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:	Kilcoole Lodge Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Lott Lane, Kilcoole, Wicklow
Type of inspection:	Unannounced
Date of inspection:	08 June 2026
Centre ID:	OSV-0007714
Fieldwork ID:	MON-0050046

About the designated centre

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

Kilcoole Lodge Nursing Home is situated in the village of Kilcoole and is in walking distance of the sea. It is a purpose-built facility which can accommodate a maximum of 89 residents, over two floors, in 81 single en-suite rooms, and 4 twin en-suite rooms. It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care for persons with learning, physical and psychological needs can also be met within the unit. Care is provided for people with a range of needs: low, medium, high and maximum dependency. The registered provider is Mowlam Healthcare Services Unlimited. The person in charge of the centre works full time and is support by a senior management team and a team of healthcare professionals and care and support staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	82

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
Monday 8 June 2026	05:00hrs to 14:50hrs	Sarah Armstrong	Lead
Monday 8 June 2026	05:00hrs to 14:50hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

Overall, the inspectors found that residents' dignity and rights were not always upheld in Kilcoole Lodge Nursing Home, and residents were not always offered choice regarding the service and care they received. Deficits were identified in the governance and management oversight systems in place, to ensure high-quality care was provided to all residents. Additionally, there were gaps in the supervision of staff practices, which directly impacted on the care of residents. For example, necessary referrals to other health and social care professionals were not always made on behalf of residents to ensure residents' needs were being appropriately met, and residents spoke of experiencing long delays waiting for assistance with personal care or toileting needs.

This unannounced, out-of-hours inspection was carried out by two inspectors of social services over the course of one day. Inspectors arrived to the centre at 5:00am on the morning of the inspection. On approaching the front door of the centre, inspectors observed from outside, that some curtains had not been drawn and residents were clearly seen sleeping in their beds. This impacted on the residents' rights to privacy and dignity, and also resulted in bedrooms filling with light from this early time in the morning. On entering the centre, the inspectors requested to speak to the nurse in charge; however, were informed that two of the three staff nurses working were in charge, one on each floor.

The inspectors then commenced a walk around of the premises. One resident on the Elm unit was up and dressed and sitting in their bedroom chair at 5:10am. This resident told inspectors, "I don't know if I want to be up this early". Inspectors observed the records from a recent staff meeting, which detailed that if residents were awake, the staff on night duty were to assist with morning care, and dress a minimum of two residents before the day staff came on duty. In addition, during the walk around, inspectors received reports from residents who were awake, that some staff members were rough in their interactions with residents. One resident told inspectors that "one day they threw me into the shower and were rough about it. I told them I wasn't feeling well that day, and I didn't want to have a shower". These practices demonstrated a task-led approach and did not promote person-centred care or respect the rights of the residents living in the centre.

Inspectors observed the morning staff handover (the process of transferring duties, tasks, and vital information from one employee or shift team to another) on both floors of the designated centre. Prior to the handover commencing, staff finishing night duty were overheard requesting if they could leave. They were informed that they must remain on the floor to supervise residents until the handover was completed. In addition, two staff members joined the handover after it had commenced and therefore did not receive all information communicated by the night staff.

As soon as the handover was completed, the day staff began their morning routine. A practice was observed in the centre whereby breakfast was routinely delivered to residents' rooms through tray service. Residents who spoke with inspectors said that they were not consulted with regarding their preferred location for breakfast. One resident said "I'm never asked where I want to eat breakfast, it just comes to my room. That's the done thing". Inspectors spoke to one resident who has just finished breakfast, and during the conversation inspectors observed ants crawling on the resident's table and bedroom floor. The resident told inspectors that they had been experiencing an ongoing issue with ants in their bedroom for a long time. The resident said "I have to always be watching, they tend to crawl up my glass of orange". Other residents also reported having problems with ants in their bedrooms, and spoke of how this meant they couldn't fully relax while spending time in their bedrooms.

