



**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:	St Colman's Residential Care Centre
Name of provider:	Health Service Executive
Address of centre:	Ballinderry Road, Rathdrum, Wicklow
Type of inspection:	Unannounced
Date of inspection:	21 July 2026
Centre ID:	OSV-0000492
Fieldwork ID:	MON-0050161

About the designated centre

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

St. Colman's Residential Care Centre is a community facility providing a variety of services to the elderly population of Wicklow. St. Colman's Residential Care Centre provides residential care, respite and palliative care for a total of 90 residents both male and female, over the age of 18 years. Accommodation is provided on three units, Primrose Place, Clover Meadow and Lavender Vale. Four beds are dedicated for respite admissions and the remainder are long term care. Bedroom accommodation is mostly multi-occupancy three and four-bedded rooms. There are two twin-rooms and four single-bedrooms - two of which are allocated to palliative care. There is a designated smoking area for residents on Primrose Place, Clover Meadow and Lavender Vale.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	82
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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 21 July 2026	08:15hrs to 17:10hrs	Niamh Moore	Lead
Tuesday 21 July 2026	08:15hrs to 17:10hrs	Laurena Guinan	Support

What residents told us and what inspectors observed

Inspectors found that St Colman's Residential Care Centre was a well-resourced centre where residents were supported by a team of staff who were kind and caring. The centre had a relaxed and friendly atmosphere. Residents were very complimentary of staff, describing them as attentive and kind. One resident said 'I feel very lucky to have got a bed here', while another said it was a 'fantastic place to live'.

This was an unannounced monitoring inspection, which took place over one day by two inspectors of social services. The centre is set in a purpose-built facility on one level with 90 registered beds. Building work on a new centre adjacent to the property was underway, and residents spoken with on the day were aware of the progress of the build. Plans were in process for the next phase of building, which included the new build to be connected to the current registered building.

On entering, there was a reception area where visitors sign in. Corridors on either side of the reception lead to offices, a kitchen and dining room, store rooms, and communal facilities such as toilets, a chapel, a snoozeleen (sensory room) and an activities room. The chapel was seen to be used by individuals in the morning, and for a singing group on the afternoon of the inspection. There was a bell facility in the chapel that alarmed in the administration office across the corridor. This was discussed with the person in charge as it posed a risk that the bell would not be attended to if the office was unoccupied, and they committed to reviewing the system. There was a spacious, bright activity room beside the chapel with tables, chairs and activities supplies. A large group of residents attended a flower arranging class facilitated by an activities staff member and a volunteer in the morning, and residents spoken with said it was very enjoyable. Activities staff used a desk in the corner of the room to plan and co-ordinate activities, and an 'education hub' had been installed beside this desk to provide an area for staff to complete training. A staff member was seen using this space in the afternoon.

The snoezelen had soft lighting and comfortable furniture to provide a calming environment for residents. The room was locked at the start of the inspection, and staff confirmed that it was routinely locked until a staff member was available to supervise residents while they were using the room. It remained locked until inspectors observed it in use by a resident and a staff member at 4pm.

The centre is divided into three residential units called Lavender Vale, Primrose Place and Clover Meadow. On the day of the inspection, there were 82 residents living in the centre. Each of the residential units had living/dining areas, communal toilets and shower rooms, as well as sluice rooms, store rooms and nurses' stations. The nurses' stations on each unit were seen to be unlocked during the day, with residents' information easily accessible. In addition, one of the office doors was held open with a chair during the inspection which posed a fire and safety hazard. A

bedroom on Primrose Place was being used to temporarily store residents' records while the nurses' station was being painted, but this room was without a secure lock.

Each unit had access to secure outdoor areas. However, the access to the outdoor areas on Primrose Place and Clover Meadow were seen to be restricted by a key or swipe card. One of the shower rooms on Clover Meadow was locked, and another on Lavender Vale was secured with a keypad. This was brought to the attention of staff on the units, and the person in charge as it did not promote a rights-based approach to care. Staff told the inspectors that the areas were locked as some residents wandered, and could be at risk when using these areas unsupervised. However, this meant that residents who could safely use these areas unsupervised were reliant on staff to provide access.

