



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

## Issued by the Chief Inspector

Name of designated centre:	Rivendell
Name of provider:	Nua Healthcare Services Limited
Address of centre:	Carlow
Type of inspection:	Announced
Date of inspection:	09 October 2025
Centre ID:	OSV-0007758
Fieldwork ID:	MON-0039337

## About the designated centre

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

Rivendell is a designated centre operated by Nua Healthcare Services Limited. It provides care and support for up to four adults whom require support with autism, intellectual disabilities, borderline personality disorders and/or individuals who exhibit behaviours that challenge. The centre is a two storey building comprising of four individual self-contained apartments located in a rural area of Co. Carlow. The centre has access to a variety of local amenities including hairdressers, a library, local parks, a community centre, horse riding centre, GAA clubs, and a selection of restaurants and social groups. The staff team consists of social care workers and support workers. The staff team are supported by a person in charge.

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

Number of residents on the date of inspection:	4
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and 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 9 October 2025	09:30hrs to 17:00hrs	Karen McLaughlin	Lead
Thursday 9 October 2025	09:30hrs to 17:00hrs	Kieran McCullagh	Support

## What residents told us and what inspectors observed

This report outlines the findings of an announced inspection of designated centre, Rivendell. This inspection was carried out to inform decision making in response to the provider's application to renew the centre's registration.

Inspectors used observations and discussions with residents, in addition to a review of documentation and conversations with key staff, to form judgments on the residents' quality of life. Overall, this inspection found that this centre was meeting the requirements of the Regulations in all areas looked at.

The centre comprised of a large property containing three apartments and one standalone unit to the rear. It was located in the Carlow countryside and is operated by Nua Healthcare Services. The centre is currently registered to accommodate up to four residents at any time. At the time of the inspection there were no vacancies.

The person in charge was present to facilitate the inspection. Inspectors were shown around the premises by the person in charge, who was knowledgeable and familiar with the assessed needs of residents. The centre was observed to be a clean and tidy, warm and comfortable environment. The premises were seen to be well maintained and nicely decorated.

Each resident had their own apartment which was decorated in line with their preferences and wishes, and inspectors observed the rooms to include memorabilia that was important to each resident. Furthermore residents had access to the communal areas of the property and the gardens.

All residents were aware of the inspection visit and were supported to meet with and talk to the inspectors. They met with three of the residents who were present on the day of the inspection, the other resident was out for the day with staff as per their personal plan. Two residents showed the inspectors around their respective apartments. One resident told the inspectors that they were happy living in the centre and enjoy accessing the community to go shopping or for coffee.

Residents were observed receiving a good quality person-centred service that was meeting their needs. Inspectors observed residents coming and going from their home during the day. Staff were observed to be responsive to residents' requests and assisted residents in a respectful manner. Residents were being supported to partake in a variety of different leisure, occupational, and recreation activities in accordance with their interests, wishes and personal preferences. For example, when inspectors asked staff what activities do residents enjoy participating in, they were told that residents enjoy bowling, movie nights, shopping, fishing, getting manicures, concerts and attending music festivals.

Inspectors spoke with two members of staff on duty on the day of inspection. They both spoke about the residents warmly and respectfully, and demonstrated a rich

understanding of the residents' assessed needs and personalities and demonstrated a commitment to ensuring a safe service for them.

Inspectors did not have an opportunity to meet with the relatives of any of the residents, however a review of the provider's annual review of the quality and safety of care evidenced that they were happy with the care and support that the residents received. One of the residents advocate visited on the day of inspection and spoke to the inspectors about the care provided. They said they were happy with the service provided and the quality of care is excellent.

The inspection found that residents in this centre were supported to enjoy a good quality of life which was respectful of their choices and wishes. The person in charge and staff were striving to ensure that residents lived in a supportive environment. It was clear that residents' views and wishes were listened to and that their autonomy was respected.

The next two sections of this report present the findings of this inspection in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being provided.

## Capacity and capability

The purpose of this inspection was to monitor ongoing levels of compliance with the regulations and, to contribute to the decision-making process for the renewal of the centre's registration. This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided.

Overall, the findings of this announced inspection were that residents were in receipt of a good quality and safe service, with good local governance and management supports in place.

Inspectors found that the provider had implemented management systems which were effective in providing oversight of risks in the service and in ensuring that residents were afforded choice over their decisions and were in receipt of a good quality and person-centred service.