Additionally, inspectors observed silverfish in various areas of the centre; for example, on the worktop in the staff canteen, in the visitors' room, at the nurses' station on the ground floor, in the communications room and the oratory. Inspectors were informed that enhanced cleaning measures had been introduced as part of the response to address the ant and silverfish issues. However, inspectors observed that many areas of the centre were visibly unclean, with dirt, debris, and food crumbs from the previous evening still present on the morning of inspection. In addition, resident equipment was observed to be unclean. For example, inspectors observed a standing hoist in a storeroom to have a significant build up of dirt and debris on its foot plate. The hoist had an "I am clean" tag attached, which had been applied by staff during the night duty shift.

After the walk around, inspectors met with person in charge and clinical nurse manager (CNM) for an introductory meeting, where the purpose of the inspection was set out. Inspectors informed the person in charge and the clinical nurse manager that the inspection was an out-of-hours risk-based inspection, following ongoing concerns in respect of the supervision of staff practices and the governance and management oversight systems in the centre. In particular, of concern were two recent items of solicited information submitted to the office of the Chief Inspector of Social Services relating to the absconsion of residents, and the failed implementation of mitigating measures, which had resulted in the second incident not being prevented.

Feedback received from residents about the service provided was mixed. Many residents were complimentary of the staff who worked in the centre, one resident told inspectors "the staff are good, they're always trying their best to help". Other residents said there were frequently new staff working in the centre, often agency staff who were not familiar with their needs and preferences. One resident told the inspectors that unfamiliar staff did not always have the same level of understanding of their needs, particularly in relation to continence care. The resident stated that they regularly had to explain their needs to these staff, which they found frustrating. The registered provider had taken measures to recruit additional staff with seven health care assistants due to commence their roles on 13 July 2026, with the aim to reduce the reliance on agency staff going forward.

All residents who spoke with inspectors reported that they commonly experienced lengthy delays waiting for assistance. One resident reported that "waiting 10 minutes would be normal, but it could often be longer". Some residents referenced 20 or 30-minute delays, which they said depended on what their needs and requests were. One resident told inspectors "on one occasion I was waiting 5 hours for a drink of water". Other residents reported times when staff had responded and told them they would return shortly to assist with their toileting needs, but they did not. In one case, this resulted in a resident having to mobilise independently, and in doing so, they experienced a fall requiring hospital admission. Throughout the day, inspectors heard call-bells ringing frequently, which contributed to a noisy and uncomfortable environment for residents, particularly on the ground floor. One resident told inspectors "those bells ring all the time".

Kind and considerate interactions between staff and residents were observed by inspectors. For example, during lunch time, staff were seen to offer a choice to residents and were explaining the daily menu to residents. Staff were responsive to residents during this time and were seen to be providing appropriate, dignified care to residents, and chatting with them in a kind and meaningful way. However, inspectors did observe occasions where some staff supervising in communal areas were not engaging with the residents, and residents were seen sitting alone with no interaction for long periods of time.

In addition, inspectors observed times when residents in communal spaces were left unsupervised by staff. This was concerning, as following a recent unwitnessed fall in a day room, the registered provider had submitted written assurances to the Chief Inspector that a staff member would be present in day rooms at all times. Residents who spoke with inspectors also commented that they would like the management personnel to have a more visible presence in the centre. For example, some residents said that they would welcome more opportunities to see and engage with the person in charge, including through attendance at resident meetings and informal visits to residents in the centre.

Despite the findings of the previous two inspections regarding the unavailability of the oratory for residents' use, the registered provider had provided assurances at a warning meeting held on 23 April 2026 that residents would be reminded of the availability of this space and encouraged to use it. However, inspectors found that the oratory remained unavailable to residents on the day of inspection, as painting works were being carried out. In addition, none of the residents who spoke with inspectors were aware that there was an oratory in the centre, despite some of them residing in the centre for a number of years. Furthermore, residents had not been consulted about the painting of the oratory, and informed that it would be unavailable for the duration of the painting works. When asked by the inspectors if they knew there was an oratory in the centre, one resident said "no, there is no oratory here", and another said "oh, I never knew that. I thought that was an office, thank you for telling me". A number of residents expressed an interest in using the oratory. One resident told the inspectors "I would enjoy that. I quite like the idea of having somewhere quiet to say my prayers".