The outdoor area on Lavender Vale was seen to be unkempt, with soil spilled on pathways, plant pots on garden seats, and unclean cushions on the garden furniture. There were also two hose pipes running across the paths, posing a trip hazard to residents mobilising in the courtyard. A panel of fencing was missing, and the placement of a bench on one side of the broken fencing, and a low wall on the other side, meant that it was possible to access an unsecured area. A physiotherapy room, hairdresser's room and visitors' room were located at the end of the corridor on the Lavender Vale unit. The rooms were clean and well-equipped, but there was a strong malodour in the physiotherapy room, and the hairdresser's and visitors' rooms were without call-bells, which meant that residents using the spaces had no way to call for assistance.

Residents bedrooms were a mix of single and multi-occupancy rooms. The multi-occupancy rooms had appropriate privacy screenings in place, and residents spoken with said that they were happy with their rooms. Many had personalised their rooms with their own belongings such as photos and cushions, and each resident had lockable storage for their valuables. Residents told the inspectors that they were happy with their rooms, and felt they had sufficient private space. However, inspectors observed that within the multi-occupancy bedrooms medicine was stored and in two of the four-bedded rooms, they stored a bed which was damaged and not in use. The storage of these items impacted on the use of available space for residents.

The inspectors saw lunch being served, and saw that it was a relaxed and pleasant experience. There was ample staff to assist, and they did so in a respectful manner, engaging residents in conversation and offering choices of drinks and condiments. Residents spoken with said that the food was very good, and that staff 'bent over backwards' to accommodate different preferences. A visitor commented that their relative had difficulty swallowing, and staff showed great patience and understanding in ensuring that the resident had the correct diet, and provided them adequate time and assistance to enjoy their meal. However, inspectors observed personal care delivered to a resident within the lounge while the meal-time had not finished for all residents. This did not promote this resident's dignity.

Visitors were seen coming and going during the day, and there was a choice of areas in which residents could receive visitors. Visitors spoken with said that they were made to feel welcome, and they felt their loved ones were safe and well-cared for. One visitor described the care as being 'top notch', and all those spoken with said that staff were proactive in keeping them informed of changes in their relatives' condition.

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

Capacity and capability

Overall, there were oversight systems in place to ensure residents were provided with quality care and support. However, not all areas of the service were effectively monitored, particularly relating to the oversight of fire precautions, the premises, and the impact this had on residents' rights.

The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended). The inspectors also followed up on the compliance plan from the previous inspection in August 2025, and solicited information received by the Chief Inspector of Social Services since then.

St Colman's Residential Care Centre is owned and operated by the Health Service Executive (HSE). There had been substantial changes to the management structure since the previous inspection. This included the person delegated by the provider with responsibility for senior management oversight of the service, a person participating in management and the person in charge all departing their roles in June 2026.

The person in charge had left and a new person in charge had been appointed and notified to the Chief inspector on an interim measure until a permanent candidate was appointed. The interim person-in-charge worked full-time in a supernumerary capacity and was an assistant director of nursing for the centre. However, the registered provider had not submitted the correct documents in a timely manner to ensure this proposed person met the criteria of Regulation 14: Person in charge. This resulted in a cautionary meeting being held with the Office of the Chief Inspector two weeks prior to the inspection and remained an issue on this inspection. This and other gaps are further discussed under Registration Regulation 6: Changes to information supplied for registration purposes.

The person in charge was supported in their role by an assistant director of nursing and each unit had clinical nurse managers allocated. Nursing staff were supported by healthcare assistants, activity staff, household and catering staff. The designated

centre was also supported by medical officers, allied health professionals and administrative staff. There were a number of staffing vacancies which were being actively recruited for. During this time, these vacancies were covered by staff taking on additional shifts and temporary staff. On the day of the inspection, inspectors found that there was sufficient staff available to attend to residents' needs.

The registered provider had a Staff Training and Development policy dated August 2025. This policy outlined the mandatory training requirements for staff working within the centre in areas such as fire safety, safeguarding, infection control, manual handling, first aid, crisis prevention and intervention. Inspectors reviewed the training matrix and found that some staff had not yet received the required training, and for others training had expired. There were also gaps in the provision of staff supervision and this is further discussed under Regulation 16: Training and staff development.

There were oversight systems in place to monitor the service provided, which included meetings, trending and auditing. Inspectors found that overall where actions were arising, there was a person identified as responsible to complete the action. Inspectors also saw improvements to the quality of care planning since the last inspection in August 2025. However, there remained some repeat findings on this inspection and poor oversight of areas relating to Regulation 17: Premises and Regulation 28: Fire Precautions.

