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:	Leopardstown Park Hospital
Name of provider:	Leopardstown Park Hospital
Address of centre:	Foxrock, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	29 April 2026
Centre ID:	OSV-0000667
Fieldwork ID:	MON-0046677

About the designated centre

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

Leopardstown Park Hospital provides care for adults who have long term needs for residential care. The centre provides services for residents with low dependency through to those residents who are maximum dependency and require full time nursing care, including care for residents who have dementia and for residents who need end of life care. Accommodation is provided across five units accommodating 120 male and female residents. Clevis unit has 29 beds and provides accommodation and services for residents who have low dependencies. The other four units provide accommodation and services for residents with higher levels of need and are located within the main hospital building. Glencullen and Glencree commonly known as the Glens units provide accommodation for 21 residents in Glencree and 22 residents in Glencullen, in a mix of single and multi-occupancy rooms. Orchard and Avoca units were recently renovated and both provides accommodation for 20 residents each. Djouce unit was also recently refurbished and accommodates 8 residents.There are garden areas to the front and rear of the property with seating available for residents. There is a large car park to the front of the building with some disabled parking spaces available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	117

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
Wednesday 29 April 2026	07:30hrs to 16:35hrs	Aoife Byrne	Lead
Wednesday 29 April 2026	07:30hrs to 16:35hrs	Niamh Moore	Support
Wednesday 29 April 2026	07:30hrs to 16:35hrs	Laurena Guinan	Support

What residents told us and what inspectors observed

This was an unannounced inspection of Leopardstown Park Hospital which took place over one day by three inspectors. During this inspection, inspectors spent time observing the care provided to residents, reviewing documentation and speaking with residents and staff. Staff were observed to provide care and support to residents in a caring and respectful manner. Overall, residents said they were happy with the care they received. One resident told inspectors "this nursing home has a reputation of the best and I don't disagree" and another resident said "the staff are brilliant", "I wouldn't go anywhere else". However, inspectors did get some recurrent feedback from residents who said that there were times where they were bored and they would like more access to activities.

Following a brief introduction to the nurse in charge, inspectors walked through the centre to review the premises which was comprised of six residential units. Most residents were in their bedrooms during this time, and breakfast was served shortly after the inspectors arrived, with most residents served their breakfast in their bedrooms and where necessary, support from staff was provided. Following this, the inspectors completed an opening meeting with the person in charge and members of the management team.

The designated centre is registered for 120 residents with 117 residents living in the centre on the day of the inspection. Inspectors observed that overall the physical environment of the centre was clean. However, there were areas which required further maintenance, such as damaged flooring and equipment, and outdoor areas where weeds were seen which made the area look unkempt and not a nice place to spend time in. In addition, the availability of call-bells in two visitors' rooms remained outstanding since the last inspection in October 2025. Inspectors also observed on the morning of the inspection that some residents did not have access to call bells. While each bedroom had a call bell in some bedrooms they were found to be clipped to the wall and not within easy reach for the residents to call for assistance if they required to.

Residents' accommodation was in three-bedded, twin and single bedrooms, with access to en-suites or shared bathrooms. Residents' bedrooms were observed to be clean and tidy and were personalised with residents' own belongings which gave them a homely feel. For example, one bedroom had potted plants which the residents' said they loved. Housekeeping staff were observed throughout the day assisting residents to clean their bedrooms. Residents confirmed they were happy with their bedrooms, however it was noted that in some of the bedrooms, not all residents had access to lockable storage to ensure their possessions were safe. A new sensory garden was in the process of being landscaped at the time of the inspection ,inspectors were told that residents will have access to enjoy the garden and an outdoor cinema with other activities planned for this area.

The inspectors observed the lunch service and saw that residents were offered a choice, with some ordering from the menu, and there was ample staff available to assist residents. The kitchen staff were updated on residents' dietary requirements and were seen to be familiar with residents' likes and needs. Some residents chose to have lunch in their bedrooms, and they told the inspectors that was their preference. They said that their meal was hot, and they were supplied with condiments and drinks. Staff were seen checking on these residents during their meal. Residents spoken with were mostly complimentary about the quality of food offered, although some residents felt there was ''a lack of variety'', '' the meat is very tough'' and,'' food is chopped up, as if for a child'', this did not encourage residents independence.

The inspectors saw some one-to-one activities in some of the units on the morning of the inspection, and many of the residents attended Mass in the auditorium. In the afternoon, there was a lively music session on the Orchard unit which was well-attended and encouraged interaction with the residents. However, due to staff vacancies 1:1 activities were not seen on every unit and therefore residents did not have equal opportunities to participate in activities throughout the centre. A number of residents told the inspectors that they were looking forward to a drinks social event on the evening of the inspection. Staff were seen to engage with residents in a kind and friendly manner, addressing them by name and knocking on doors before entering bedrooms.

