



**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:	Tara Winthrop Private Clinic
Name of provider:	Tara Winthrop Private Clinic Ltd.
Address of centre:	Nevinstown Lane, Pinnock Hill, Swords, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	19 May 2026
Centre ID:	OSV-0000183
Fieldwork ID:	MON-0050067

About the designated centre

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

Tara Winthrop private Clinic is situated close to the village of Swords, Co Dublin. The centre provides nursing care for low, medium, high and maximum dependency residents over 18 years old. The centre is organised into five units made up of 136 beds of which 112 are en-suite bedrooms. There are eight sitting room areas and six dining room areas and at least 15 additional toilets all of which are wheelchair accessible. The centre is set in landscaped grounds with a visitor's car park to the front of the building. It is serviced by nearby restaurants, public houses, library, cinemas, community halls, the Pavilions Shopping Centre, a large variety of local shops, retail park and historical sites of interest and amenity such as Swords Castle, Newbridge House and Demense, Malahide Castle and Demesne.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	116
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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
Tuesday 19 May 2026	07:50hrs to 17:15hrs	Sarah Armstrong	Lead
Tuesday 19 May 2026	07:50hrs to 17:15hrs	Sharon Boyle	Support
Tuesday 19 May 2026	07:50hrs to 17:15hrs	Bernadette McDonald	Support

What residents told us and what inspectors observed

Overall, the inspectors found that residents living in Tara Winthrop Private Clinic were well cared for and supported to enjoy a good quality of life by a team of dedicated staff. Feedback received from residents was mostly positive, with residents being particularly complimentary of the staff working in the centre and the food provided. One resident told inspectors "the nurses are terrific", and another said "the food is very good - I actually like it too much!". However, some residents expressed dissatisfaction with aspects of the service they received, including delayed call-bell response times and poor staff manual handling practices.

The inspectors also spoke with members of the staff team. Most staff who spoke with the inspectors said they liked working in the centre and felt they had good support from the management team. Whilst staff felt that the day-time staffing levels were sufficient, some staff commented that staffing levels in the evenings did not support residents to have their needs met in a timely manner. Staff also spoke of positive changes they had noted since the last inspection in November 2025, including improved workplace culture and better supports for staff members. Staff told inspectors that these improvements had made them more comfortable and empowered to speak up about any concerns they had in respect of the service provided to residents.

The feedback from visitors was mixed. Some visitors who spoke with the inspectors reported that they were very happy with the care their relative was receiving and said that the staff were always approachable if they had any questions. However, other visitors reported a different experience and said that they were not assured that their relatives would be assisted properly at meals, and that they often had concerns regarding the supervision arrangements in the day rooms.

This was an unannounced inspection carried out by three inspectors of social services over the course of one day. On arrival to the centre, the inspectors introduced themselves to the person in charge and completed a walkabout of the premises. During the walkabout, the inspectors had the opportunity to meet with residents and staff as they were preparing for the day ahead and to observe the morning practices. Inspectors observed that a small number of residents were up and dressed for the day and utilising the communal spaces. Others were still in bed or relaxing in their bedrooms. The breakfast meal was being served to residents at the time of the inspectors' walkabout, and residents had a choice of where to take their meal which included in their bedroom, in the dining rooms or in the sitting rooms.

The atmosphere in the centre during the morning and throughout the day was calm and relaxed. When call-bells rang, they were observed to be quickly answered by staff and it appeared, on the day of inspection, that there were sufficient staff on duty to meet the needs of residents. However, inspectors received feedback from

residents throughout different units in the centre, that they often experienced delays in staff responding to their call-bells, and also in staff addressing their needs, particularly residents' toileting needs. One resident told inspectors "they come down to me but when they hear I need to go to the toilet, they go off again. They tell me they will be back, but they might not come back. They don't take it seriously". Another resident said "the toilet is a problem. Staff need to bring me to the toilet and they take a long time. I could be waiting an hour". Another resident told inspectors that having rang their call-bell, they had waited over two hours for assistance on one occasion and had to resort to phoning the reception desk to seek assistance from staff.

