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:	Loughshinny Residential Home
Name of provider:	Bartra Opco No. 1 Limited
Address of centre:	Blackland, Ballykea, Loughshinny, Skerries, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	24 March 2026
Centre ID:	OSV-0006616
Fieldwork ID:	MON-0049649

About the designated centre

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

Loughshinny Residential Home is a designated centre registered to provide 24-hour health and social care for up to 126 male and female residents, usually over the age of 65. It provides long-term residential care, convalescence and respite care to people with all dependency levels and varied needs associated with ageing, physical frailty as well as palliative and dementia care. The philosophy of care as described in the statement of purpose is to provide a person-centred, caring and safe alternative for older people and to enable each resident to maintain their independence and thrive while enjoying a more fulfilled and engaged life. The designated centre is a modern two-storey purpose-built nursing home on the edge of the village of Loughshinny in North County Dublin. Accommodation is provided in 124 single and one twin bedroom, each with its own en-suite facilities and decorated to a high specification standard. There is a wide range of communal areas, including dining rooms, sun rooms and lounges available to residents, as well as a hairdresser facility. There are several enclosed, safe, wheelchair accessible gardens available for residents to use during the day. There is ample parking available for visitors.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	122

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 24 March 2026	07:30hrs to 16:00hrs	Aislinn Kenny	Lead
Tuesday 24 March 2026	07:30hrs to 16:00hrs	Sheila McKevitt	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors found that residents reported they were happy living in Loughshinny Residential Home. It was evident that staff were working towards improving the quality of life and promoting the rights and choices of residents in the centre. Residents said their rights were upheld and they felt safe and secure living in the centre. All residents who were spoken with were complimentary of the staff. When asked about the staff delivering the care, residents described them as 'all very kind'. One resident told inspectors 'I can't say enough good things about the place'. Visitors spoken with told inspectors 'nothing is ever any bother' and 'staff are amazing'. Residents who were living with a diagnosis of dementia or cognitive impairment who were unable to express their opinions on the quality of life in the centre appeared to be relaxed and enjoying being in the company of staff.

This unannounced inspection was conducted with a focus on adult safeguarding and reviewing the measures the registered provider had in place to safeguard residents from all forms of abuse. During the inspection, the inspectors spoke with residents and visitors to gain an insight into the residents' lived experience in the centre. The inspectors also spent time observing interactions between staff and residents, as well as reviewing a range of documentation and speaking with staff and management.

The inspectors arrived to the centre early in the morning and observed that the front door was locked and the entrance used by staff was open. Inspectors were able to make their way into the residents' areas and this posed a potential risk. This issue was brought to the attention of the management team and later in the day, the inspectors observed that the entrance door into the residential corridor was fixed. Throughout the morning, the centre was calm and peaceful. Most residents were in their bedrooms or sleeping in bed. Some residents were observed eating their breakfast, walking around the centre and being assisted by staff in their bedrooms.

The centre provided accommodation for 126 residents. The premises was laid out with wide corridors containing handrails to encourage and aid independence. The centre was visibly clean, tidy and well-maintained. Call-bells were available in all areas. Many bedrooms were personalised and decorated according to residents' taste. There was access to outdoor areas for residents to use. This included a secure courtyard on the ground floor.

The complaints procedure was on display and it included the contact details for advocacy services. Residents spoken with told the inspectors that they brought any concerns they had to the attention of the person in charge and these were acted upon immediately.

The inspectors observed staff supervising residents in the main communal living areas and in the dining rooms at lunchtime. On several occasions during the day staff were observed being attentive to residents' individual needs, such as, assisting a resident to mobilise to their bedroom and assisting them with their meals.

Staff were observed knocking on bedroom doors and seeking permission prior to entering residents' bedrooms and each bedroom had a privacy lock in place. Each resident had access to adequate storage facilities within their bedroom for personal items, including a secure storage facility for valuable items.

The residents attended televised Mass as each morning they gathered in the living areas for morning refreshments and activities. There was an activities schedule on display spanned over five days a week, and external activities were provided on the sixth day. Residents spoken with said that they had the choice to participate or not and that their choice was respected by 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 was an unannounced inspection with a focus on adult safeguarding and reviewing the measures the provider had in place to safeguard residents from all forms of abuse. This inspection found that there were management systems in place to protect residents and that there was effective oversight of these systems. The inspectors also followed up on information received following the last inspection of July 2025 and found that some improvement was required to ensure that the CCTV policy was consistently applied as discussed under Regulation 23: Governance and Management.

The registered provider of the centre was Bartra Opco No.1 Limited. The inspectors found that there was a clear governance and management structure in place in the centre. The person in charge was supported in their management of the centre by an assistant director of nursing (ADON), clinical nurse managers, staff nurses and health care assistants. Other staff working in the centre included administrative, laundry, domestic and catering staff. Since the previous inspection, nursing hours had been increased. On the day of the inspection, there were sufficient numbers of staff available to support residents' assessed needs.

The registered provider maintained a suite of written policies and procedures in line with the regulations, such as those relating to staff training and development, safeguarding residents from abuse and a complaints policy.