Visitors were seen coming and going on the day of the inspection and those spoken with said that they were always made feel welcome, with some joining in the music session in the afternoon. They said that staff were proactive in communicating with them about their loved one, and they felt that their loved one was well-cared for.

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

This was an unannounced inspection with the aim of monitoring compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended) in the centre. Inspectors found that improvements were required to comply with the regulations in respect of the oversight and management processes in place to ensure that the services provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced particularly in the areas of governance and management oversight, and ensuring correct and accurate documentation.

The inspectors followed up on the compliance plan from the previous inspection in October 2025 and found many of the items were not completed in full, or hd yet to

be addressed, despite the date by when they were to be completed having passed. These included maintenance issues, visitors rooms and policies not in line with the requirements of the regulations.

Leopardstown Park Hospital is the registered provider of Leopardstown Park Hospital. The management structure within the centre was clear, with identified lines of authority and accountability. The person in charge worked full time and was supported in their role by an assistant director of nursing, clinical nurse managers, a team of staff nurses health care assistants, housekeeping, catering, activities, laundry and administration staff.

There was a system of governance meetings in place to enable efficient communication in the centre amongst management and staff, however, issues raised by residents had no action plans and it was unclear if issues were being addressed by management. For example; residents highlighted that they would like more activities which was also identified at the last inspection in October 2025. The quality and safety of care was being monitored through audits including falls, care plans, infection prevention and control, however there was inconsistencies with the audit schedule and this is discussed further under Regulation 23: Governance and Management.

An annual review of the quality and safety of care delivered to residents had been completed for 2025 and included a quality improvement plan for 2026 which was seen to be implemented and actions were ongoing.

The inspectors reviewed the staff rosters and saw that there was 2.6 WTE activity staff, however the registered provider had committed to employing 4 WTE activity staff in their Statement of Purpose submitted as part of their registration. This was a repeat finding from the previous two inspections, and records of management meetings showed that two extra activities staff were requested in February 2025. Activities staff spoken with on the day also told the inspectors that a staff member was not allocated to fill their role in their absence. This was discussed with the person in charge and the clinical nurse manager at the feedback meeting. They confirmed that there was a recruitment campaign underway for two new activities staff, but the process had not yet reached interview stage. They also confirmed that when an activities staff was absent, staff on the units were required to provide activities. Residents spoken with on the day said that there was often no activities on their unit, and the request for more activities was documented in residents' meetings. This will be discussed under Regulation 15: Staffing.

Staff had access to training appropriate to their roles. Inspectors reviewed the training matrix in the centre and found that there were high levels of compliance with training in areas such as managing behaviour that is challenging and restrictive practice. However, supervision of staff was not always effective to ensure that care plans were documented in accordance with their assessed needs.

Numerous statutory notifications of alleged abuse had not been reported to the Chief Inspector within the prescribed time frames.

Regulation 15: Staffing

The staff and skill mix was appropriate to the number and needs of residents, with the exception of ensuring that all residents had access to meaningful activities. This was evidenced by:

- The centre did not have the number of activities staff as set out in their statement of purpose.
- There were no arrangements in place to cover the absence of activities staff.

Some residents spoken with on the day of the inspection said that there was often no activities provided apart from the main group activity in some of the units, particularly Djouce, Orchard and Avoca unit. This is a repeat finding.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff had access to a programme of training that was appropriate to the service. All staff were up-to date with mandatory training.

Judgment: Compliant

Regulation 19: Directory of residents

An updated directory of residents was maintained in the centre. This included all of the information as set out in Schedule 3 of the regulations.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place required review to ensure that the service provided was consistent and effectively monitored. This was evidenced by:

- Meetings and audits conducted did not always have documented aligned action plans, resulting in issues identified not being addressed in a timely and appropriate manner. For example:

i. Residents meetings repeatedly documented requests from residents including more activities. These meetings had no action plan to address the residents concerns raised.This is a repeat finding from the last inspection in October 2025.

ii. While cleaning audits were conducted these were done on a monthly basis by an external company and no action plans were in place to address concerns raised.

- A number of areas the registered provider had committed to addressing in the compliance plan from the inspection in October 2025, had not been actioned. For example;

i. Maintenance issues remained outstanding.

ii. Two visitors rooms were still being used as storage spaces.

iii. There was no private visiting space on Djouce unit.

iv. There was inadequate furniture in the sitting areas in Glencree and Djouce units.

v. Risk management and Visitors policies did not meet the requirements of the regulations.

- Audits were not occurring as per the providers schedule for 2026, for example; planned audits in care planning and documentation had not occurred and therefore deficits in these areas were not identified or actioned.