Whilst the majority of residents said they felt safe living in the centre and spoke highly of the staff who cared for them, a small number reported that staff were sometimes rough when assisting with their moving and handling needs. One resident told the inspectors "most staff are good, but some can be rough when they're changing you, pulling and pushing you in the bed, it's too much for someone of my age". The registered provider was aware of reports of rough handling by staff before the inspection, and had enhanced the supervision arrangements by including observations of staff manual handling practices in their daily checks in the centre.

The designated centre is set out across two floors, accessible by stairs and a passenger lift. The ground floor contained the kitchen, laundry, staff changing rooms, canteen, and office facilities. The laundry, where residents' personal clothing and towels were laundered, was seen to be tidy and well-organised. The layout supported the functional separation of the clean and dirty phases of the laundering process.

Resident accommodation was set out across five units. Lambay, Shennick and Erris were located on the ground floor, while Columba and Iona were on the first floor. The centre comprised 86 single-occupancy and 25 twin-occupancy bedrooms. Residents had access to either an en-suite bathroom facility or shared bathroom facilities within their unit. Bedrooms had comfortable seating, and were personalised with treasured items from home, such as family photographs, artwork, bedding and ornaments. The bedrooms had a television, locked storage, and call-bell facilities. On the day of inspection, inspectors observed residents' call-bells to be placed within their reach. In terms of communal space, each unit had its own dining room, sitting rooms and day spaces. There was also a ground-floor library and an oratory.

During the premises walkabout, inspectors observed differing cleaning standards between the units. Whilst most units were observed to be clean and generally in a good state of repair, Shennick unit was unclean and, in some cases this presented an infection control risk for residents. For example, there was faecal matter present on the floor in a communal toilet and shower room adjacent to the nurses' station, and the sink basin had items including empty shower gel bottles in it, which meant it was not available for residents to wash their hands. The cleaning checklist for this toilet had not been updated in the previous two days. Another communal toilet on Shennick unit contained a cupboard for storing boxes of disposable gloves. Inspectors observed that these boxes and the gloves were contaminated with faecal matter. In addition, a chair in the sitting room was also soiled with faeces. An

immediate action was issued to the registered provider to remove soiled items and implement immediate cleaning of the area. In addition, communal showers on Shennick unit were observed to contain unlabelled sponges, which did not promote good infection control practices, as these items could potentially be shared between residents and result in the spread of infections. Some examples of wear-and-tear were noted in other areas of the premises and these findings are discussed later in the report.

Inspectors observed the mealtime experience for residents. All residents whom the inspectors spoke with were complimentary of the home-cooked food and the dining experience in the centre. The daily menu was displayed in the dining room. The inspectors observed the main lunchtime meal in the three dining rooms. Lunchtime was a relaxed and sociable experience, with residents enjoying each other's company, as they ate while engaging in conversation. Meals were freshly prepared in the centre's on-site kitchen and served in all three dining rooms by the staff. Residents confirmed they were offered a choice of starter, main meal, and dessert. On the day of inspection, these choices included a starter of tomato soup followed by a choice of roast beef, pork bacon or white bean stew, served with vegetables. For dessert, there was an option of strawberry cheesecake or custard. The food served appeared hot, nutritious and appetising and was of adequate portion size. Staff were observed to be respectful and where residents required the support of staff to take their meal, staff were providing this care in a discreet and unhurried manner. The inspectors observed that drinks and snacks were offered to residents in the morning and afternoon on the day of inspection. Most residents who chose to receive lunch in their rooms, were observed sitting upright in an appropriate position. However, one resident was seen trying to eat their lunch independently, while positioned half-way down their bed, with the backrest in the upright position and the bed table up to their chest. The inspectors immediately sought support and requested that the resident receive assistance to sit upright in a more comfortable and safe position. Some visitors were seen assisting their relatives at lunch and spoke with the inspectors. One said that they ensure there is a family member available for every meal so that they know their loved one is eating properly. Another said they come to assist their loved one because they cannot be assured that there will be enough staff to ensure that their relative would be assisted without being rushed. The centre provided a laundry service for residents. All residents' whom the inspectors spoke with on the day of inspection were happy with the laundry service, and there were no reports of items of clothing missing.

