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:	The Residence Santry
Name of provider:	TLC Spectrum Limited
Address of centre:	Northwood Park, Santry, Dublin 9
Type of inspection:	Unannounced
Date of inspection:	21 May 2026
Centre ID:	OSV-0000184
Fieldwork ID:	MON-0049670

About the designated centre

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

The Residence Santry is a designated centre located in north Dublin, registered to provide care for 46 men and women over the age of 18 years in single and twin bedrooms across three storeys. The ethos of The Residence Santry is to promote an individualised person-centred approach to care for residents and their families who choose to live in the designated centre. The Residence Santry aim to ensure freedom of choice, promote dignity and respect within a safe, friendly and homely environment. All staff encourage residents to maximise their independence, achieve their potential and maintain interests. We support residents to develop new friendships and participate in activities appropriate to their needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	44

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
Thursday 21 May 2026	08:25hrs to 15:00hrs	Sheila McKevitt	Lead
Wednesday 3 June 2026	08:20hrs to 10:00hrs	Sheila McKevitt	Lead

What residents told us and what inspectors observed

Residents' feedback about life in the centre was overwhelmingly positive about all aspects of the care they received.

The inspector viewed occupied bedrooms on the ground floor and found that they were warm, bright and homely spaces. They were personalised with personal furniture, ornaments, soft furnishing and photographs. Each single bedroom had sufficient storage space for residents' clothing and personal possessions. Many residents told inspectors that they were satisfied with their refurbished accommodation, including the support they received from staff to keep their bedroom clean.

The second floor had been fully refurbished. The furniture and fittings in the 28 single en-suite bedrooms, the sitting rooms and dining room had all been replaced. The floor covering in the en-suites, bedrooms, communal spaces and corridors had been replaced. Some works were not fully completed on day one of the inspection however, the outstanding items had been addressed by day two of the inspection.

The design and layout of the centre promoted a good quality of life for the residents. Residents reported that they enjoyed walking in the corridors and the refurbished garden, one resident said they used it daily.

There were information boards available for residents' information. There was also information available on the complaints procedure, advocacy services and activities available. Residents knew the person in charge by their first name and said that if they had a complaint they would say it to the person-in-charge.

Residents could attend the individual dining rooms or have their meals in their bedroom if they preferred. The daily menu was displayed on tables in each dining room. Residents described the food as "good" and "very good" and one resident said they particularly enjoyed the breakfast club as you always got to chat to other residents.

Residents who spoke with the inspector were very positive about the support received from the staff working within the centre saying that they were "respectful","brilliant" and maintained their privacy and dignity at all times. One resident said coming into the centre was "the best decision" they had made and although soul searching, the carers made it feel like home and they were very happy with the care and attention received. Another resident said they were extremely religious and enjoyed the oratory on the ground floor which they could access independently and pray in the peaceful surroundings. The inspector observed residents using this room on a number of occasions throughout the inspection.

Residents reported to feel safe within the centre and said that staff responded to their requests for assistance promptly. From the inspector's observations, it was clear that staff were familiar with residents and their visitors who were greeted by name and residents were seen to enjoy the company of staff.

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

Capacity and capability

This unannounced inspection was conducted following the provider informing the Chief Inspector that the refurbishment of the second floor of the centre was completed and they were now in a position to request the removal of restrictive condition number six from the certificate of registration. Three restrictive conditions were attached to the registration of the designated centre following findings of concern identified on the last inspection of 25 November 2025, with regards to fire safety and failure to progress works related to premises in line with commitments given to the Chief inspector. These conditions, restricted the admissions of residents to the third and second floor and obliged the provider to complete all the outstanding premises work by 30th September 2026. In addition, the occupancy of the centre was reduced to a maximum of 46 residents. On day one of this inspection, the refurbished second floor did not meet the requirements outlined in Regulation 17: Premises. However, the outstanding issues were addressed by day two of the inspection.

The provider is TLC Spectrum Limited which is part of the larger Emeis group. The senior management team was made up of a regional operations manager and person in charge who reported to the provider on a regular basis via governance meetings. The person in charge and two assistant directors of nursing worked full-time in the centre and on any given day, one of them was nominated to provide out-of-hours on-call support if needed.

Established management systems were effective in ensuring the centre was operating in compliance with the regulations. They included thorough governance and management oversight through staff meetings, committees, service reports, monitoring key performance indicators (KPIs), and auditing. These audits informed ongoing quality and safety improvements in the centre. There was a proactive management approach in the centre, which was evident by the ongoing action plans that were in place to improve safety and quality of care.