- The management of theft/loss incidents was found to be insufficient. A new standard operating procedure was introduced in February 2026 which outlined that the Gardai would be notified when theft was suspected and that all incidents would be assessed from a safeguarding perspective. The registered provider conducted a review of four incidents that outlined these incidents occurred in two of the six units. However, the conclusion of the review did not identify the units as high risk locations from a safeguarding perspective. Additionally, while five incidents were reported to the Chief Inspector, only four of these were reviewed.

- Inspectors were told of the personal possessions log used to maintain oversight of resident's belongings. It was noted that a key finding of the review into items missing, was that some belongings were not recorded in the log. Inspectors reviewed the record of one resident who recently reported money was missing and saw that this record had not been updated since January 2026 and did not accurately list their valuables.

- The oversight systems in place to ensure that all medicinal products were stored securely was not fully effective. For example:

i. Blister pack medications for numerous residents were left unattended in a dining room.

ii. A clinical room and medicine cupboard were left open and freely accessible.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had not notified the Chief Inspector of numerous allegations of safeguarding concerns. An outbreak of a notifiable disease was not notified within the required two working day time frame.

This is a repeat finding.

Judgment: Not compliant

Quality and safety

The inspectors found that the provider was, in general, delivering a good standard of care and support to residents. Residents reported that they received good care and support from staff and felt safe living in the centre. However, some actions were required with regards to policies, personal possessions, the premises and residents' rights to comply with the regulations, these findings are detailed under the relevant regulations.

Inspectors reviewed a sample of residents' records in each unit. Validated risk assessments were regularly completed to assess clinical risks such as the risk of malnutrition, falls and pressure ulcers. Inspectors observed examples of very good person centred-care plans that clearly outlined residents' assessed needs and included their preferences relating to their daily routine and their likes and dislikes. As discussed earlier in this report the care delivered was not always reflected in care plans as outlined under Regulation 5: Individual assessments and care plans.

Residents had access to a general practitioner on-site Monday to Friday and out of hours services if required. There was evidence of referrals to health and social care professionals to meet residents' needs. Records showed a variety of these practitioners were involved in caring for the residents, including physiotherapy, occupational therapy, dietitian and speech and language therapy. Where medical or specialist practitioners had recommended specific interventions, evidence was seen that in most occasions nursing and care staff implemented these, however some

gaps were identified where residents did not get timely access to the multidisiplinary team and this is further discussed under Regulation 6: Healthcare.

Activities staff spoken with were enthusiastic about providing new and varied activities to the residents. Documentation in residents' files showed that they assessed residents' interaction and response to activities so the residents' likes and abilities were accurately recorded. They also worked closely with the occupational therapist to provide suitable activities. Both the activities and management staff said that there was a reliance on staff on the units to support the provision of activities. There were a maximum of two activities staff on duty each day to provide activities to 120 residents over six units. This made it difficult to provide meaningful engagement on a consistent basis for all residents on each unit. The inspectors saw an activity schedule with a variety of group activities, such as bingo and music, held in the main auditorium and on each unit. One-to-one activities were also scheduled in the morning for each unit, but these not seen to be carried out in all units on the morning of the inspection. Some residents said that if they chose not to attend group activities there was no alternative, and they watched TV or read instead, while others said that they attended to gardening or knitting when not at group activities. Residents spoken with on one of the units said that they were not offered one-to-one activities such as hand massage or card games, although the inspectors saw residents on a different unit engaged in a picture game and card games with a member of the activities staff. Residents not attending the music session in the afternoon were seen to be watching TV or listening to music. Overall, residents from all units said that they enjoyed the activities on offer but that they would like more, and had requested this at residents' meetings.

The inspectors saw minutes of residents' meetings, but there was no schedule of meetings to inform residents how often they were held, and there were no action plans in place to address issues raised by residents at these meetings. Improvements regarding consulting with residents had not been actioned as identified in the compliance plan. Residents' rights to exercise choice was also impacted by the location and availability of call-bells. On the morning of the inspection, inspectors observed that on the Glencree unit, four residents who were in bed did not have a call-bell placed nearby to them to ensure they were able to call for assistance if and when required. In addition, the layout of one bedroom on this unit did not allow sufficient access to the call-bell and instead a bell was provided to the resident. This created a risk that the residents call for assistance would not always be heard as this was not connected to the main call-bell system, and this resident stated there can be delays to staff responding to their calls for assistance.

On the day of the inspection, there were no visiting restrictions in place and visitors were observed coming and going to the centre. Residents were able to meet with visitors in private or in the communal spaces in some of the units with the exception of Djouce unit that had no visitors room available and two visiting spaces in Orchard and Avoca were not available for use. The visiting policy required review as discussed under Regulation 11: Visiting.