Since the last inspection, a new policy on the management of volunteer roles had been developed. This policy outlined that volunteers would have induction checklists, a volunteer agreement and a performance review every six months. The policy also outlined that volunteers would not commence in their roles until satisfactory Garda Síochána (Irish police) vetting had been received, in line with HSE policies. However, inspectors found that this policy was not implemented into practice and therefore there were gaps in compliance with Regulation 30: Volunteers.

Notifiable incidents were not always submitted to the Chief Inspector in line with the timeframes set out in regulatory requirements, as detailed further under Regulation 31: Notification of incidents.

Registration Regulation 6: Changes to information supplied for registration purposes

The registered provider had not supplied full and satisfactory information, within 10 days of the appointment of a new person in charge, in regard to the matters set out in Schedule 2.

In addition, the registered provider had not notified the Chief Inspector in writing of any change in the identity of any person participating in the management of a designated centre within 28 days of the change and supply full and satisfactory

information in regard to the matters set out in Schedule 2 in respect of any new person participating in the management of the designated centre.

Judgment: Substantially compliant

Regulation 15: Staffing

Sufficient staffing levels were observed throughout the day in the centre. There was an appropriate skill-mix of staff in each unit including a staff nurse day and night to provide a safe and quality service to residents.

Judgment: Compliant

Regulation 16: Training and staff development

The training matrix provided to inspectors highlighted gaps in mandatory training as set out in the provider's policy. For example:

- 10 percent of staff did not have up-to-date training in fire safety.
- 20 percent of staff did not have up-to-date training in safeguarding.
- 45 percent of staff did not have up-to-date training in dementia care.
- 14 percent of clinical staff did not have up-to-date training in first aid.

The person in charge had not always ensured that staff were adequately supervised as evidenced by:

- A fire door was propped open.
- Nurses' stations were left unlocked, with residents' information easily accessible.
- Residents' information was stored in a room without a secure lock.
- Equipment, including some with 'I am clean' stickers, were seen to be visibly unclean.
- Inappropriate storage practices in store rooms, bedrooms and in bathrooms were seen.

Judgment: Substantially compliant

Regulation 23: Governance and management

While the registered provider had some assurance systems in place regarding the quality and safety of the service, the monitoring systems in place were not sufficiently robust. This was evidenced by:

- The provider had set out timebound actions to address the issues identified on previous inspections regarding volunteers, residents' rights, the premises and fire precautions. However, inspectors found that these issues had not been fully-addressed and remained evident on this inspection. The gaps are further outlined under the relevant regulations.
- The poor oversight of the premises impacted on residents' usable space in multi-occupancy bedrooms and in access to the outdoors and communal areas.
- Oversight systems did not ensure that the Chief inspector had received timely notification of changes and appropriate contact information for incoming management personnel.

While an annual review on the quality and safety of care delivered to residents in 2025 was available, this review was not prepared in consultation with residents and their families.

Judgment: Substantially compliant

Regulation 30: Volunteers

Inspectors reviewed the records of two people involved within the centre on a voluntary basis, and found gaps in the supervision records and Garda Síochána vetting. For example, the provider's policy outlined that volunteers would have induction records and volunteer agreements but these were not available for either persons. While there was valid vetting in place for both persons, inspectors found that one of these volunteers had not received this disclosure prior to their role commencement within the designated centre. This is a repeat finding from the inspection of August 2025.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not submitted all notifiable incidents within two working days of their occurrence as set out under Schedule 4 of the regulations. An allegation of abuse and an unexpected death of a resident were both submitted six days following the events.

Judgment: Not compliant

Quality and safety

Residents living in St Colman's Residential Care Centre were seen to receive a high standard of care from staff who were familiar with their needs. However, gaps were seen in the promotion of residents' rights, the implementation of learnings from safeguarding investigations, information contained in the residents' guide and the risk management policy, the oversight of the premises and fire precautions.

The inspectors reviewed a sample of care plans and saw that residents had a comprehensive assessment within 48 hours of admission to the centre. Validated assessment tools were used, and care plans were implemented that accurately reflected the assessments. Inspectors observed examples of very good person-centred care plans that clearly outlined residents' preferences and needs.