There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The registered provider had implemented management systems to monitor the quality and safety of services provided to residents including annual reviews and six-monthly reports.

The provider ensured that there were suitably qualified, competent and experienced staff on duty to meet residents' current assessed needs. There was a regular core staff team in place and they were knowledgeable of the needs of the residents and

had a good rapport with them. There was a planned and actual roster maintained for the designated centre. Rotas were clear and showed the full name of each staff member, their role and their shift allocation. However, some improvements were required in relation to information and documentation required by staff currently employed at the designated centre.

Staff completed relevant training as part of their professional development and to support them in their delivery of appropriate care and support to residents. The person in charge provided support and formal supervision to staff working in the centre.

Records set out in the schedules of the regulations were made available to the inspectors on the day of inspection. When reviewed by the inspectors these were found to be accurate and up to date including an accurate and current directory of residents, a record of attendance for staff training and a maintenance record of fire-fighting equipment.

Furthermore, an up-to-date statement of purpose was in place which met the requirements of the regulations and accurately described the services provided in the designated centre at this time.

The provider had effected a contract of insurance against injury to residents and had submitted a copy of their insurance policy to support the application for renewal of the centre's certificate of registration.

The provider had a complaints policy and associated procedures in place as required by the regulations. The inspectors reviewed how complaints were managed in the centre and noted there were up-to-date logs maintained.

Overall, this inspection found that systems and arrangements were in place to ensure that residents received care and support that was safe, person-centred and of good quality.

### Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted a complete application to the Chief Inspector of Social Services, for the renewal of the designated centre's registration.

One inspector reviewed the application prior to this inspection. All required information and documentation specified in Schedule 2 and Schedule 3 were included in the application.

Additionally, the provider ensured that the fee for renewing the registration of the designated centre, as outlined in Section 48 of the Health Act 2007 (as amended), was paid in full.

Judgment: Compliant

## Regulation 15: Staffing

On the day of the inspection, the provider had ensured that there was a sufficient number of staff with the appropriate skills, qualifications, and experience to meet residents' needs at all times, in alignment with the statement of purpose and the centre's size and layout. However, improvements were needed regarding the information and documentation related to staff currently employed at the designated centre.

The person in charge was supported in their role by two shift lead managers, while the staff team included assistant support workers and relief personnel. Inspectors spoke to the person in charge, and to four staff members on duty, and found that they were all knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

Effective roster management, conducted by the person in charge, ensured appropriate staffing levels. A review of July and August 2025 rosters confirmed consistent deployment of regular staff, maintaining continuity of care for residents. Vacant shifts were covered using a small, managed pool of relief staff. Roster documentation was accurate and comprehensive, reflecting all staffing details, including full staff names for all shifts.

Improvements were necessary to ensure that robust recruitment procedures were implemented, including thorough checks and full employment history. For example, following an inspector's review of documents outlined in Schedule 2, there was a six- year employment history gap for one staff file reviewed.

Judgment: Substantially compliant

## Regulation 16: Training and staff development

There was a system in place to evaluate staff training needs and to ensure that adequate training levels were maintained.

All staff were up to date in training in required areas such as safeguarding vulnerable adults, infection prevention and control, manual handling and fire safety.

Staff had also completed human rights training to further promote the delivery of a human rights-based service in the centre.

Furthermore, staff had completed additional training in behaviour support,

communication, autism awareness, risk assessment and mental health awareness.

Supervision records reviewed by the inspectors were in line with organisation policy and inspectors found that staff were receiving regular supervision as appropriate to their role.

Judgment: Compliant

### Regulation 21: Records

On the day of the inspection, records required and requested were made available to the inspectors.

Records viewed pertaining to Schedule 3 and 4 were correct and in order and inspectors found that records were appropriately maintained.

Inspectors reviewed the designated centre's statement of purpose, residents' guide, fire safety log, including a record of drills and the testing of equipment. A record of all complaints made by residents or their representatives or staff concerning the operation of the centre was also maintained as per the requirements of the regulations.

The sample of records reviewed on inspection, reflected practices in place.

Judgment: Compliant

### Regulation 22: Insurance

The service was sufficiently insured to cover accidents or incidents. The necessary insurance documentation was submitted as part of the application to renew the centre's registration.

Upon review, one inspector confirmed that the insurance policy covered the building, its contents, and residents' personal property.

Additionally, the insurance also provided coverage for risks within the centre, including potential injury to residents.