Most residents spoken with said they were very happy with the activities programme in the centre. Some residents preferred their own company and they had access to newspapers, books, radios, the internet, and televisions. Inspectors observed an activities schedule displayed in resident areas, but the locations of the activities were not recorded to allow residents to know where to attend if they chose. This is a repeat finding from the last inspection. Despite the activity schedule being on display, some residents informed inspectors that they were unaware of that day's schedule and one resident had an activity schedule in their bedroom that was out-of-date.

The following two sections of the report present the findings of this inspection regarding the centre's governance and management arrangements and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that while the provider was making progress in strengthening the oversight systems, further action was required to ensure a safe, high quality service was provided at all times to the residents.

This inspection was carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the registered provider's progress with the compliance plan from the previous inspection carried out in November 2025, statutory notifications submitted by the provider and items of unsolicited information received since the last inspection. The unsolicited information received included themes of inappropriate manual handling practices by staff, poor personal care practices and ineffective supervision of care delivered. During this inspection, inspectors identified similar findings aligned to this unsolicited information received, both from observations on the day and in feedback received from residents.

Tara Winthrop Private Clinic had recently undergone a change to the management team, with a newly appointed person in charge, commencing in their role in late March 2026. The person in charge had previously held the role of Group Head of Quality, Compliance and Environmental Social Governance within the Grace Healthcare Group, and their appointment was an interim arrangement until a permanent candidate was appointed.

In the short time in their role, the person in charge had identified areas for service improvement and had implemented a system for daily clinical and quality walk arounds. These daily checks captured areas including resident experience and dignity, staffing, supervision and culture, manual handling and safe transfer, infection prevention and control, environmental and oversight of mealtimes and nutrition. The person in charge was observed to be present on the floor on the day of inspection. Staff who spoke with the inspectors referenced improved workplace culture and feeling more empowered to raise concerns with the management team through the improved support they received from management in the centre. However, despite these good practices, inspectors identified a number of gaps and further areas for improvement in the oversight of the general environment and cleanliness in some areas, in particular Shennick unit and in the supervision of care delivered to ensure it was safe and appropriate.

Tara Winthrop Private Clinic Limited is the registered provider of Tara Winthrop Private Clinic. It is part of the Grace Healthcare Group. There was a person in charge who worked full-time in the centre and who was supported by a regional operations manager and a chief executive officer (CEO). Three assistant directors of nursing (ADON), six clinical nurse managers (CNM), a team of staff nurses, healthcare assistants, activities coordinators, catering staff, housekeeping staff, physiotherapists, administrative and maintenance staff made up the remainder of the staffing complement in the centre.

An audit schedule was in place to monitor the quality of the service provided to residents. Inspectors reviewed a sample of audits, including those related to wounds, call-bells and falls, and mostly found them to be comprehensive, with areas identified for service improvement. For example, call-bell audits identified that whilst residents' call-bells were responded to in a timely manner, there was a requirement for greater team coordination in order to ensure that the specific needs and requests of residents were heard and addressed. Audit findings and recommendations were communicated to staff during staff huddles and at staff meetings.

The inspectors also reviewed a sample of meeting records, including resident forum meetings and staff meetings. Resident forum meetings were taking place every three months and there was evidence that residents were supported to speak openly about the service and where they felt improvements could be made. There was evidence that these suggestions were considered and measures were put in place to action residents' requests. Clinical nurse managers met on a monthly basis. These meeting records demonstrated that staffing allocations were discussed to ensure that an appropriate number and skill-mix of staff was planned and added into staffing rosters, to promote better care experiences for residents. Incidents and complaints were also discussed, and staff were reminded of the supports available to them through the employee assistance programme (EAP). Staff and unit meetings were also held monthly.

Inspectors found that there were a number of statutory notifications relating to incidents that occurred within the designated centre which were not submitted to the Chief Inspector in line with the required time frames, or by using the correct notification types. This finding is discussed under Regulation 31: Notification of incidents.