Residents were seen to be reviewed by a general practitioner on a regular basis, and they were also referred promptly for acute conditions. A physiotherapist was employed in the centre, and residents were seen to be assessed as required, with physiotherapy plans in place as appropriate. Residents also had access to other health services such as occupational therapy, speech and language therapy, a dietician, a tissue viability nurse, and a chiropodist, and there was evidence that residents were facilitated to attend external hospital appointments. Recommendations by these allied health professionals were seen to be implemented in practice. Residents and visitors spoken with were happy with access to health care and said that they were kept informed of appointments, diagnosis and treatments.

Residents were seen to have end-of-life care plans in place that detailed wishes such as religious and funeral arrangements. Residents who did not presently wish to discuss end-of-life care also had this documented. The inspectors reviewed the records of residents who had recently passed away and saw that residents' wishes were followed, and where possible, family were facilitated to be with the resident at the end-of-life stage.

Throughout the centre, the inspectors saw areas of chipped and damaged paintwork, woodwork, walls and ceilings. Torn wallpaper, and stained and damaged flooring was also seen. This was not conducive to a homely environment, and are repeat findings from the previous two inspections in October 2024 and August 2025. Each unit had store rooms, and the inspectors saw that a large amount of equipment was stored in the rooms, making wall units inaccessible. Bags of clothing and loose items of clothing that were unmarked were seen in these rooms. Equipment such as hoists and wheelchairs were also stored inappropriately in bathrooms. Inspectors saw that chairs, wheelchairs and shower chairs were visibly

unclean. Some of these had 'I am clean' stickers'. These issues will be discussed under Regulation 17: Premises.

A residents' guide was available, although some of the information contained in it was inaccurate. For example, the centre was described as a non-smoking centre; however, each unit had a smoking room, and residents were also facilitated to smoke in one of the courtyards. The residents' guide also stated that visitors were to give cigarettes and alcohol for residents to staff for safe keeping. This was not implemented in practice. This will be discussed under Regulation 20: Information for residents.

Residents told the inspectors that they felt safe living in the centre. They said they would feel comfortable raising concerns with staff, and felt that staff would listen and support them. The inspectors reviewed the management of three safeguarding concerns and saw that they had been investigated fully. Learnings from two of the investigations were incorporated into the residents' care plans: however, the learnings from the third investigation were not detailed in the residents' care plans. Staff spoken with showed a good understanding of recognising signs of abuse, and the correct escalation pathways to follow, although not all staff had up-to-date training in safeguarding.

The inspectors saw many kind interactions between staff and residents during the day, and it was evident that staff and residents were familiar with each other. There was a system of residents' meetings in place, and issues raised were seen to be addressed. Residents were currently deciding on names for residential units in the new building, and they were kept updated on the progress of the build. There was a variety of activities on offer, and residents said they particularly enjoyed the outings. There were two or three activities staff on duty each day, although staff reported that activities staff were often reallocated to cover staff absences. This meant that there may only be one staff allocated to provide activities to 90 residents. Activities staff said that they then relied on staffing in each residential unit to provide assistance to carry out planned group activities, but that one-to-one activities would often be compromised. On the day of the inspection, one of the activities staff had been reallocated to work on one of the residential units, and as a result, the snoezelen room was locked and unused until 4pm. A review of the roster showed that the same reallocation had occurred the previous day. Two visitors spoken with had told the inspectors that one-to-one activities, and the snoezelen room in particular, was an important part of their loved ones life.

The registered provider had some good fire safety processes in place. For example, there was a fire safety management policy, fire safety equipment was provided and routinely serviced. However, fire safety training was not up-to-date for all staff, and residents personal emergency evacuation plans (PEEPs) were not sufficiently detailed. This and further gaps in compliance are discussed under Regulation 28: Fire Precautions.

Regulation 13: End of life

Residents had end-of-life care plans which detailed their wishes. Those receiving end-of-life care were seen to be afforded appropriate care and comfort. The residents' families were facilitated to be present with them.