Inspectors also spoke with several staff, which included staff who were working on the night and day shifts. Whilst some staff confirmed to inspectors that there had been improvements in the availability of basic supplies, including personal protective equipment and personal care supplies since the last inspection, other staff said that gloves, in particular, were sometimes not available. Inspectors reviewed the main stock room on their arrival at the centre, and again in the late morning and on both occasions found there to be limited availability of gloves, wipes and continence wear. Inspectors were informed by the person in charge that the stocks were replenished daily by a designated staff member, and that an additional stock room was located on the first floor. However, inspectors saw that this stockroom was locked, and only one staff member had access to it. Despite some improvements in the oversight of the stock ordering system since the previous inspection, staff did not always have timely access to the supplies needed to support the delivery of safe and appropriate care to residents.

The next two sections of this report set out the findings of this inspection in relation to the governance and management arrangements in place in the designated centre, and how these arrangements impacted on the quality and safety of the services being delivered.

Capacity and capability

Overall, inspectors found that the registered provider had failed to establish a robust management structure that defined the lines of authority and accountability for all areas of care provision in the centre. This was having a direct impact on the quality and safety of care provided to residents living in the centre.

Mowlam Healthcare Services Unlimited was the registered provider of Kilcoole Lodge Nursing Home. There was a person in charge who worked full-time in the centre. The person in charge was supported by a Healthcare Manager and a Quality Control Manager. The Quality Control Manager was present on the day of inspection. The role of the assistant director of nursing (ADON) had been vacant since 07 May 2026, and whilst a new assistant director of nursing was in the process of being recruited, inspectors found that additional supervisory duties were delegated to staff without appropriate levels of support and supervision. Deficits were identified in the oversight and supervision of staff practices, which resulted in inadequate care delivery outcomes for residents. For example, referrals to appropriate health and social care professionals were often delayed or not carried out, and oversight systems to ensure safeguarding concerns were investigated were not effective, which resulted in allegations of abuse made by residents not being appropriately addressed and managed.

Inspectors also found that the registered provider had failed to ensure that actions they committed to in multiple correspondence to the Chief Inspector were implemented into practice in the centre, in order to improve the standards of care

provided to residents. For example, inspectors identified that parts of the compliance plan of the last inspection carried out in March 2026 had been identified for completion by the registered provider by 31 May 2026. Inspectors noted these actions were not completed within the agreed time frame. In addition, actions and mitigating measures to prevent recurrence of specific incidents as provided in a provider assurance report and in notifications submitted to the chief inspector were also not implemented. Due to the risks identified on this inspection, inspectors issued an urgent compliance plan to the registered provider requiring them to review Regulations 23: Governance and management, Regulation 6: Health care, Regulation 8: Protection and Regulation 16: Training and staff development to ensure effective governance and oversight of the service and to ensure that the needs of residents were being appropriately met.

Additionally, the registered provider attended a Warning meeting following the inspection, at which time they were informed that the Chief Inspector of Social Services would issue a notice of proposed decision to attach a condition to the registration of the designated centre. The purpose of this condition is to stop new admissions to the centre until the Chief Inspector is satisfied that the provider puts in place an effective governance and management structure, and achieves compliance with key regulations which underpin the quality and safety of care provided to residents.

Inspectors found that whilst the number of staff on duty appeared appropriate on the day of inspection, the skill-mix of staff was not sufficient to ensure that residents' needs were met appropriately. There was no designated staff member on the night duty shift assigned overall responsibility for the oversight of residents' care during the night. Inspectors observed gaps in the care provided during this time. For example, residents assisted to bed with their curtains left open, and one resident assisted to get up and dressed at a very early hour. In addition, on the day of inspection, the clinical nurse manager was covering an unexpected absence, and was required to provide assistance to residents. This impacted on the management and oversight of care practices in the centre. These findings are discussed further under Regulation 15: Staffing.

