued. The other listed restrictive practice related to a resident's finances with documentation provided around this outlining the rationale for its use and how this practice was to be managed. Aside from this, on the day of inspection the inspector did observe that the door to a room where the centre's boiler was located was

locked. However, it was noted that the key to this was located beside this room's door with management of the centre advising that residents could use this key themselves which meant it was not restrictive. No other restrictive practices was observed during this inspection nor highlighted by staff and management spoken with.

Judgment: Compliant

Regulation 8: Protection

Two matters of a safeguarding nature had been notified from this centre during 2026. Documentation relating to these two safeguarding matters was reviewed during this inspections which confirmed that these safeguarding matters had been subject to preliminary screenings with safeguarding plans out in place in response. This provided assurances that appropriate safeguarding procedures in keeping with relevant national safeguarding policy were being followed within the centre. In addition, it was noted that the measures outlined in safeguarding plans were being implemented. For example, a new door bell had been installed at the front door of the centre in response to one of the safeguarding matters from 2026.

Information about safeguarding processes to be followed was seen to be on display in the centre. This included details of a designated officer for the centre. A designated officer reviews safeguarding concerns but it was noted that the individual highlighted as holding this role had been on period of absence since December 2025. While the information on display had not been updated to reflect this, when queried, the inspector was informed that another designated officer was in place for this centre. It was also noted that the staff spoken with during this inspection were aware of who to report a safeguarding concern if required. All staff working in the centre had completed safeguarding training based on a training matrix reviewed during the inspection.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 32: Notification of periods when the person in charge is absent	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Hillview A OSV-0001515

Inspection ID: MON-0044612

Date of inspection: 12/03/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: A review of staff documentation will be conducted to ensure all staff documentation is all up to date. Any actions because of this review will be implemented in a timely manner. The rota for the residence has been updated to reflect the actual working hours of the PIC in the residence and will indicate going forward; when they are absent or working elsewhere.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The annual reviews will include feedback from resident representatives specific to Hillview A and will only include matters relevant for that year. • All administrative errors to be corrected in 6 monthly reports.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The PIC and Provider wish to assure the Chief Inspector that all notifiable incidents, respective of the timeline and frequency for submission, will be submitted in a timely and correct manner.	
Regulation 32: Notification of periods when the person in charge is absent	Not Compliant
Outline how you are going to come into compliance with Regulation 32: Notification of periods when the person in charge is absent:	

The Provider wishes to reassure the Chief Inspector that going forward, if the PIC will be absent for more than 28 days, Provider will notify the Chief Inspector of their absence as soon as this absence becomes apparent.

Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: The PIC and provider wish to assure the Chief Inspect that from the 01.04.2026 any complaints recorded will be kept up to date in respect of status, follow ups, outcome and closure. The outcome will also be noted if resident is satisfied with the outcome and if not; that they will be provided with information to appeal.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The tap that was identified as needing to be replaced will be and a check of all other taps will take place to determine need for replacement. Outside of the premises will be cleaned and painted.	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: All PEEPS have been updated to reflect the mobility aid that is required for resident and support will be provided to ensure all residents can exit during an evacuation in a timely manner. PEEPs specifically indicate if residents need support to open the thumb locks on the doors.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The PIC wishes to assure the Chief Inspector that as of 01.04.2026, that the outstanding review date for goals has been inputted and that this will be kept up to date going forward.	

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(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Substantially Compliant	Yellow	13/03/2026
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	01/05/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	01/06/2026

Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	01/07/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	13/03/2026
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	30/03/2026
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated	Not Compliant	Orange	30/03/2026

	centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 32(3)	Where the person in charge is absent from the designated centre as a result of an emergency or unanticipated event, the registered provider shall, as soon as it becomes apparent that the absence concerned will be for a period of 28 days or more, give notice in writing to the chief inspector of the absence, including the information referred to in paragraph (2).	Not Compliant	Orange	01/04/2026
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	01/04/2026
Regulation 05(6)(c)	The person in charge shall ensure that the	Substantially Compliant	Yellow	01/05/2026

	personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.			