Judgment: Compliant

Regulation 17: Premises

The registered provider had not ensured that the premises conformed to the matters set out Schedule 6 as evidenced by:

- Communal rooms such as the chapel, the outdoor smoking area, the hairdresser's room and the visitors' room were without appropriate call-bell facilities.
- Areas of the premises were in a poor state of repair with chipped and worn paintwork and woodwork, damaged ceiling and walls, and stained and damaged flooring. A glass panel in a lounge was also broken. This is a repeat finding.
- Areas of the corridors on two of the units were poorly lit.
- A strong malodour was evident in the physiotherapy room.
- Equipment such as wheelchairs and shower chairs were visibly unclean.
- The courtyard on Lavender Vale unit was unkempt and not conducive to a safe and pleasant environment.
- An upper panel of fencing in the Lavender Vale courtyard was missing, posing a potential absconsion risk.

Judgment: Not compliant

Regulation 20: Information for residents

The residents' guide did not correctly detail the facilities in the centre as evidenced by the description of the service as a non-smoking campus.

The residents' guide did not correctly detail the terms and conditions relating to residence in the centre as it detailed a practice whereby staff routinely held residents' cigarettes and alcohol. This was not implemented in practice.

Judgment: Substantially compliant

Regulation 26: Risk management

Inspectors were provided with the risk management policy within the Schedule 5 folder on the day of the inspection which was dated April 2025 and remained with the same gaps as identified on the inspection in August 2025. The registered provider submitted the updated version following this inspection. Inspectors saw that this policy had been reviewed in November 2025, however, it did not meet the criteria of the regulations. For example it did not identify the following:

- the measures and actions in place to control risks identified
- the measures and actions in place to control the specified risks of
 - abuse
 - accidental injury to residents, visitors or staff
 - aggression and violence
- the arrangements for the identification, recording and investigation of serious incidents or adverse events involving residents
- a process for the implementation of actions and recommendations arising
- a process for the audit, review and learning from events
- A plan in place to respond to major incidents

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was required by the registered provider to take adequate precautions against the risk of fire, and to provide suitable means of escape, and ensure staff were familiar with the actions to take in the event of a fire. For example:

- A review of the fire drills found that while fire drills were being conducted in one of the units, these drills were not practicing high risk scenarios such as the evacuation of the largest compartment with lowest staffing levels. The documentation for the other two units were seen to be discussions and not the implementation of fire drills.
- There were key-guard boxes with keys available to use on locked external exit doors on the N11 corridor, however to exit into the secure garden there were pad locks on both gates and one gate also had a rusted bicycle in front of it. Staff spoken with were unclear of the process to access keys to attend the assembly point if a full evacuation was to occur. Inspectors were told the key was held in the staff office which was observed, later management told inspectors that this key was now held in the area by the exit doors. This area was also poorly lit if an external evacuation at night-time was required. This may impact on the evacuation time for staff, residents and visitors.
- The procedure and staff numbers for the evacuation of all residents was not clear. Personal emergency evacuation plans for one resident did not identify how many staff members were required to assist with their evacuation. In addition, another record indicated that two staff members were required. However, this residents evacuation had not been trialled.

- A fire door was held open with a chair during the inspection, which created a fire hazard.
- Two fans were plugged into sockets on corridors. These practices created a risk of fire on escape routes.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

The registered provider had ensured that assessments were completed and care plans implemented within 48 hours of a resident's admission.

Judgment: Compliant

Regulation 6: Health care

Residents were seen to be referred to allied health professionals in a timely manner, and their recommendations were seen to be implemented in practice.

Judgment: Compliant

Regulation 8: Protection

While the person in charge had investigated allegations of abuse, learnings from these investigations were not always incorporated into the residents' care plans to prevent further safeguarding concerns from arising.

Not all staff had received up-to-date training in safeguarding.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The registered provider had not always ensured that residents had the opportunity to participate in activities in accordance with their interests and capacities, as evidenced by the reallocation of activities staff that impacted on the delivery of meaningful one-to-one activities.

The registered provider had not always ensured that residents could exercise choice, as evidenced by the restricted access to locked communal areas such as courtyards and shower rooms.