Judgment: Compliant

### Regulation 23: Governance and management

The governance and management systems in place had ensured care and support was delivered to residents in a safe manner and that the service was consistently and effectively monitored. There were effective leadership arrangements in place in this designated centre with clear lines of authority and accountability.

There was clear evidence of consistent oversight and monitoring of the care and support provided within the designated centre, with regular management presence on-site. There was suitable local oversight and the centre was sufficiently resourced to meet the needs of all residents. The staff team was led by an appropriately qualified and experienced person in charge. The person in charge worked full-time and was based in the centre. They demonstrated a comprehensive understanding of the service needs and of the residents' needs and preferences. The inspectors saw that there were systems in place to support the person in charge in fulfilling their regulatory responsibilities. They were supported by a director of operations who in turn reported to a deputy chief operating officer.

A series of audits were in place including monthly local audits (fire safety, staff training, medication management and maintenance) and six-monthly unannounced visits. These audits identified any areas for service improvement and action plans were derived from these.

There were effective arrangements for staff to raise concerns. Staff spoken with told the inspectors that they could raise any concerns with the management team. In addition to the support and supervision arrangements, staff attended team meetings which provided a forum for them to raise any concerns.

The provider was adequately resourced to deliver a residential service in line with the written statement of purpose. For example, there was sufficient staff available to meet the needs of residents, adequate premises, facilities and supplies and residents had access to three transport vehicles.

Judgment: Compliant

### Regulation 3: Statement of purpose

As part of the application to renew the registration of the designated centre, the provider submitted a statement of purpose that clearly described the services offered and met the regulatory requirements.

One inspector reviewed the statement of purpose and found that it clearly outlined the care model and the support provided to residents, as well as the day-to-day operations of the designated centre. The statement of purpose was made accessible to the inspector during the inspection and was also made available to residents and their representatives in a format that suited their communication needs and preferences.

Additionally, a walk-around of the designated centre confirmed that the statement of purpose accurately reflected the available facilities, including room sizes and their intended functions.

Judgment: Compliant

### Regulation 34: Complaints procedure

The registered provider had provided an effective complaints policy and procedure. The procedure was in accessible format for residents to understand. Residents were supported to make complaints and had access to independent advocacy services.

There was an up-to-date complaints log and procedure available in the centre. This was in easy-to-read format and accessible to all.

One inspector reviewed the log and found that complaints were being responded to and managed locally. Furthermore compliments were also recorded.

Judgment: Compliant

### Quality and safety

This section of the report provides an overview of the quality and safety of the service provided to the residents living in the designated centre. Overall, the findings of this inspection were that residents reported that they were happy and felt safe.

The provider and the person in charge were operating the centre in a manner that ensured residents were in receipt of a service that was person-centred, which offered a comfortable and homely place to live. It was apparent to inspectors that the residents' quality of life and overall safety of care in the centre was prioritised and managed in a human rights-based and person-centred manner.

Inspectors found the atmosphere in the centre to be warm and relaxed, and residents appeared to be happy living in the centre and with the support they received.

The premises was clean, bright, homely, nicely-furnished, and laid out to the needs of the residents living there. The provider had endeavoured to make the living arrangements for residents as homely and personalised as possible throughout. There were adequate private and communal spaces for residents to enjoy.

The person in charge had ensured that residents' health, personal and social care

needs had been assessed. The assessments informed the development of care plans and outlined the associated supports and interventions residents required. Residents were receiving appropriate care and support that was individualised and focused on their needs.

There were comprehensive communication plans in place that gave clear guidance and set out how each person communicated their needs and preferences. Throughout the inspection, inspectors observed that staff demonstrated flexibility and adaptability in their use of various communication strategies. Information was made available to residents in a way that they could understand in order to support them to make informed choices and decisions.

Positive behaviour support plans were developed for residents, where required. The plans were up to date and readily available for staff to follow. Staff had also completed training in positive behaviour support to support them in responding to behaviours of concern.

Residents' well-being and welfare was maintained by a good standard of evidence-based care and support practices.

The service was operated through a human rights-based approach to care and support, and residents were being supported to live their lives in a manner that was in line with their needs, wishes and personal preferences. Residents' daily plans were individualised to support their choice in what activities they wished to engage with and to provide opportunity to experience live in their local community.

The provider had implemented measures to identify and assess risks throughout the centre. All resident risk assessments were individualised based on their needs. There was a risk management policy in place. Overall, risks identified in the centre were appropriately managed and reviewed as part of the continuous quality improvement to enable effective learning and mitigate against risk.