There were sufficient resources in place in the centre to ensure effective care delivery. There was an adequate number of staff with the appropriate skills to care for the 44 residents living in the centre.

The required refurbishment works for the second floor had been completed by the second day of inspection.

Records requested and reviewed were overall in compliance with the regulatory requirements.

Regulation 19: Directory of residents

There was a directory of residents established within the designated centre. This directory contained all the information required by the regulations, and where there were any admissions and discharges of residents, the directory was up-to-date.

Judgment: Compliant

Regulation 22: Insurance

The designated centre had insurance in place which met the regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. Members of the management team were aware of their lines of authority and accountability. They demonstrated a clear understanding of their roles and responsibilities. They worked well together, supporting each other through an established system of communication.

There were clear systems in place for the oversight and monitoring of care and services provided for residents. The issues found at the last inspection had been addressed and the provider was working towards completing the necessary works required by the conditions of registration.

The annual review for 2025 was completed and available for review. It included feedback from the residents and their families together with a quality improvement plan for 2026.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose had been updated to include the staffing levels and organisational structure linked with the current certificate of registration.

Judgment: Compliant

Regulation 34: Complaints procedure

The complaints procedure was on display in a prominent position within the centre. The complaints policy and procedure identified the person to deal with the complaints and outlined the complaints process. Complaints on file were reviewed and the inspector was satisfied that they were being managed in line with the complaints policy.

Judgment: Compliant

Quality and safety

Residents were receiving a high standard of quality care as stated in the registered provider's statement of purpose. However, some improvements were required in relation to nursing records.

The inspector reviewed a sample of resident records such as nursing notes, care plans and validated assessment tools. These were observed to be person centred. Validated risk assessment tools were used to identify specific clinical risks, such as risk of falls and pressure ulceration. Assessments and care plans were updated in line with regulatory timeframes, such as within 48 hours of admission and at internals of at least every four months. However, the inspector found that the information in some care plans did not always reflect the care being provided or include up-to-date relevant information. This is discussed further under Regulation 5: Individual assessment and care plan.

The ground floor was clean and uncluttered and residents living on this floor were settled back into their newly refurbished bedrooms. The flooring in the ground floor corridor had been replaced since the last inspection and the second floor had been completely refurbished. On day one of the inspection, the premises on the second floor was not fully ready to beregistered for admitting residents, due to the following outstanding issues;

- The wall-mounted televisions were not installed in all bedrooms.
- The newly purchased blinds and curtains for each bedroom and communal room windows had not yet been installed.
- Some bedroom doors were damaged
- The call-bell in some of the en-suite bedrooms required review to ensure they could be easily cleaned.
- The flooring in many areas appeared unclean due to the snagging list being worked through by the workmen on site.

These issues had all been addressed in full by day two of the inspection. There was a plan in place to transfer residents from the first floor back into their refurbished bedrooms on the second floor and commence a full refurbishment of the first floor once the restrictive condition six was removed.

The fire procedures and evacuation plans were displayed prominently throughout the centre. The external fire exit doors were clearly sign-posted and were free from obstruction. Records showed that fire-fighting equipment had been serviced within the required time-frame. Clear and detailed records of each fire drill practiced with staff were available for review. The records showed that staff had a clear knowledge of how to evacuate residents in a timely manner in the event of a fire.

Regulation 17: Premises

The centre was found to be clean and tidy. The premises met the need of the 44 residents currently living in the centre. The 28 single en-suite bedrooms second floor and several communal rooms had been fully refurbished. The third floor remained closed while works were being completed in line with the requirements of the registration.

Judgment: Compliant

Regulation 20: Information for residents

The residents guide had been updated in May 2026 and it met the regulatory requirements.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While, overall care plans reviewed were person-centered, some gaps were identified which required action, for example:

- There was a lot of information repeated in some residents' care plans making it difficult to identify their exact care needs.
- Some care plans were not detailed enough to reflect the care being provided.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant

Compliance Plan for The Residence Santry OSV-0000184

Inspection ID: MON-0049670

Date of inspection: 03/06/2026

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 5: Individual assessment and care plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan: 1. By 31st August 2026, all staff nurses will receive refresher training in care planning and will be reminded of the importance of updating care plans whenever there are changes in a resident's condition to ensure they accurately reflect the resident's care needs. 2. From 1st July 2026, a care plan tracker has been implemented to track progress in this area. This will be monitored by the CNM and ADON monthly. Complete and ongoing 3. A monthly audit schedule is in place to ensure that care plans remain person-centred. Findings from these audits will be reviewed by the PIC and the Regional Director, and actions will be taken to support continuous improvement Monthly. Complete and ongoing	

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 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/08/2026