Staff training records were made available to the inspectors. These records indicated that staff had been provided with all mandatory training and where gaps were identified there was a plan in place to address this.

There were systems in place to monitor and respond to risks that may impact on the safety and welfare of residents. The centre had a risk register which identified clinical and environmental risks, and the controls required to mitigate those risks. There were systems in place to identify, document and learn from incidents involving residents.

Regulation 15: Staffing

On the day of the inspection the registered provider had ensured that the number and skill-mix of staff was appropriate, having regard to the needs of residents and the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

A review of training records indicated that staff were up-to-date with training on the safeguarding of residents from abuse. Other training was available to staff to ensure their knowledge and skills were maintained or enhanced, as needed. There were arrangements in place to ensure that staff were appropriately supervised, according to their individual roles.

Judgment: Compliant

Regulation 23: Governance and management

While there was a clearly defined management structure in place, action was required to ensure that the service provided was safe, appropriate, consistent and effectively monitored:

- Oversight and audit systems in place did not identify gaps in care planning documentation as detailed under Regulation 5: Individual assessment and care planning.
- Systems in place did not identify that CCTV was being used outside the scope and purpose of the registered provider's own policy leading to a risk that it could be misused.

Judgment: Substantially compliant

Quality and safety

The inspectors were assured that residents were living in a centre where their rights were upheld and where adequate resources, policies, procedures and supervision generally ensured that residents were safeguarded in their home.

Appropriate staffing levels impacted positively on the quality and safety of consistent person-centred care delivered to residents.

There was a low level of restraint use within the centre. Residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) at times had a care plan in place which reflected trigger factors and de-escalation techniques that staff could use to prevent the behaviour escalating.

The inspectors reviewed a sample of residents' records and saw that residents were assessed using a variety of validated tools and had care plans in place for each identified need. Communication care plans were in place and they were person-centred, the safeguarding and social care plans reflected a person-centred approach to safeguarding residents and upholding their rights. However, the information within a small number of assessments and care plans for those residents living with a pressure ulcer was not always accurate. The person in charge is required to ensure that the treatment and interventions identified in the care plan is delivered to residents. The care plans reviewed were not detailed enough to guide practice. This is outlined further under Regulation 5: Individual assessment and care plan.

The premises ensured the safety of residents. They had independent access to the enclosed garden which they enjoyed using independently and some under the supervision of staff. Residents were facilitated to lock their bedroom door and staff respected their right to privacy and maintained their dignity during this inspection.

The inspectors saw evidence that all staff had garda vetting in place prior to commencing employment in the centre. There was a safeguarding policy in place. Staff had completed safeguarding training and overall were aware of what to do if they suspected any form of abuse. Any incidents that had occurred in the centre were appropriately investigated and all residents reported that they felt safe and secure in the centre. The processes for management of residents' finances were robust and reflected the centre's policy.

Residents confirmed that they had a choice to socialise and participate in activities and there was a varied activities schedule on weekdays and external entertainment on Saturday or Sunday. Residents’ rights, and choices were respected. Resident

feedback was sought in areas such as activities and meals. Information regarding advocacy services was displayed in the centre. Residents had access to daily national newspapers, Internet services, books, televisions, and radios.

Regulation 10: Communication difficulties

There were adequate systems in place to allow residents to communicate freely. Care plans reflected personalised communication needs. Staff were knowledgeable and appropriate in their communication approach to residents.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Gaps were identified in nursing assessments and care plans of those residents with pressure ulcers. From the sample reviewed inspectors observed the following:

- One resident whose documents were reviewed had incorrect information contained in their latest skin integrity risk assessment. This meant they were identified as at risk of developing a pressure ulcer when in fact they were living with a pressure ulcer. Inaccurate assessments posed a risk that interventions outlined in the care plans did not effectively meet the needs of the resident.
- A review of night-time care documents showed that residents were repositioned on average every six hours, when the recommendation from a tissue viability specialist and the residents' care plan stated that repositioning was to be completed every two to four hours.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The centre was actively promoting a restraint-free environment, in line with national policy. Alternatives to restraint were in use where assessed as being suitable.

The policy on managing behaviour that is challenging was available for review. Residents who exhibited responsive behaviours had person-centred care plans in place to support the management of their behaviours. These care plans described the behaviours, known triggers and de-escalation techniques used by staff to ensure

safe care delivery. Antecedent, Behaviour and Consequence charts (ABC charts) were also maintained.

Judgment: Compliant

Regulation 8: Protection

There was a safeguarding policy in place. Staff had completed safeguarding training and were aware of what to do if they suspected any form of abuse. Any incidents that had occurred in the centre were appropriately investigated and all residents reported that they felt safe and secure in the centre.