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	
Registration Regulation 6: Changes to information supplied for registration purposes	Substantially compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 30: Volunteers	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for St Colman's Residential Care Centre OSV-0000492

Inspection ID: MON-0050161

Date of inspection: 21/07/2026

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
Registration Regulation 6: Changes to information supplied for registration purposes	Substantially Compliant
<p>Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes:</p> <p>A registration compliance checklist and registration change control process will be implemented immediately. The Person in Charge and Registered Provider will review changes in management and registration information to ensure that all notifications under Regulation 6 are identified promptly and all required documentation is submitted in a timely manner within the regulatory timeframes.</p> <p>A central HIQA registration and notification register will be maintained, recording the date of change, notification required, statutory deadline, responsible person, date submitted and confirmation of submission.</p> <p>The Person in Charge will complete a monthly review of the register and the registered provider will review compliance quarterly through governance. Any identified gaps will be immediately escalated, actioned and monitored to completion.</p> <p>In relation to the PPIM role, we are awaiting HSE CEO approval to proceed with recruitment for this post. This post is a Grade VIII role and is the only person in Older Persons who holds a higher grade than the PIC and below the Registered Provider Representative. Once approval is received we will progress this as quickly as possible. In the interim the RPR is trying to identify options to fulfill this requirement.</p> <p>The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations</p>	

Regulation 16: Training and staff development	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The newly appointed PIC has completed a comprehensive training gap analysis. All outstanding training identified has been scheduled. Further training dates have been booked to ensure all outstanding training is completed by 18th November 2026.</p> <p>Since our last inspection 25 staff have attended Fire Safety training and 30 staff have completed Dementia Care training. A further 9 training sessions have been booked for Fire training and a further 6 sessions have been booked for Dementia training. Staff are being facilitated protected time to complete outstanding safeguarding training identified and training due to expire on HSEland. A further 8 sessions of First aid training has been scheduled to ensure all out-standing training and training due to expire is completed by 18th November 2026.</p> <p>The PIC and Nursing Management Team initiated daily inspections on each unit to ensure adequate supervision of staff. Each unit manager has also commenced daily walk around inspections in each of their units to further enhance clinical supervision of staff.</p> <p>A new key pad lock has been installed on the nurses' station. All resident information is adequately stored in a room with a secure lock.</p> <p>Each unit has implemented a new cleaning schedule to ensure equipment is adequately cleaned.</p> <p>Storage practices have been addressed on each unit to ensure appropriate storage is maintained. A staff member will be assigned to check the storage room daily to ensure compliance is maintained. Each unit manager will monitor this on a daily basis on their walk around inspection and through audit.</p>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>The Registered Provider along with the Person in Charge is currently reviewing the governance and management systems within the designated centre to ensure effective oversight of quality, safety and regulatory compliance.</p> <p>A premises compliance audit tool is being developed and will be completed fortnightly by each local unit Clinical Nurse Manager and reviewed by the Director of Nursing. This will form the basis of a comprehensive action plan to address all findings identified during the</p>	

inspection. Progress against the action plan will be reviewed on a monthly basis by the Person in Charge and Nursing Management Team and reported through the centres governance structures until all actions are completed.

The audit tool will specifically review:

- Resident usable storage space within multi-occupancy bedrooms.
- Storage practices within resident accommodation.
- Access to communal rooms.
- Access to shower facilities.
- Access to outdoor courtyards.
- Suitability and cleanliness of outdoor areas.

All equipment not required for resident care has been removed from resident bedrooms and this will be monitored on an ongoing basis by the local Clinical Nurse Manager on a daily environmental and safety walk around, and formally captured on the fortnightly audit.

Monthly audits relating to premises, fire safety, resident rights, volunteer management, notifications and training compliance will be completed and trends reviewed at local governance meetings.

A full review of all communal and outdoor areas was completed on 30th September 2026 to ensure residents can access these facilities in accordance with their rights and preferences. Any restrictions on access will be individually risk assessed, documented and reviewed regularly.

The Person in Charge is compiling a compliance register to ensure all regulatory notifications, management changes and compliance actions are tracked, monitored and evaluated where required.

The annual review completed in 2025 will be reviewed to ensure that consultation that occurred with residents and families through resident meetings, surveys and feedback was incorporated to inform service improvement.

The Registered Provider Representative will maintain oversight of outstanding actions through quarterly provider audits and governance reviews to ensure improvements are sustained.

A detailed painting schedule has been completed to enhance areas of the premises that needed to be upgraded. Ongoing painting works will be completed in Lavender Vale and Heather Rest by 30th of October 2026. Painting works completed in Primrose place and Clover Meadow has already had a positive impact on residents in those units.