Regulation 15: Staffing

On the day of inspection, the registered provider had ensured that the number and skill mix of staff was appropriate to meet the needs of the residents in the centre, considering the layout of the premises. There was at least one registered nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to training appropriate to their roles and there was a high level of compliance with training including fire safety training and safeguarding vulnerable adults.

Judgment: Compliant

Regulation 23: Governance and management

Inspectors found that the management systems in place were not always effective to ensure the service provided to residents was consistent and effectively monitored. This included the oversight of care provision and cleaning practices in the centre and the appropriate notification of incidents to the Chief Inspector. For example;

- The systems to ensure staff were supervised appropriately and supported to adhere to best practice were ineffective. This resulted in care practices that did not promote safe, person-centred care including staff not supporting residents to sit in a safe position to take their meals.
- The systems to ensure adequate oversight of the general environment and equipment for residents were not robust as inspectors observed some areas to be visibly dirty, including a communal shower room, communal toilet and residents' mobility equipment. For example, the cleaning checklist in the dirty shower room had not been completed by staff for two days. Smoking areas were not always appropriately equipped with suitable fire safety equipment and there were significant gaps in staff completing the safety checklist for the smoking area. In addition, environmental walkabouts had not identified resident areas which had no call-bell facility, including the hairdressing room.
- Not all incidents notifiable to the Chief Inspector were notified in line with the required reporting time frames set out under Regulation 31.

An immediate action was issued on the day of inspection in respect of the cleanliness of Shennick unit and the provider's response assured inspectors that appropriate measures had been put in place to address it.

Judgment: Not compliant

Regulation 3: Statement of purpose

The registered provider had prepared in writing a statement of purpose relating to the designated centre and this statement of purpose contained all the information as set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge had not ensured that incidents set out in paragraphs 7 (1) (a) to (i) of Schedule 4 of the regulations were notified in writing to the Chief Inspector within the required time frame. This was evidenced by the following findings;

- Two statutory notifications were submitted to the Chief Inspector outside of the two-day reporting timeframe since the last inspection.
- The provider had not notified the Chief Inspector of two safeguarding concerns. Instead one of these was notified to the Chief Inspector as part of the quarterly notification process.
- The provider had not notified the Chief Inspector of the death of five residents via the appropriate notification process.

Judgment: Not compliant

Quality and safety

Overall, residents in Tara Winthrop Private Clinic received a good standard of care, however improvements in respect of care planning arrangements, safeguarding, the management of restraints and premises was required to ensure that their clinical and social care needs were met and that a high quality and safe service was provided at all times.

Residents had good access to health care professionals including medical general practitioners (GPs) and physiotherapists. GP services were also available out-of-hours to provide medical support if needed. There was evidence that appropriate referrals to, and review by health and social care professionals took place where required. From a review of residents' records, the inspectors found that recommendations from the GP and other health care professionals were incorporated into residents' care plans. Whilst the premises were well-maintained for the most part, the inspectors observed evidence of wear-and-tear in some areas, inconsistent environmental hygiene standards and insufficient oversight of the premises and equipment for use by residents living in the centre. These findings are discussed further under Regulation 17: Premises.

Residents expressed overall satisfaction with food, snacks and drinks. Residents had access to fresh drinking water. Choice was offered at all mealtimes, and adequate quantities of food and drink were provided. Food was freshly prepared and cooked on site. Residents' dietary needs were met.

Inspectors reviewed a selection of residents' care plans, including care plans for elimination, mood and behaviour, moving and handling, safeguarding and end-of-life. End-of-life care plans were found to be person-centred and clearly outlined the spiritual needs of the residents and their end-of-life wishes and preferences. Other care plans reviewed did not always reflect the current assessed needs of residents and some were written in a manner which was generic and therefore, did not guide staff to provide appropriate, person-centred care to residents. These findings are discussed further under Regulation 5: Individual assessment and care plan.

Staff were knowledgeable about the use of restraints and had received training in this area to inform good practices. However, from a review of residents' records, inspectors identified an example where restraint was used without evidence of less restrictive measures being trialled. Another resident had the use of restraints continued in practice despite successful trials of the restraint being removed. Inspectors also identified occasions where restraint was being used without any documented record of consent having been obtained from the resident, or their family, as appropriate. This is not in line with best practice and is discussed further under Regulation 7: Managing behaviour that is challenging.