Inspectors found that there were deficits in the supervision of staff practices in the centre to ensure that residents were receiving good quality, safe, person-centred and appropriate care. All residents who spoke with inspectors referenced experiencing lengthy delays in response to their requests for assistance, in particular, their personal care and toileting needs. Inappropriate infection prevention and control practices were observed by inspectors. For example, some staff were seen wearing face masks despite there being no outbreak in the centre, and inspectors were advised that this was a precautionary measure. However, the masks were not consistently worn correctly, and hand hygiene was not always performed after contact with the face mask. These findings are discussed further under Regulation 16: Training and staff development.

Despite being identified during the last inspection in March 2026, the inspectors again saw areas where residents’ information was not kept in a safe and secure manner, which impacted on the residents' rights and privacy. For example, general

practitioner (GP) lists and contracts of care belonging to residents who had been discharged from the centre or had passed away, were kept unsecured in an unlocked communications room and resident files were left unsecured at nurses' stations, on desks and kept in unlocked presses. This is discussed further under Regulation 21: Records.

Inspectors found that statutory notifications relating to incidents that occurred within the designated centre were not always submitted to the Chief Inspector in line with the required time frames, and in some cases, were not notified at all. This finding is discussed in more detail under Regulation 31: Notification of incidents.

Regulation 15: Staffing

The registered provider had failed to ensure that the skill-mix of staff was appropriate having regard to the needs of the residents and the size and layout of the centre. The findings of the inspection were that there were insufficient management resources available, when assessed against the provider's Statement of Purpose;

- The assistant director of nursing position was vacant – albeit recruitment was underway
- The provider had committed to employing 3.5 WTE (whole time equivalent) clinical nurse managers (CNM), however on the day of inspection there was only 3.0 WTE employed. Management informed the inspectors that the only staff vacancies were one HCA and the ADON position.
- There was no assigned staff member on the night duty shift with delegated responsibility for the oversight of resident care.
- On the day of the inspection there was one clinical nurse manager on duty. However, due to unexpected staff absences, the clinical nurse manager was not available to supervise resident care as they were providing direct resident care.

Judgment: Not compliant

Regulation 16: Training and staff development

The person in charge had failed to ensure that the delivery of care was appropriately supervised. This was evidenced by the following;

- Inadequate assessment of residents care needs
- Failure to ensure that residents received care appropriate to their needs
- Inadequate response to residents' requests for assistance.

- Inappropriate use of Protective Personal Equipment (PPE), including the inappropriate use of surgical face masks.
- Inadequate cleaning and storage of residents' equipment. For example;
    - Inappropriate storage of equipment in an assisted bathroom
    - A standing hoist which had an 'I am clean' tag attached during the night shift had not been cleaned and was seen to have a dirty tissue and an excessive amount of dead skin on the stand

In addition, oversight of the staff induction process was insufficient as by the failure to supervise the processes in place for the induction of new staff members. In the absence of such supervision, the person in charge could not be sure that staff were receiving appropriate training and support.

This is a repeated non-compliance.

Judgment: Not compliant

Regulation 21: Records

The registered provider had failed to ensure that residents' records were kept in such a manner as to be safe. This repeat finding was evidenced by:

- 11 archive boxes containing residents' personal information, contracts of care and GP lists were stored in an unlocked unsecured communications room.
- Residents' files were stored in an unlocked press at a nurses' station with documentation containing residents' information left unattended and easily visible on desks.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to put in place a management structure that clearly defined the lines of authority and accountability for all areas of care provision, particularly in relation to the supervision and oversight of care delivery. This was evidenced by:

- There were deficits in the registered provider's governance and management of the care of residents in the centre
- The failure to allocate responsibility for the supervision of staff working on night duty
- The failure to recognise and respond to deficits in the care of residents.

- The failure to implement appropriate systems for the induction of new staff members.
- The failure to implement remedial measures designed to address identified deficits as set out in the following;
    - The compliance plan following the inspection completed on 19 March 2026
    - A provider assurance report submitted to the Chief Inspector on 28 April 2026

- The failure to take appropriate effective mitigating action following a resident safety incident to reduce the risk of such an incident reoccurring.