Residents' clothing was laundered in the centre and arrangements were in place to ensure their clothing was returned to them following the laundering process. Overall residents gave positive feedback on the laundry provisions. However, the management of personal possessions was insufficient to ensure residents could retain control of all of their belongings. This is further discussed under Regulation 12: Personal possessions.

The inspectors reviewed the risk management policy and found that it did not meet all the requirements of the regulations. This will be discussed under Regulation 26: Risk management.

There were some systems in place to monitor fire safety procedures within the centre. Fire escape maps were present throughout the building. The registered provider had engaged a competent person to complete an assessment of fire precautions in December 2025. Following this report, it was recommended that the provider commenced a full assessment of the fire doors, wall assessment, passive fire safety systems and develop an ongoing maintenance programme. Inspectors were informed this was currently in progress and an action plan was submitted in respect of this with a timeframe of completion by June 2026. There was evidence of a high level of attendance at fire safety training and a good level of knowledge from staff. Staff were provided with residents evacuation plans during handovers and simulated evacuation drills were conducted at regular intervals. However, not all scenarios had been trialled during these fire drills. This is further discussed under Regulation 28: Fire Precautions.

Regulation 11: Visits

While the provider had reviewed the visitors' policy since the last inspection, this did not meet the requirements of the regulations. For example, it did not include the process and the arrangements for residents to receive nominated support persons.

Not all units in the centre had suitable private areas available for residents to receive visitors. This was evidenced by the following findings:

- There was no private visitors' areas on the Djouce units.
- On the Orchard and Avoca unit, inspectors found that the two visitors' rooms as per the registered floor plans had been repurposed as storage spaces. This is a repeat finding.

Judgment: Substantially compliant

Regulation 12: Personal possessions

Inspectors reviewed records which outlined that residents' belongings and or money had recently gone missing in the centre, and found action was required to ensure that residents could retain control over their personal belongings. For example:

- Not all residents had access to adequate lockable space to store and keep their personal possessions safe. Inspectors saw that some of the older wardrobes did not have a lockable storage space.This posed a risk that residents valuable items were not secure.

Judgment: Substantially compliant

Regulation 17: Premises

Some areas of the premises did not conform to the requirements set out in Schedule 6 of the regulations to meet the needs of the residents, for example:

While the overall premises met the needs of the residents, some areas were not kept in a good state of repair, for example:

- Not all areas for use by residents were equipped with call bell facilities. This is a repeat finding. For example, the visitors' rooms on the Glencree and Glencullen units did not have call bells.
- Surfaces and finishes such as shower trays and grab rails, in the bathrooms of some units, particularly the Glencree and Glencullen units, were worn and poorly maintained and as such did not facilitate effective cleaning.
- The flooring in various areas of the centre such as the dining room on the Glencree unit and the staff changing areas in the glencullen unit was damaged.
- The lock to the door of the hoist store room in the Glencree unit was damaged.
- The ceiling was stained and damaged in the ADL office area in the Glencullen unit.
- The garden of the Glencullen unit was poorly maintained with weeds visible, and paint worn off the bench seat.
- Damaged ceilings, walls and skirting in Djouce unit. This is a repeat finding.

Judgment: Substantially compliant

Regulation 26: Risk management

The risk management policy did not meet the requirements of the regulations as evidenced by:

- Abuse was not included as a specific risk.
- The measures and actions in place to control risks were not outlined.
- The arrangements to identify, record and investigate serious incidents were not outlined in the policy.
- The process to implement actions and recommendations was not outlined.
- A process for the audit, review and learning from events was not included.
- There was also no plan in place to respond to major incidents.

This is a repeat finding.

Judgment: Not compliant

Regulation 28: Fire precautions

Routine fire drills were being carried out and there was evidence of learning being identified such as ensuring the appropriate supervision of residents at all times of the evacuation. However, these drills were using day time staffing levels and in some cases it was taking 5 minutes and 45 seconds to evacuate four residents. The drills did not reflect high risk scenarios such as evacuating a full compartment with night-time conditions, when staffing levels are at their minimum, particularly in the case of residents with complex mobility and evacuation needs.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While all residents had care plans in place that were initiated within 48 hours from admission and reviewed at regular intervals, from a review of a sample of residents' records, inspectors found that further action was required in relation to individual assessment and care planning. This was evidenced by the following;

- A resident's nutrition care plan evidenced that the resident should be supported to eat their meals in a less stimulating environment such as their bedroom, this was not seen to take place on the day of the inspection where the resident was provided with their lunch-time meal in the dining room.
- A resident's wound care plan evidenced that wound care should be provided every three days, however there was gaps of six days and another gap of twelve days. Inspectors were told that at times the resident would refuse due to pain and this was the reason for the gaps in wound care, however this was not documented.
- A resident's wound records indicated that pain was noted at times of dressings, however there was no pain relief provided to assist with this.