Staff working in the centre had received appropriate training in the detection, prevention and response to abuse and those spoken with expressed a good knowledge of safeguarding vulnerable adults. However, the person in charge had not recognised a report of missing items belonging to a resident as a potential safeguarding concern and as a result, had not carried out the necessary investigation at the time the allegation was made, or notified the Chief Inspector of the allegation in the manner required under the regulations. This finding is discussed in more detail under Regulation 8: Protection.

Regulation 13: End of life

The inspectors reviewed a sample of end-of-life care plans for residents and found that residents' wishes for their end of life arrangements were discussed with them and documented in their file.

Judgment: Compliant

Regulation 17: Premises

The inspectors found that the premises did not conform to all matters set out in Schedule 6 of the regulations. For example;

- Not all areas used by residents were fitted with call-bell facilities to be used in the event of an emergency, including the hair dressing room.
- Some areas of the centre were not in a good state of repair. This included scuffed paintwork on the walls, architraves and doorways to some residents' bedrooms.
- Holes were observed in surfaces including a wall in a resident's bedroom and flooring in the physiotherapy room. This prevented effective cleaning of these damaged surfaces.
- The ventilation in a sluice room in Erris unit was not working effectively, which was resulting in a malodour.
- Residents' furniture on Shennick unit was observed to be torn, and in some cases, was visibly soiled.
- Two communal toilet/shower areas were visibly unclean and soiled and there was no evidence of cleaning checks having been completed for two days.
- The smoking areas for use by residents were not appropriately equipped to ensure all necessary fire safety equipment was present and in good working order.

Judgment: Not compliant

Regulation 18: Food and nutrition

All residents had access to fresh drinking water. Choice was offered at all mealtimes and adequate quantities of food and drink were provided. Food was freshly prepared and cooked on site. The meals were served hot and in the consistency outlined in residents' individualised nutritional care plan. Residents' dietary needs were met. Regular drinks and snacks were provided throughout the day.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The person in charge had arranged a comprehensive assessment for residents on admission to the centre, however, inspectors found that updated assessments were not carried out in response to changes in residents' needs. For example;

- One care plan documented that the resident required a continence assessment to be completed on admission, every four months and in response to any changes in need. Although an assessment was completed on admission which identified the resident to be continent, the resident had

since become incontinent, however, no reassessment had been undertaken following this change. As a result, the resident's current needs were not appropriately assessed to inform the care required.

Not all care plans were revised and updated when reviewed. For example,

- One care plan documented that the resident was administered a COVID-19 vaccination by the HSE team on 11/05/2026, however in brackets beside this was documented 'Refused', which was confusing.
- One elimination care plan was not developed following the most recent continence assessment for that resident and as a result, did not specify that the resident's needs had changed and they now required continence wear.
- One elimination care plan contained conflicting information describing the resident as both continent of urine and faeces, and experiencing episodes of incontinence. However, the care plan also described the requirement for a size large continence pad, and there was no evidence that a continence assessment had been completed to support this need.
- One care plan detailed recommendations from a tissue viability nurse, along with other daily care notes regarding wound care. However, the dates of the professional recommendations in the care plan were unclear, and it was not possible to determine the most up-to-date wound management guidance to promote the resident's comfort and safety.
- Two care plans for residents at high risk of developing pressure ulcers did not include details of preventative measures, such as air mattress settings or how often the resident needed to be repositioned.

Judgment: Not compliant

Regulation 6: Health care

Residents were supported by good access to medical practitioners, specialist nursing services and health and social care professionals, such as physiotherapists, tissue viability nurses, speech and language therapist, dietitians and chiropodists where required. Where a resident required a review by a medical or health and social care professional, they received timely access to this care and recommendations by professionals were incorporated into residents' care plans

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Staff had up-to-date training appropriate to their role, to respond to and manage behaviour that is challenging. However, the person in charge had not always

ensured that where a resident behaved in a manner that was challenging or posed a risk to themselves or others, that response was effected in the least restrictive manner possible. For example:

- One resident's episode of challenging behaviours was managed using a therapeutic hold without any documented evidence of alternative, less restrictive de-escalation techniques being tried.