The inspection found that the management systems in place to ensure that the service provided was safe and consistently monitored were not effective, particularly in relation to the systems in place to supervise, monitor and support staff. This was evidenced by:

- Inadequate systems of communication to ensure all staff had information pertinent to the needs of residents. As a result, essential interventions and supports required to effectively meet those needs were not consistently communicated to staff or implemented.
- Inadequate oversight systems in place to ensure that timely health and social care reviews were available to residents.
- Inadequate systems in place to identify safeguarding concerns and ensure that safeguarding investigations were carried out following residents raising safeguarding concerns.
- Inadequate oversight systems to ensure that known pest control issues were definitively addressed. As a result, the centre was not cleaned to the required standard.

Judgment: Not compliant

Regulation 31: Notification of incidents

The person in charge had failed to ensure that the incidents set out in paragraphs 7(1)(a) to (i) of Schedule 4 of the regulations were notified in writing to the chief inspector within the required time frame of 2 working days. For example;

- Two incidents of alleged or confirmed abuse of a resident had not been notified to the Chief Inspector by means of an NF06 notification.
- An NF05 notification of the absence of a resident received in April 2026 not submitted within the required 48 hours and instead was submitted 18 days late.

- An NF03 notification of a serious incident/ injury to a resident received in June 2026 was submitted 3 days after the event occurred rather than within the two day time frame required by the regulations.

Judgment: Not compliant

Quality and safety

Overall, inspectors identified that there were a number of areas for improvement to ensure that all residents living in Kilcoole Lodge Nursing Home were supported to receive appropriate, consistent, safe and timely care. For example, improvements were required in areas including the appropriate assessment of residents' needs, timely referrals to health and social care professionals, the investigation and prevention of incidents and allegations of abuse concerning vulnerable adults, and in ensuring that residents' rights were upheld and promoted.

Inspectors reviewed a sample of residents' records, which included their assessments and care plans. From this review, inspectors identified that residents did not always receive appropriate access to medical care and timely referrals to health and social care professionals, including occupational therapists, dietitians and dentists. This finding is discussed further under Regulation 6: Health care.

During review of resident records, inspectors found that the registered provider had failed to ensure that the needs of residents were met in accordance with their assessments, and in some cases, residents' needs were not appropriately assessed. One resident's food and nutrition care plan outlined a food intolerance; however, no assessment or medical history was available to support this information. Furthermore, despite a dietetic assessment being completed, this resident's care plan outlined that they should be offered milk with their meal. Staff spoken with were not aware that this resident's care plan identified a lactose intolerance. These findings are discussed in more detail under Regulation 5: Individual assessment and care planning.

Inspectors observed lunch time meal for residents, and found that residents were offered a choice. Most residents chose to dine in the communal dining spaces, and there was an adequate number of staff available to assist them with their meals. Residents had a choice of roast turkey or bacon with vegetables and potatoes, and inspectors observed staff addressing residents' requests for other options which were not listed on the menu. However, pureed foods for residents were all fortified with high-calorie ingredients, despite not all residents requiring high-calorie, high-protein foods. These findings are discussed further under Regulation 18: Food and nutrition.

The person in charge had notified the Chief Inspector of two separate incidents of residents absconding from the centre since the last inspection in March 2026. This

was of concern as the inspectors found that the mitigating measures identified following the first incident in March, were not implemented effectively, which had given rise to the similar second incident occurring in May. Inspectors followed up on the systems in place to ensure that residents who presented with exit-seeking behaviours were appropriately safeguarded in the centre. Staff, including administrative and reception staff, who spoke with inspectors, were aware of residents who presented with exit-seeking behaviours. Staff were updated and informed on a daily basis of the residents who were at risk. Where residents were identified as requiring safety checks at defined time points, staff were aware of this requirement, and there was evidence to show that these checks were completed. Improvements had been made to the management and oversight of foot traffic through the main door, to ensure residents' safety was upheld. Missing person profiles, including recent photographs of residents, were available in the reception area.