There were fire safety systems and procedures in place throughout the centre. There were fire doors to support the containment of smoke or fire. There was adequate arrangements made for the maintenance of all fire equipment and an adequate means of escape and emergency lighting provided.

On review of residents' medical records, inspectors found that medications were administered as prescribed. Residents' medication was reviewed at regular specified intervals as documented in their personal plans and the practice relating to the ordering; receipt; prescribing; storing; disposal; and administration of medicines was appropriate.

Overall, inspectors found that the day-to-day practice within this centre ensured that residents were receiving a safe and quality service, delivered by a stable, consistent team of suitably qualified staff.

## Regulation 10: Communication

The provider demonstrated respect for core human rights principles by ensuring that residents could communicate freely and were appropriately assisted and supported to do so in line with their assessed needs and wishes.

Residents had communication care plans in place which detailed that they required additional support to communicate. Each resident had an up-to-date communication passport. Inspectors reviewed two of these passports on the day of the inspection and found that they accurately described the residents respective communication styles and supported their communication needs.

All staff spoken with during the course of the inspection demonstrated comprehensive knowledge of residents' needs, personal preferences, communication needs and how they expressed choice and preference.

Staff were observed to be respectful of the individual communication style and preferences of the residents as detailed in their personal plans.

Residents had access to telephone and media such as radio and television.

Furthermore Communication aids, including augmentative technology and a VR (Virtual Reality) Headset, had been implemented in line with residents' needs and were readily available in the centre.

Judgment: Compliant

## Regulation 13: General welfare and development

The registered provider had ensured that residents had sufficient access to facilities for recreation, and opportunities to participate in activities in line with their interests, capacities, and wishes.

Residents' daily plans were individualised to support their choice in what activities they wished to engage with and to provide opportunity to experience life in their local community.

All residents had their own personalised day service provision and had access to transport and the community when they wanted. They were supported to access activities pertaining to their own likes and interests such as going to the cinema, shopping, coffee, Pride events, going on holidays and to visit family, Powerscourt waterfall, accessing hairdressers and barbers.

There was evidence that the designated centre was operated in a manner which was respectful of all residents' rights. Residents were observed engaging in activities

of their choice together such as mealtimes and going on outings in the community.

Staff were observed to be available to residents should they require any support and to make choices.

Judgment: Compliant

### Regulation 26: Risk management procedures

Inspectors found that the provider had ensured that their risk management policy safeguarded residents living in the designated centre. The risk management policy was recently reviewed and was next due review in November 2027.

One inspector reviewed the policy and procedure on risk management which evidenced that the provider had ensured that the risk management policy had arrangements in place for the identification, assessment, mitigation, monitoring, recording, and escalation of risk. The provider also ensured that the policy included all necessary information in accordance with regulatory requirements. For instance, it contained detailed information on managing the unexpected absence of a resident, accidental injuries, and self-harm.

In line with the risk management policy, there was a centre specific risk register in place which was reviewed by one inspector. The risk register detailed potential risks in the centre as well as the measures in place to reduce or eliminate them.

On the day of this inspection, inspectors found that each residents' safety, health and wellbeing was supported through individual risk management plans. Risk management plans included appropriate measures and actions in an attempt to control and mitigate identified risks. For instance, where risks were identified for a resident relating to behaviours that challenge, the provider had put a number of appropriate controls in place some of which included the provision of staff training in positive behavioural supports. In addition, the resident was provided with a multi element behaviour support plan (MEBSP).

Where risks were identified for a resident during times in the community, the provider had put in place a number of measures to control the risk. For example, two to one ratio of staffing support for the resident, and staff were required to follow the resident's support care plans.

Judgment: Compliant

### Regulation 28: Fire precautions

The provider had taken appropriate steps to mitigate the risk of fire by

implementing effective fire prevention and oversight measures. During this inspection, inspectors observed that the designated centre was equipped with fire and smoke detection systems, emergency lighting, and firefighting equipment. A review of maintenance records by one inspector confirmed that these systems and equipment were subject to regular checks by staff, and inspections and servicing by a specialist fire safety company.

Inspectors noted that the fire panel was addressable and easily accessible in the staff office in the designated centre. Additionally, information pertaining to fire zones were readily available and accessible to the staff team in the event of an emergency. One inspector observed that all fire doors, including bedroom doors, closed properly when the fire alarm was activated. Furthermore, all fire exits were equipped with thumb lock mechanisms, which ensured prompt evacuation in the event of an emergency.