Restrictive practices were not always used in accordance with national policy as published on the website of the Department of Health. For example;

- One restrictive practice care plan had documented that there had been three successful trials without the use of a bed alarm and bed wedge, however the care plan documented that due to continued safety concerns and potential risk of falls, both were still in use.
- One resident who was using bedrails at the request of their family did not have an appropriate rationale for their use documented or a risk assessment completed prior to the bed rails being used.
- One bed rail assessment identified that the resident was at risk of entrapment and that there was a weakness that put them at risk of using bedrails; however, the level of risk or rationale for using the bed rails was not documented.
- One restraint assessment for the use of a lap-belt had documented that no consent was obtained, however it contained a comment that consultation and consent were documented in the care plan. There was no evidence of this in the resident's care plan.

Judgment: Not compliant

Regulation 8: Protection

Staff had received training in relation to the detection, prevention of and responses to abuse. However, some incidents were not identified as safeguarding concerns and therefore were not appropriately investigated. For example;

- While an allegation of missing clothing and money was made by a resident and some action was taken by the management team, this incident was not recognised as a potential safeguarding concern, and therefore a full investigation into the allegation had not been carried out at the time it occurred.
- Additionally, a complaint made regarding wound care and concerns about a resident losing weight were not identified as allegations of neglect or safeguarding concerns to be investigated.

Judgment: Substantially compliant

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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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Tara Winthrop Private Clinic OSV-0000183

Inspection ID: MON-0050067

Date of inspection: 19/05/2026

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The daily management walk-around tool has been revised to include explicit observation of meal-positioning, moving and handling technique, call bell response and environmental cleanliness across all units. Walk-around records are maintained in the DONs office and reviewed at weekly Head of Department (HOD) meetings. • A toolbox talk on the correct and safe positioning of residents during mealtime care has been delivered to all care staff. Care plans for all residents requiring mealtime assistance have been reviewed to ensure that appropriate positioning guidance is clearly documented and accessible to staff. • A unit-level environmental audit has been introduced, completed by each Clinical Nurse Manager with sign-off required. Any concern identified is escalated immediately to the ADON or DON for action. • A full fire safety audit of all outdoor smoking areas across Lambay, Shennick and Erris units has been completed. All required equipment i.e.: fire extinguishers, fire blankets, smoking aprons and call bells has been replenished and confirmed in place. Smoking area safety is included as a standing check in the walk-around tool. • A call bell has been installed in the hairdressing room, ensuring residents are able to call for assistance with the help of the hairdresser when using the facility. • Compliance action plan is a standing agenda item at weekly HOD meetings, chaired by the DON. The registered provider receives a monthly update on compliance plan progress from the Head of Quality, and the Regional Manager.	

Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: • The management team has established a robust system to ensure all HIQA notifiable incidents and obligations are identified, reviewed and submitted in a timely manner in line with Schedule 4 of the Health Act 2007. This system is overseen jointly by the DON, the Regional Manager and the Group Quality, who review all notifications as a standing item at management meetings to ensure accuracy and compliance with required timeframes. • A named deputy has been assigned to maintain oversight of notification obligations during any period of absence of the Person in Charge, ensuring continuity of compliance.	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: • A call bell has been installed in the hairdressing room, ensuring residents are able to call for assistance with the help of the hairdresser when using the facility. • A phased repainting and repair programme is underway. Shennick unit doors, architraves and storerooms have been painted. The Columba dining area has been painted. Erris unit painting is scheduled for August 2026, covering radiators, doors, architraves, storerooms and the dining area. The bedroom wall surface and physiotherapy room flooring has been repaired to ensure effective cleaning can take place. • The sluice room ventilation fault on Erris unit has now been repaired. • All torn and visibly soiled furniture on Shennick was removed on the day of inspection and has been replaced. The cleaning checklist for unit furniture has been reinforced with housekeeping and nursing staff to ensure consistent IPC adherence. An ongoing programme of furniture audit and replacement is in place; a full audit will be completed, and all identified replacements actioned. • Cleaning checklists for all communal toilet and shower areas were reinforced on 19 May 2026 and are verified daily by the Clinical Nurse Manager for each unit. • A full fire safety equipment audit of all outdoor smoking areas has been completed and all required equipment replenished across all units, as outlined under Regulation 23.	