Judgment: Substantially compliant

Regulation 6: Health care

Overall, residents had good access to medical care and records indicated that residents were reviewed regularly. However, some residents did not receive timely referral for specialist review and this was seen to impact them on the day of the inspection. For example:

- Following a resident's dentures being misplaced, they were referred to speech and language therapy to have the texture of their meals reassessed and this was changed to Level 4 consistency (puréed foods). A medical review of the resident noted that the resident was losing weight since this change as they were not enjoying this consistency, and it was recommended they were supported to obtain replacement dentures to facilitate their health and comfort. This review took place seven weeks prior to the inspection, and there was no evidence that the resident had been referred to a dentist or for new dentures. Inspectors reviewed the resident's weight monitoring and noted weight loss had continued in these seven weeks, and also observed on the day of the inspection this resident did not eat their lunch-time meal.
- A resident's mobility care plan referenced ensuring the resident was seen by the chiropodist for nail care. However, the last documented chiropody review occurred in November 2025.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

Following up on the compliance plan from the last inspection in October 2025, all staff were up to date in responsive behaviour training.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had not ensured that all residents had equal opportunities to participate in activities. This was evidenced by:

- Inconsistent provision of activities between units.
- There was a reliance on care staff on the units to provide activities. This often resulted in residents not having an alternative activity when group activities

were being held, or when activities staff were working with residents on other units.

The registered provider had not ensured that all residents could exercise choice to seek assistance when required, as not all residents had easy access to a call-bell.This created a risk as there can be delays to staff responding to their calls for assistance.

The registered provider had not ensured that all residents had the facilities for occupation and recreation, as there was inadequate furniture in the sitting areas of the Glencree or Djouce units. Residents in these units sat in their own chairs or on dining chairs.

The registered provider had not ensured that all residents could undertake personal activities in private, as evidenced by two visitors' rooms being unavailable for use by residents, and no private visitors area on the Djouce unit.

The registered provider had not ensured that all residents were consulted about or participated in the organisation of the centre. This was evidenced by:

- There was no schedule for residents' meetings to inform residents when they would be held.
- Issues raised at residents' meetings did not have action plans to address them. This meant that issues were not always resolved in a timely manner. For example, residents had regularly requested more activities during meetings, and this was outstanding on the day of the inspection.

Judgment: Not 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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 19: Directory of residents	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 11: Visits	Substantially compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Leopardstown Park Hospital OSV-0000667

Inspection ID: MON-0046677

Date of inspection: 29/04/2026

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Two full-time Activities Staff have been recruited, bringing activity staffing in line with the Statement of Purpose and ensuring consistent provision of meaningful activities across all residential units. In the absence of Activities Staff, Occupational Therapy Assistants will provide planned cover to maintain continuity of the activity programme. Designated HCAs on each unit will continue to support and facilitate daily meaningful engagement, recognising that promoting social participation and diversional therapy is the responsibility of all staff. A planned programme of activities is available seven days per week, including evenings and weekends, with weekly schedules displayed on each unit and developed in accordance with residents' assessed needs, preferences and interests. Resident participation, activity provision across each unit, staffing levels and programme delivery will be monitored through monthly activity audits, supervision and governance meetings. Any gaps identified will be addressed through corrective action plans and reviewed by the Person in Charge to ensure sustained compliance and continuous improvement.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The governance and quality assurance framework within the centre has been strengthened to ensure the service is safe, appropriate, consistently delivered and effectively monitored. All audits, inspections, resident meetings, reviews and quality improvement initiatives will result in documented SMART action plans, with each action assigned to a named manager, allocated a completion date and monitored through the	

centre's Quality Improvement Action Tracker. Progress will be reviewed at Senior Management Team meetings and governance meetings until all actions are completed and evidenced.

Residents' meetings will be held in accordance with the annual schedule and will include documented action plans identifying the actions required, the person responsible and agreed completion dates. Progress against outstanding actions will be reviewed at subsequent meetings, and feedback will be provided to residents to demonstrate how concerns raised have been addressed. Particular oversight will be maintained regarding activity provision and other recurring themes identified through resident consultation.

Environmental cleanliness will continue to be monitored through daily environmental checks and monthly external hygiene audits. All findings requiring improvement will generate corrective action plans, which will be assigned to a responsible manager, monitored to completion and reviewed through the governance structure to ensure improvements are implemented and sustained.

Maintenance issues will continue to be managed through the electronic maintenance management system incorporating QR-code reporting. All maintenance requests will be reviewed daily, prioritised according to risk, assigned to the appropriate personnel and monitored weekly by management to ensure completion within agreed timeframes. Outstanding works will be escalated through the governance process until completed. Visitor rooms previously used for storage will be restored to their intended purpose following the relocation of storage facilities, and communal areas have been enhanced through the provision of additional seating and furniture to improve residents' comfort and recreational opportunities.