Residents usable space in multi-occupancy bedrooms has been fully reviewed by the managers in each unit to ensure all space is fully accessible to residents at all times. Staff have been educated on ensuring no equipment is moved or left in a resident's usable space with immediate effect. Internal communal areas will be fully accessible to residents at all times. Staff training will only be done in activity room when it is not been accessed by residents with immediate effect.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations

Regulation 30: Volunteers	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 30: Volunteers: No person will commence or undertake a volunteer role unless all required pre-commencement checks, Garda vetting and documentation have been completed.</p> <p>A Volunteer Compliance Checklist will be introduced and retained for each volunteer. Six-monthly performance reviews and supervision will be recorded.</p> <p>All new volunteers will complete a full induction, all mandatory training and have a volunteer agreement in place. They will have a mentor appointed to them to ensure they are supported and supervised appropriately.</p>	
Regulation 31: Notification of incidents	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 31: Notification of incidents:</p> <p>The Person in Charge has reviewed all notification processes and will ensure all notifiable incidents are submitted within the statutory timeframes.</p> <p>A notification tracking register has been introduced to record all incidents requiring notification and submission dates.</p> <p>Notification compliance will be reviewed on a regular basis by the Person in Charge and monitored monthly through governance meetings. Any delays or omissions identified will be investigated and corrective actions implemented immediately.</p>	
Regulation 17: Premises	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises: Call bells have been installed in the chapel, the outdoor smoking area, the hairdresser's room, and the visitors' room.</p> <p>A detailed painting schedule for each unit has been completed to ensure upgrading of areas identified by 16th December 2026.</p> <p>The glass panel in the lounge has been fixed.</p>	

A review of lighting on both units has been completed and addressed to ensure they are adequately lit.

The physiotherapy room had been closed for a month due to planned holidays. A deep clean was completed of the physiotherapy room and all equipment to ensure there was no malodour.

Equipment cleaning schedules have been implemented on all units to ensure equipment such as wheelchairs and shower chairs are adequately cleaned.

The courtyard on Lavender Vale has been reviewed, cleaned and removal of items no longer required to ensure a safe and a pleasant environment for our residents. Fencing on Lavender Vale courtyard has been fixed. This will be continuously monitored and audited monthly by the unit manager.

Regulation 20: Information for residents

Substantially Compliant

Outline how you are going to come into compliance with Regulation 20: Information for residents:

A full review of the residents guide has been completed against the requirements of Regulation 20.

The guide is being updated to ensure it accurately reflects:

- All services and facilities available within the designated centre.
- Smoking arrangements and designated smoking areas.
- Resident's rights and responsibilities.
- Terms and conditions relating to residence.
- Arrangements for the management of personal property.
- Complaints procedures.
- Visiting arrangements
- Advocacy and support services available.

The inaccurate reference to the centre as a non-smoking facility will be removed.

The statement that staff routinely retain residents' cigarettes and alcohol is being removed and replaced with information reflecting the Centre's actual practices, including individual assessment and resident choice.

All previous version will be withdrawn. Updated copied will be available throughout the centre, at reception and as part of the admission process.

The residents guide will be reviewed annually or sooner if service changes occur.

Regulation 26: Risk management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 26: Risk management:</p> <p>A full review of the risk management policy will be undertaken to ensure all criteria of the regulations and any identified gaps will be incorporated in the policy by 30th October 2026.</p>	
Regulation 28: Fire precautions	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 28: Fire precautions:</p> <p>A full review of fire drills have been implemented on each unit and identified gaps have been addressed. Each unit has completed a monthly fire drill since our last inspection which practices high risk scenarios using the lowest staffing levels to evacuate the largest compartment on their unit. This will be on an ongoing basis. A night fire drill has also been completed since the last inspection and will be done quarterly going forward.</p> <p>All staff have been educated on the process of accessing keys on each unit. The gate keys have been changed to ensure the same key accesses both gates and is easily accessible to staff. The bike has been removed. We have reviewed external lighting to ensure it is adequately lit should evacuation be required.</p> <p>A full review of PEEP's have been completed on each unit to ensure they identified the amount of staff required for evacuation. All staff have been educated at local level on each unit so they are fully aware of this.</p> <p>All staff have been reminded that fire doors cannot be held opened. This is monitored by each unit manager on their daily walk around inspections.</p> <p>The two fans were removed and staff were educated on the risks that they posed.</p>	
Regulation 8: Protection	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <p>Learnings from investigations will be included in resident care plans to prevent further safeguarding concerns from arising. The care plan for the resident mentioned has been updated to include learnings that were identified.</p>	

All safeguarding training identified from the training gap analysis and that is due to expire soon has been scheduled and all staff will be in full compliance by 18th of November 2026. Staff have also been facilitated protected time whilst on duty to completed safeguarding training on HSEland.