The provider had implemented comprehensive measures to ensure that each resident was aware of fire safety procedures. For instance, one inspector reviewed the personal evacuation plans of all four residents living in the designated centre. Each plan had been recently updated, and outlined the specific support required to assist residents during an evacuation, both during the day and at night.

The inspector also examined the fire safety records, including fire drill documentation, and confirmed that regular fire drills were conducted in accordance with the provider's established policy. The provider demonstrated that they were capable of safely evacuating residents under both daytime and nighttime conditions.

Judgment: Compliant

## Regulation 29: Medicines and pharmaceutical services

There were safe practices in relation to the ordering, receipt and storage of medicines. There was a system in place for return of out of date medicines to the pharmacy. The medication administration records clearly outlined all the required details including; known diagnosed allergies, dosage, doctor's details and signature, and method of administration.

The provider had appropriate lockable storage in place for medicinal products and a review of medication administration records indicated that medicines were administered as prescribed.

Medication audits were being completed as per the providers policy and any recommendations or findings from audits were a topic discussed within staff meetings.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

One inspector reviewed four residents' files and saw that files contained up-to-date and comprehensive assessments of need. These assessments of need were informed by the residents, their representative and the multidisciplinary team as appropriate. The assessments of need informed comprehensive care plans which were written in a person-centred manner and detailed residents' preferences and needs with regard to their care and support. For instance, the inspector observed plans on file relating to mental health, positive behaviour support, communication, money management, and healthcare related plans.

Staff who spoke with inspectors demonstrated full awareness of residents' personal plans and the care support plans that were in place to empower the residents to live as independently as they possibly could.

Judgment: Compliant

## Regulation 7: Positive behavioural support

Inspectors found that there were arrangements in place to provide positive behaviour support to residents with an assessed need in this area. For example, three multi element behaviour support plans (MEBSP) reviewed by one inspector were detailed, comprehensive and developed by an appropriately qualified person. In addition, each plan included information pertaining to precursor behaviours, triggers and setting events in order to minimise and reduce the risk of behaviours of concern from occurring.

The provider ensured that staff had received training in the management of behaviour that is challenging and received regular refresher training in line with best practice. Staff spoken with were very knowledgeable of support plans in place and inspector observed kind, caring, and positive communications and interactions throughout the inspection between the residents and staff.

There were a high number of restrictive practices used in this centre. However, one inspector completed a thorough review of these and found they were the least restrictive possible and used for the least duration possible. Restrictive practices in use had been notified to the Chief Inspector on a quarterly basis in line with the regulations. Additionally, each resident had on file a detailed "Restrictions Passport" which was in an easy-to-read format and provided detailed information on each restrictive practice in use.

Inspectors found that provider and person in charge were promoting residents' rights to independence and a restraints free environment. For example, all restrictive practices in use were reviewed by the person in charge and the behaviour specialist

on a quarterly basis. Minutes of the most recent meeting reviewed by one inspector evidenced that meetings were used as an opportunity to review all restrictions and explore in detail the justification and rationale for the use of restrictive practices in place.

Inspectors found that all restrictive practices were appropriately risk assessed, as per the provider's policy, clearly documented, and appropriate multidisciplinary professionals were involved in the assessment and development of the evidence-based interventions with the resident.

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
<b>Capacity and capability</b>	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
<b>Quality and safety</b>	
Regulation 10: Communication	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant

# Compliance Plan for Rivendell OSV-0007758

Inspection ID: MON-0039337

Date of inspection: 09/10/2025

## Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and 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
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ol style="list-style-type: none"> <li>1. The Person in Charge (PIC) supported by HR, will review all Team Member files to ensure each contains full employment history and all relevant vetting forms. Due Date: 10 December 2025</li> <li>2. Any missing documentation will be requested from the Team Member and filed. Due Date: 15 December 2025</li> <li>3. A member from the Quality Assurance team will conduct an audit on the files once the Person in Charge and HR have confirmed completion of the above two actions in order to ensure compliance. Due Date: 19 December 2025</li> </ol>	

**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).

<b>Regulation</b>	<b>Regulatory requirement</b>	<b>Judgment</b>	<b>Risk rating</b>	<b>Date to be complied with</b>
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	07/12/2025