Regulation 5: Individual assessment and care plan	Not Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: • Care plans identified as not accurately reflecting a resident's current assessed needs have been updated. • The specific findings related to the accuracy and currency of assessments and documentation regarding incontinence, and to two clinically significant gaps in pressure ulcer prevention detail, have also been addressed. The clinical team ensures that any care plan will accurately inform all staff of the actual resident care needs (i.e.: assessed incontinence wear, requirement for pressure relieving mattress). • Since inspection, all residents' incontinence assessment has been updated. • Any change in a resident's health or care needs now triggers a care plan review and update within 24 hours. • The contradictory COVID-19 vaccination entry and all similar documentation errors identified during the audit have been corrected. Nursing staff have been reminded of their responsibility to ensure that all care plan entries are accurate, current and consistent. • The wound care plan template now includes a mandatory field for the date of the most recent professional recommendation, linked to tissue viability nurse review. All care plans for residents at high risk of pressure ulcer now include mandatory fields for air mattress settings and repositioning frequency. • A nursing care plan audit and update will be completed across all residents by 28 August 2026. The findings of this audit, including any outstanding care plan updates identified and actioned, will be reported at the weekly HOD meeting following completion. The DON will confirm to the registered provider that the audit is complete and that all care plans accurately reflect each resident's current assessed needs.	
Regulation 7: Managing behaviour that is challenging	Not Compliant
Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging: • A full review of all restrictive practice care plans across the service has been undertaken, triangulating current restrictive practices in use, the supporting risk assessments, and consent documentation for each resident and, where applicable, their family or nominated representative. This review, including confirmation that all resident and family consents are in place and properly documented, will be completed by 28 August 2026. • Care plan on therapeutic hold has now been discontinued following resident care needs re-assessment. An education session has been completed with the staff to reinforce	

proper assessment and consultation with the use of restrictive practice in line with the regulation.

- The bed alarm and bed wedge in use following successful trials without them, were reviewed immediately following the inspection. Where trials without restraint had been successful, the rationale for any continued use has been documented.
- The relevant resident's bedrail documentation has been completed, including a full risk assessment, identification of the entrapment risk, documented consent and rationale for continued use. All bedrail assessments across the centre have been reviewed to ensure they are complete.
- The lap-belt consent documentation has been reviewed immediately. Where consent could not be confirmed, the restrictive practice was discontinued and an updated assessment completed.

Regulation 8: Protection

Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- A formal safeguarding investigation has been opened and NF-06 submitted in respect of the report of missing clothing and money. The investigation has been completed in line with the HSE Safeguarding Policy and the centre's own safeguarding procedures.
- A safeguarding screening step has been introduced at the point of receiving any complaint or incident report. All complaints and incidents are now screened for possible safeguarding concerns, including missing or unexplained loss of property or finances, unexplained weight loss, concerns about wound care or pressure area management, unexplained injury, poor standards of personal care, and any other concern about the quality of care a resident is receiving. This screening is completed by the DON or designated deputy and communicated to the team.
- Safeguarding is a standing agenda item at the weekly HOD and monthly LMT meeting, ensuring that all open safeguarding concerns are reviewed regularly, that investigations are progressing within required timeframes, and that any required HIQA notifications are submitted promptly.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 17(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	31/10/2026
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	Orange	31/08/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of	Not Compliant	Orange	07/08/2026

	the incident within 2 working days of its occurrence.			
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).	Not Compliant	Orange	28/08/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	28/08/2026
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	28/08/2026
Regulation 7(3)	The registered provider shall ensure that, where	Not Compliant	Orange	28/08/2026

	restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	07/08/2026