The processes for management of residents' finances were robust and reflected the centre's policy.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected in this centre. Residents had opportunities to participate in activities. Access to daily newspapers, television and radio was available. Details of advocacy groups was on display in the centre.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and 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	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Loughshinny Residential Home OSV-0006616

Inspection ID: MON-0049649

Date of inspection: 24/03/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and 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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Loughshinny Residential Home has a strong governance and management framework led by a full-time Person in Charge (PIC), supported by the Assistant Director of Nursing (ADON) and four supernumerary Clinical Nurse Managers (CNMs). Regular audits, governance meetings, and KPI reviews support oversight of clinical care and service quality, with action plans implemented to drive continuous improvement. Staff training, supervision, competency assessments, and ongoing professional development are prioritized to ensure high standards of care. Overall, effective leadership, structured communication, and continuous monitoring ensure residents' needs are consistently met in line with best practice and regulatory requirements. The action plan below will further strengthen surveillance to ensure care is safe, appropriate, consistent, and effectively monitored in line with regulatory requirements. Inspection findings, including deficits in care planning documentation, were shared with the clinical management team, nurses, and healthcare assistants at meetings on 22/04/26 and 29/04/26 (morning and afternoon) along with proposed action plan to strengthen assessment and care plan practices. The PIC has reinforced CNMs and nurses to continue intentional rounds focused on repositioning, to ensure care delivered aligns with documented care plans and highlights any discrepancies. Compliance monitoring is enhanced through daily review by the nurse in charge and weekly review by the CNM as part of weekly KPI analysis, with gaps addressed promptly through supervision and training. The PIC will share trends from care plan audit analysis at monthly meetings, ensuring findings are discussed with clear actions, assigned responsibilities, and tracked	

completion.

Oversight will be strengthened through increased unannounced out-of-hours management visits, with a focus on verifying that care plans are accurate, up to date, and reflective of residents' current needs.

PIC will continue with targeted, regular observational spot-checks, particularly in high-risk areas such as wound care and repositioning, to ensure care is delivered in line with documented plans.

The provider will continue to act within the scope and purpose of its CCTV policy ensure residents safety.
CCTV footage will only be accessed and reviewed for purposes explicitly outlined within the centre's CCTV policy, including safeguarding, security incidents, investigations, and health and safety concerns. Any use outside the defined purpose will be considered a breach of policy and managed accordingly.
Access to CCTV footage will be strictly limited to the Person in Charge (PIC) and Group Maintenance Manager only, in line with the organisation's CCTV policy.
The centre will ensure CCTV signage remains prominently displayed throughout all monitored areas in accordance with GDPR requirements and organisational policy. The retention and storage of CCTV footage will continue to comply with the 30-day retention period outlined within the policy unless required for investigation purposes.

The centre remains committed to ensuring that CCTV is used appropriately, proportionately, and in a manner that fully respects residents' rights and privacy while supporting safety and quality of care. Incidents of CCTV will be highlighted in the monthly operations meeting attended PIC and Chief Risk, Compliance and Services officer.

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:
At Loughshinny Residential Home, each resident undergoes a thorough person-centred assessment process beginning with a pre-admission assessment by the PIC, ADON, or CNM to ensure their needs can be met. On admission, residents receive initial risk screenings followed within 48 hours by a comprehensive assessment completed in partnership with the resident and/or their representative. An individualized care plan is then developed to address medical, social, emotional, and personal needs, reflecting the resident's preferences, strengths, and wishes. Care plans are shared with the

multidisciplinary team to ensure consistent care delivery and are regularly reviewed and updated through ongoing monitoring, daily documentation, and formal reviews at least every four months or sooner if needs change. This continuous process ensures care remains responsive, safe, and tailored to each resident's wellbeing and quality of life.

This has been said, following the inspection, all residents with wounds have had their skin integrity risk assessments and care plans reviewed to ensure they reflect their current condition and treatment needs. Wound care plans are kept separate from general skin care plans, with an individual plan for each pressure ulcer and Chronic wounds. A designated nurse manager has been delegated to audit all wound care plans by 14/05/26 to confirm full compliance.

Each resident has a named nurse responsible for keeping their care plan accurate and up to date. Monthly comprehensive audits of assessments and care plans are conducted by CNM, with 10% of residents' care plans reviewed each month. Audit findings include trend analysis, action tracking, and learning outcomes, which are shared at staff meetings. Hand over processes are strengthened by reviewing handover sheets to ensure all staff are aware of current care plans, especially repositioning schedules and wound care needs.

The PIC has liaised with the training provider and scheduled refresher training for all nursing and healthcare staff in pressure ulcer prevention and management, accurate use of risk assessment tools, and person-centered care planning to be completed by July 2026.

This action plan ensures all care plans at Loughshinny Residential Home remain accurate, up to date, and reflective of residents' individual needs.

A single combined repositioning chart was introduced on 05/05/26 across all units to replace separate bed and chair charts. This ensures clear and consistent recording of repositioning frequency, position changes, times, and staff involved. Repositioning practices have been reviewed to ensure they follow care plans and specialist recommendations. Daily checks of repositioning records will be carried out by the nurse in charge, and weekly reviews will be completed by the CNM and oversight by the PIC. Any gaps will be addressed immediately.

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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 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	30/04/2026
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	14/05/2026
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	Substantially Compliant	Yellow	14/05/2026

	necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			