Residents living in the centre were not always protected from the risk of abuse. Inspectors identified occasions where residents had made allegations of abuse, and appropriate steps to safeguard that resident had not been followed. In addition, inspectors also found examples of where residents had made allegations of rough manual handling when requiring assistance. The person in charge had not carried out investigations into these allegations, and as a result, no learning was identified to ensure improved care practices and enhanced safeguarding of residents going forward. These findings are discussed further under Regulation 8: Protection.

Inspectors found that residents' rights to choice were not always upheld and promoted in the centre. Despite the findings of the previous two inspections, inspectors found that the oratory remained unavailable for use by residents. This is contrary to the assurances provided by the registered provider in a warning meeting on 23 April 2026, where the registered provider confirmed that residents would have access to, and be encouraged to utilise this space. The oratory was in the process of being painted, however painting had commenced earlier in the week prior to the inspection date and the person in charge was unaware of when the area would be ready for resident use. Additionally, none of the residents who spoke with inspectors were aware that there was an oratory available for their use in the centre, nor had they been consulted with about the painting of the oratory and that it would be unavailable for the duration of the works. In addition, residents were not supported to undertake personal activities in private. This included sleeping.

Regulation 18: Food and nutrition

Inspectors observed that residents had access to fresh drinking water, and that choice was offered to residents at mealtimes. However, not all residents received meals in line with their nutritional assessments and care plans. Inspectors were told that all pureed diets were routinely fortified with high-calorie and high-protein

ingredients. This practice does not align with ensuring that residents' individual nutritional dietary needs are met.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The person in charge had failed to ensure that the needs of residents were appropriately assessed. For example;

- A food and nutrition care plan described a resident as being lactose intolerant. However, there was no evidence within the resident's assessment records or medical history to support this. Furthermore, staff who spoke with inspectors were unaware of any lactose intolerance, and recommendations following a dietetic review advised that the resident be offered milk with their meals.
- One resident who spent a significant amount of time in bed due to a decline in their mobility, did not have a skin integrity risk assessment completed to identify if they were at risk of developing pressure wounds, or what pressure relieving measures may be required to prevent compromise to their skin integrity.

The inspectors found that although care plans had been reviewed within the time frames set out in the regulations, they had not always been updated to remove historical information that was no longer relevant to the current care needs of the resident concerned. This did not inform staff of the appropriate, person-centered care required. For example;

- One skin integrity care plan referenced the resident having a Grade 4 pressure ulcer and contained information about a referral to a tissue viability nurse. However, this information dated back to a pressure ulcer the resident had in 2022 and 2023. Inspectors confirmed on the inspection that this resident no longer had this pressure ulcer, and their current skin integrity concern was a skin rash.

Inspectors found that not all residents were consulted with in preparing their care plan. For example:

- Three residents who were assessed as having capacity to make decisions, were not always directly consulted with or involved in planning their care. Additionally, the records for two of the residents evidenced that residents families were consulted with regarding decisions about the resident's care, prior to any communication with the resident's themselves.

Judgment: Not compliant

Regulation 6: Health care

The registered provider had failed to ensure that residents were provided with access to appropriate medical and health care. For example;

- Two residents who experienced a deterioration in their clinical condition did not have evidence documented that a prompt nursing assessment or review was completed. Consequently, changes in their health status were not adequately monitored, or assessed and did not provide assurance that these residents received timely and appropriate clinical interventions.
- One resident with a diagnosis of diabetes and a weight management issue had not been referred to a dietitian for review. In addition, there was no record that the resident had been weighed since December 2025, meaning the resident's care was not appropriately informed by an accurate assessment of the resident's current status.
- A resident who had broken teeth was not referred to a dentist for review and treatment.
- A resident who required a specialised chair was only referred for assessment by an occupational therapist on 13 May 2026, despite staff in the centre advising the resident that the referral had been sent several months before this.
- A resident, whose cognitive status had begun to deteriorate had not had appropriate referrals made for an assessment of their capacity.

Judgment: Not compliant

Regulation 8: Protection

The registered provider failed to ensure that residents were protected from the risk of abuse and to ensure that the person in charge investigated all incidents or allegations of abuse. For example;

- The registered provider failed to ensure appropriate investigation of complaints made by two residents that staff were rough with them and that staff had failed to meet their continence needs. In addition, the person in charge had not notified these safeguarding incidents to the Chief Inspector in line with their statutory obligations, because the families of the concerned residents did not wish for the matter to be notified to the Chief Inspector.
- The registered provider failed to ensure that a safeguarding allegation made by a resident was managed in an appropriate manner.