The annual audit programme has been reviewed to ensure all planned audits, including care planning, documentation, medication management, infection prevention and control, environmental audits and governance audits, are completed in accordance with the annual audit schedule. Audit findings will include measurable corrective action plans, which will be monitored through the Quality Improvement Programme and governance meetings until all actions have been completed and evaluated for effectiveness.

The revised Standard Operating Procedure for theft and loss incidents will be fully implemented and monitored. All incidents will be assessed from a safeguarding perspective, investigated in accordance with the procedure, reported to An Garda Síochána where appropriate, and notified in line with regulatory requirements. Quarterly trend analysis will be undertaken to identify patterns, implement preventative measures and evaluate the effectiveness of controls.

Clinical Nurse Managers will maintain oversight of residents' personal property records to ensure inventories remain accurate, complete and reflect residents' current valuables and possessions. Regular audits will be undertaken to verify compliance and any discrepancies will be addressed promptly.

Medication management systems have been strengthened through enhanced managerial oversight, daily medication storage and environmental checks, regular medication management audits and reinforcement of safe medicines management practices. Any

deficits identified will be addressed immediately through corrective action, staff supervision, learning and re-audit to ensure medicines are stored securely and managed safely at all times.

To ensure sustained compliance, progress against this Compliance Plan will be incorporated into the centre's Quality Improvement Programme. The Senior Management Team will review progress monthly, verify evidence of completion and monitor the effectiveness of all implemented actions to ensure continuous quality improvement and ongoing compliance with Regulation 23.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The management process for statutory notifications has been strengthened to ensure all notifiable incidents are identified, reviewed and submitted to the Chief Inspector within the regulatory timeframes. The Person in Charge retains overall responsibility for ensuring compliance with Regulation 31, supported by the Assistant Director of Nursing and Clinical Nurse Managers. All safeguarding concerns, alleged abuse, notifiable disease outbreaks and other incidents requiring statutory notification will be reviewed immediately following identification to determine reporting requirements. A notification checklist will be used to ensure all incidents requiring notification are identified and submitted within the prescribed timeframe. A statutory notification register will be maintained to record all notifiable incidents, the date the incident occurred, the date the notification was submitted and confirmation of compliance with the regulatory reporting requirements. The register will be reviewed weekly by the Person in Charge to ensure no notifications remain outstanding. Compliance with statutory notification requirements will be monitored through the centre's governance meetings and quality assurance programme. Any delays or omissions identified will be reviewed to determine the underlying cause, with corrective actions implemented, shared with the relevant management team and monitored to completion to support continuous improvement and prevent recurrence.

Regulation 11: Visits	Substantially Compliant

Outline how you are going to come into compliance with Regulation 11: Visits:

The Visitors' Policy has been reviewed and updated to ensure full compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013. The revised policy now includes clear arrangements for residents to receive visits from nominated support persons and reinforces residents' rights to receive visitors in a manner that respects their privacy, dignity, independence and personal preferences. The Resident and Visitor Guide has also been updated to align with the revised Visitors' Policy, ensuring residents, families and visitors receive clear, consistent and accessible information regarding visiting arrangements, nominated support persons, residents' rights, advocacy services and the supports available within the centre. The revised policy and guide have been communicated to staff and made available to residents and visitors. Additional storage facilities have been provided to enable the visitor rooms on the Orchard and Avoca units to be restored to their intended purpose as private visiting spaces. These rooms will remain designated for residents and visitors and will not be used for storage purposes. Residents accommodated in Djouce continue to have access to suitable private visiting facilities through the designated visitors' room adjacent to the chapel and the library, ensuring appropriate private visiting facilities are available across the centre. The Person in Charge and Clinical Nurse Managers will maintain ongoing oversight of visiting arrangements through regular environmental inspections, resident and family feedback, and governance reviews to ensure private visiting facilities remain available, the Visitors' Policy is consistently implemented, and residents continue to exercise their rights to receive visitors in accordance with Regulation 11. Any issues identified will be addressed promptly through the centre's Quality Improvement Programme and monitored to completion.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Residents are supported to retain control over their personal property, possessions and finances in accordance with their individual wishes, assessed needs and the requirements of Regulation 12. Secure storage facilities, including lockable storage for money and valuables, are available to all residents who wish to use them. Where a resident requests additional secure storage facilities, these will also be made available to ensure their personal belongings can be stored safely while promoting independence, privacy and choice.