Training compliance will be monitored the Person in Charge. Where staff fail to complete mandatory training within the required timeframe, appropriate action will be taken to ensure compliance and resident safety.

Regulation 9: Residents' rights

Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: The Person in Charge has completed a review of activity provision across the designated centre.

Activity staff will no longer be routinely reallocated to cover staffing deficits except in exceptional emergency circumstances authorised by the Person in Charge. Activity staffing levels will be reviewed weekly through roster management processes.

A programme of group and one-to-one activities is being developed for each unit based on residents' assessed interests, preferences and abilities. Participation in activities will be recorded daily and reviewed monthly by the Activity Coordinator to identify any residents not accessing meaningful activity.

The Snoezelen room, activity room and communal facilities will be available daily between 09:00 and 17:00 and activity staff will facilitate resident access throughout this period.

Residents' participation, feedback and satisfaction with activities will be reviewed through resident meetings, surveys and monthly activity audits and any identified gaps will form part of the quality improvement programme.

A comprehensive review of all communal and outdoor areas has been completed throughout the centre to ensure residents can access them as freely as possible while maintaining safety.

Locked areas have been reviewed and access arrangements revised to ensure restrictions are minimised and individualised risk assessments are implemented where required.

Monthly environmental audits will be completed to monitor residents' access to communal facilities and outdoor areas. Findings will be reviewed through the governance structure and any barriers to resident access will be addressed immediately.

Resident feedback regarding access and choice will be sought through residents' meetings and satisfaction surveys and incorporated into service improvement plans.

The compliance plan response from the registered provider does not adequately assure the Chief Inspector that the action will result in compliance with the regulations

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
Registration Regulation 6 (1) (b)	The registered provider shall as soon as practicable supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of the new person proposed to be in charge of the designated centre.	Substantially Compliant	Yellow	30/10/2026
Registration Regulation 6 (3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the centre)	Substantially Compliant	Yellow	30/11/2026

	within 28 days of the change and supply full and satisfactory information in regard to the matters set out in Schedule 2 in respect of any new person participating in the management of the designated centre.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	18/11/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	18/11/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	16/12/2026
Regulation 20(2)(a)	A guide prepared under paragraph (a) shall include a summary of the services and facilities in that designated centre.	Substantially Compliant	Yellow	30/10/2026
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the	Substantially Compliant	Yellow	30/10/2026

	designated centre concerned.			
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.	Substantially Compliant	Yellow	30/10/2026
Regulation 23(1)(f)	The registered provider shall ensure that the review referred to in subparagraph (e) is prepared in consultation with residents and their families.	Substantially Compliant	Yellow	30/10/2026
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording and investigation of serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	30/10/2026
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the implementation of actions and recommendations	Substantially Compliant	Yellow	30/10/2026

	arising from subparagraph (d).			
Regulation 26(1)(f)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the audit, review and learning from events.	Substantially Compliant	Yellow	30/10/2026
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control the risks identified.	Substantially Compliant	Yellow	30/10/2026
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control abuse.	Substantially Compliant	Yellow	30/10/2026
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control accidental injury to residents, visitors or staff.	Substantially Compliant	Yellow	30/10/2026
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/10/2026

	risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.			
Regulation 26(2)	The registered provider shall ensure that there is a plan in place for responding to major incidents likely to cause death or injury, serious disruption to essential services or damage to property.	Substantially Compliant	Yellow	30/10/2026
Regulation 28(1)(b)	The registered provider shall provide adequate means of escape, including emergency lighting.	Substantially Compliant	Yellow	30/10/2026
Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques	Not Compliant	Orange	30/10/2026

	and the procedures to be followed should the clothes of a resident catch fire.			
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	30/10/2026
Regulation 30(b)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre receive supervision and support.	Substantially Compliant	Yellow	14/10/2026
Regulation 30(c)	The person in charge shall ensure that people involved on a voluntary basis with the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.	Not Compliant	Orange	14/10/2026
Regulation 31(1)	Where an incident set out in	Not Compliant	Orange	30/09/2026

	paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	18/11/2026
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	18/11/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	21/10/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	21/10/2026