Clinical Nurse Managers will ensure residents' personal property inventories are completed on admission, reviewed regularly and updated whenever changes occur to accurately reflect residents' belongings and valuables retained within the centre. Residents and, where appropriate, their representatives will be involved in confirming the accuracy of these records.
Our policy is being reviewed to take these issues into consideration.
Compliance will be monitored through regular audits of residents' personal property records, environmental checks and ongoing management oversight. Any issues identified

will be addressed promptly through corrective action plans and reviewed through the centre's governance structure to ensure residents' personal possessions remain secure and their rights are protected in accordance with the regulations.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A planned preventative maintenance programme is in place to ensure the premises are maintained in accordance with Schedule 6 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and continue to provide a safe, comfortable and homely environment for residents. An upgraded call bell system has been tendered, with installation scheduled to commence on 20 July 2026 in the visitors' rooms on the Glencree and Glencullen units, ensuring residents have access to appropriate call bell facilities in all designated areas. A structured maintenance programme is in place to address all environmental issues identified during the inspection, including worn shower trays and grab rails, damaged flooring, ceilings, walls, skirting, repair of the hoist storeroom lock on the Glencree Unit, and refurbishment of the ADL Office ceiling. External environmental improvements, including maintenance of the Glencullen garden and outdoor seating areas, are also incorporated into the planned maintenance schedule. The centre's electronic maintenance management system, incorporating QR-code reporting, has been fully implemented. Staff can report maintenance issues immediately using the QR-code system, enabling defects to be identified, prioritised according to risk, allocated to the appropriate personnel and monitored through to completion. Progress is reviewed regularly by the Facilities Department and Senior Management Team to ensure timely completion of all works. The Person in Charge, Facilities Manager and Senior Leadership Team maintain oversight of the maintenance programme through regular environmental inspections, maintenance audits, resident feedback and governance meetings. Outstanding actions are monitored through the Quality Improvement Programme until completed, ensuring the premises continue to meet regulatory requirements and provide a safe, accessible and well-maintained environment for all residents.

Regulation 26: Risk management	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:

The Risk Management Policy is currently undergoing a comprehensive review in consultation with the organisation's insurers to ensure full compliance with Schedule 5 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The revised policy will clearly identify and document the measures in place to manage and control all risks specified within Schedule 5, including abuse, unexplained absence of a resident, accidental injury, aggression and violence, self-harm and infectious diseases. The policy will also include clear arrangements for the identification, reporting, investigation and management of serious incidents, implementation and monitoring of corrective actions, organisational learning arising from incidents, and a comprehensive Major Emergency Response Plan to support preparedness and business continuity.

Risk management processes will continue to be supported through the centre's incident management systems, risk register, incident review processes and governance framework. All incidents and identified risks will be reviewed, investigated where appropriate, assigned corrective actions and monitored to completion. Learning arising from incidents, audits and reviews will be shared with staff and incorporated into practice to promote continuous quality improvement.

The Risk Management Policy will be approved through the centre's governance process and communicated to all staff. Compliance with the policy will be monitored through regular risk audits, governance meetings, review of the organisational risk register and ongoing management oversight. The policy will be reviewed in accordance with the centre's policy review schedule, or sooner where legislative changes, incidents or identified risks require amendment, ensuring continued compliance with Regulation 26.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The fire drill programme has been reviewed and strengthened to ensure fire evacuation drills reflect realistic emergency scenarios and provide assurance that residents can be evacuated safely under a range of operational conditions. Fire evacuation drills are now undertaken using both day and night-time staffing levels and include high-risk scenarios, such as the evacuation of a full compartment, residents requiring maximum assistance, and residents using specialist evacuation equipment. These drills are designed to test the effectiveness of evacuation procedures under minimum staffing levels and to ensure staff are confident in responding to a fire emergency. Each fire drill is documented, timed and formally debriefed. Learning identified during drills is recorded, with corrective actions assigned to a responsible person, allocated a completion date and monitored through to completion. Where improvements are identified, additional training, supervision or further drills will be completed to ensure the required standard is achieved. The Person in Charge and Fire Safety Lead will maintain oversight of the fire drill programme through

regular review of fire drill records, fire safety audits and governance meetings. Compliance with the fire safety programme will be monitored on an ongoing basis to ensure evacuation procedures remain effective, staff competency is maintained and continuous improvement is demonstrated in accordance with Regulation 28.

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:

Residents' assessed needs, preferences and choices will continue to be reflected within their individual care plans and implemented consistently in daily practice. Nursing staff will complete ongoing clinical assessments and ensure care plans are reviewed promptly following any change in a resident's condition, preferences or clinical needs, with all updates clearly documented in the resident's clinical record. Care interventions, including nutritional support requirements, wound management and pain management, will be delivered in accordance with residents' assessed needs and evidence-based practice. Where a resident requires meals in a specific environment to support their nutritional intake, this will be implemented and documented. Wound care will be completed in line with the prescribed treatment plan, with any refusal of treatment clearly documented together with the actions taken and clinical rationale. Pain assessments will be completed before, during and following wound care where indicated, with pain management interventions implemented and evaluated to ensure residents remain comfortable. Clinical Nurse Managers will maintain oversight of care planning through regular documentation audits, supervision of clinical practice and review of residents' records. Audit findings will be discussed through the governance structure, with corrective actions assigned, monitored and re-audited to ensure care plans accurately reflect residents' needs and that care is delivered consistently in accordance with those plans.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: Systems have been strengthened to ensure residents receive timely access to appropriate healthcare services and specialist professional expertise in accordance with their assessed needs. All referrals to specialist healthcare services, including dental, chiropody and other allied health professionals, will be initiated promptly following clinical assessment and documented within the resident's clinical record. Clinical Nurse Managers

will maintain oversight of all outstanding referrals to ensure appointments are progressed, outcomes are followed up and any recommendations are incorporated into residents' care plans without unnecessary delay. A referral tracking system is in place to monitor all external healthcare referrals from the date of referral through to appointment, outcome and completion. Outstanding referrals will be reviewed regularly by the multidisciplinary team and escalated where delays are identified to ensure residents receive timely access to the healthcare services they require. Compliance will be monitored through regular clinical documentation audits, multidisciplinary team reviews and governance meetings. Audit findings will inform quality improvement actions, with corrective measures assigned, monitored and reviewed to ensure residents continue to receive safe, effective and person-centred healthcare in accordance with Regulation 6.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Residents' rights to dignity, privacy, independence, choice, consultation and meaningful participation will continue to be promoted and supported in accordance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The recruitment of two additional Activities Staff has strengthened the provision of meaningful activities across all residential units. A planned programme of group and individual activities is provided seven days per week and is developed in accordance with residents' assessed interests, abilities and preferences. Resident participation and satisfaction with activities will be monitored through resident feedback, activity audits and governance reviews to ensure equitable access across the centre.

Call bell accessibility has been reviewed, and Clinical Nurse Managers will maintain ongoing oversight to ensure residents have appropriate access to call bell systems. Where a resident is unable to use a standard call bell, individualised alternative arrangements will be identified through clinical assessment, documented within the resident's care plan and reviewed regularly to ensure the resident can summon assistance safely and effectively.

Additional furniture has been provided within the Glencree and Djouce communal sitting areas to improve residents' comfort, recreation and social engagement. Private visiting facilities have also been restored and are available across the centre, ensuring residents can meet family and visitors in a private, comfortable and dignified environment.

Residents' meetings are held in accordance with an annual schedule and provide residents with meaningful opportunities to participate in the organisation and development of the service. Each meeting includes a documented action plan identifying agreed actions, the responsible person and completion dates. Progress against previous

actions is reviewed at subsequent meetings and feedback is provided to residents to demonstrate how their views have informed service improvements.

Compliance with residents' rights will be monitored through resident satisfaction surveys, resident meetings, clinical and environmental audits, governance meetings and ongoing management oversight. Any areas identified for improvement will be incorporated into the centre's Quality Improvement Programme, with actions monitored through to completion to ensure residents' rights continue to be upheld.

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 11(1)(iii)	The registered provider shall ensure that the designated centre has a written policy, to include the process for arrangements for residents to receive nominated support persons.	Substantially Compliant	Yellow	15/08/2026
Regulation 11(3)(b)	The person in charge shall ensure that having regard to the number of residents and needs of each resident, suitable communal facilities are available for a resident to receive a visitor, and, in so far as is practicable, a suitable private area, which is not the resident's room, is available to a resident to receive a visitor if required.	Substantially Compliant	Yellow	15/09/2026

Regulation 12(c)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that he or she has adequate space to store and maintain his or her clothes and other personal possessions.	Substantially Compliant	Yellow	31/08/2026
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/09/2026
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.	Substantially Compliant	Yellow	30/09/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to	Not Compliant	Orange	30/09/2026

	ensure the effective delivery of care in accordance with the statement of purpose.			
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	30/09/2026
Regulation 26(1)(c)(vi)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control infectious diseases.	Not Compliant	Orange	31/08/2026
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.	Not Compliant	Orange	31/08/2026
Regulation 26(1)(c)(ii)	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	Not Compliant	Orange	31/08/2026

	unexplained absence of any resident.			
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.	Not Compliant	Orange	31/08/2026
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control aggression and violence.	Not Compliant	Orange	31/08/2026
Regulation 26(1)(c)(v)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes the measures and actions in place to control self-harm.	Not Compliant	Orange	31/08/2026
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,	Substantially Compliant	Yellow	30/06/2026

	residents, are aware of the procedure to be followed in the case of fire.			
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	30/06/2026
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	15/07/2026
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	15/07/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in	Not Compliant	Orange	15/07/2026

	accordance with their interests and capacities.			
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	15/07/2026
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	15/07/2026