Judgment: Not compliant

Regulation 9: Residents' rights

The registered provider had failed to ensure that residents' rights were upheld. For example;

- The registered provider had failed to ensure that residents could exercise choice in their daily lives. For example;
    - Staff meeting records described how staff were instructed to ensure that at least two residents, when already awake must be dressed by the staff on night duty. Inspectors observed one resident, fully dressed and sitting in their chair in their bedroom at 5.10am. When asked, this resident told inspectors that they did not know if they wanted to be out of bed and dressed at that time.
    - Residents told inspectors that they were not offered choice of the dining space for their breakfast meal.

- Not all residents were able to undertake personal activities in private. Several residents were observed in bed sleeping with their curtains open on the morning of the inspection, and these residents could be observed from outside the building at 5am on the morning of the inspection.
- Residents spoken with told inspectors that they commonly experienced lengthy delays in staff responding to their needs. Other residents reported times where staff had responded to their call bell and told them they would return shortly to assist with their toileting needs, but they did not.
- Despite repeat inspection findings regarding the unavailability of the oratory for residents, inspectors found that residents had not been informed of, or encouraged to use this space. Additionally, the space remained unavailable for their use on the day of 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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 18: Food and nutrition	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Kilcoole Lodge Nursing Home OSV-0007714

Inspection ID: MON-0050046

Date of inspection: 08/06/2026

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant

Outline how you are going to come into compliance with Regulation 15: Staffing:

• An Assistant Director of Nursing (ADON) has been recruited, and while the candidate is unable to commence in post until October 2026, in the interim we have promoted a Clinical Nurse Manager (CNM) to the Acting Assistant Director of Nursing (AADON) position until the ADON commences in post. This post is fully supernumerary, and the AADON has received induction to the interim position from the Person in Charge (PIC), Healthcare Manager (HCM) and the Quality & Compliance Coordinator (QCC).
• We have revised the CNM hours so that they will no longer be routinely required to work as clinical staff nurses but instead will be fully committed to supervision of staff and oversight of the daily care environment. This will significantly increase the supernumerary hours and will enhance the supervision on both floors. The roster will be planned to ensure that there will be a supernumerary CNM on each floor on weekdays in addition to the Staff Nurses, and a supernumerary CNM/ADON on each floor at weekends.
• There are 3 full-time CNMs in post (one is an interim CNM to cover the CNM who is covering the AADON role but has previously worked in the centre as a CNM). We have this far been unsuccessful in recruiting a part-time CNM (0.5wte), so we have increased the supernumerary hours for all 3 CNMs and they are now fully supernumerary, which will provide a significant increase to the supervisory hours in the centre, including weekends.
• The PIC will ensure that a CNM will also be on duty until 10pm on some evenings which will facilitate a comprehensive handover to the night staff and ensure that the designated nurse in charge is aware of all relevant clinical issues. The CNM will also conduct a management walkabout before the shift ends.
• There is a designated Nurse in charge every night in the centre who will receive a handover from the CNM or Staff Nurse on each floor to ensure they are aware of all relevant clinical issues in the centre; the nurse in charge is the Fire Warden for the shift and this is highlighted on the roster.
• The PIC, supported by the Healthcare Manager, will continuously monitor the roster to

ensure it is updated to reflect any changes to personnel.
• The ADON/CNM will ensure that duties are delegated appropriately, that staff are appropriately deployed throughout the centre, and will provide support to staff and residents and ensure the skill mix of staff facilitates the provision of person-centred care.
• The PIC and ADON will monitor the roster and ensure that if there are vacant posts these will be backfilled with agency staff if permanent staff are unavailable. We are working with trusted agencies to ensure that insofar as possible, the staff allocated to the centre will be familiar with the centre and know the working practices, residents and staff. We will ensure that any new agency staff will receive an induction and there is a template form which will guide nurses and CNMs in the induction process.
• Meanwhile, we will continue to recruit staff to fill vacant posts.

Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
• The PIC has reviewed the supervision arrangements and roles and responsibilities have been clarified; the AADON and CNMs provide supervision hours over seven days each week. The role will include the appropriate delegation of duties, providing support to staff and residents, having oversight of the provision of safe, dignified daily care to residents. The PIC will maintain oversight of the supervision within the Centre. The PIC and management team will ensure that all staff understand the care requirements of the residents in their care.
• Supervision of staff has been significantly enhanced by ensuring that the CNMs no longer routinely work clinical hours and instead they are fully supernumerary. The team has been better structured so that there is a CNM allocated to each floor every day and they are fully focused on supervising all aspects of care.
• The QCC is providing support to the AADON and CNMs to ensure that all staff receive a full induction; we have introduced an induction template for each staff group, including agency staff, and the QCC will support the CNM in overseeing the induction processes.
• Regular call-bell audits will be carried out by the management team to identify any learning and improvements that may be required. As part of the CNM role in supervision, staff will be actively reminded to respond in a timely manner to call bells in their areas. Nurses will also be responsible to ensure that bells are responded to without undue delay and that will respond themselves if Healthcare Assistants are providing care to other residents.
• A Quality Improvement Plan (QIP) will be developed by the QCC and agreed with the management team in the centre; this will identify the improvements required. This QIP will be shared and discussed with staff and progress reviews will be undertaken every week by CNM / AADON and PIC.
• The PIC will ensure that all direct care staff attend a daily handover at the beginning of their shift utilizing the ISBAR handover tool. At this meeting any concerns, risks and

relevant resident information is shared. A mid shift daily safety pause will also be attended by all direct care staff to share information relating to resident care and to raise any concerns that may require further attention.
• The AADON and CNMs will oversee the assessment of residents' care needs and ensure that the care plans are person-centred, developed in consultation with the resident and/or their nominated representative, and that they accurately reflect the residents' needs and preferences.
• The PIC will ensure that the AADON, CNMs and nurses are available, visible and accessible to staff, residents and families, and that they are closely supervising staff and providing guidance and direction as required to ensure that the standards of care are maintained at a high level, including on night duty.
• The PIC will ensure that all agency staff receive induction, using the approved template that has been developed by the Quality Team, and its use will be monitored as part of QCC site visits.
• The PIC will ensure that the ISBAR handover document is used at daily shift hand over and also at mid shift safety pause. In addition to handovers this document includes information on all resident risks, including falls and safety awareness. The information is updated as changes occur, and all clinical staff are provided with a copy for reference.
• The Manager's (PIC/ADON) daily walkabout includes the checking of all resident areas and equipment to ensure the environment is safe and clean for residents. Two CNMs will be IPC (Infection Prevention & Control) link nurses for the centre, IPC link Practitioner training is scheduled for September. The PIC will ensure that staff use PPE in accordance with HPSC guidelines and the centre's own policies.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• A comprehensive review of the storage of documents in the centre has been commenced by members of the Senior Administration team from Support Office. This review includes safe and appropriate storage of records.
• The PIC has addressed the issue of documents being left unattended and easily visible on desks, and this will be monitored as part of management walkabouts and will be part of the CNM's supervisory role to ensure GDPR compliance.
• The PIC as part of Manager daily walkabout will monitor use of papers containing resident information and will discuss as part of handover / safety pause meeting.
• The PIC / CNM will ensure that all staff are aware that the nurse's station must be kept clutter free and computers must be shut down when not in use.
• The PIC will ensure that all staff complete GDPR training on the Mowlam Online Academy.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

• The PIC will be supported by the AADON and 3 CNMs, who will provide supervision and oversight of all staff and ensure that all residents' assessed care needs can be met safely and effectively.

• The PIC is also supported in the achievement of all objectives by the HCM, who will visit the centre regularly and will ensure that the PIC has sufficient resources to ensure that there are safe, high-quality systems of governance and management in place.

• The PIC and HCM will hold weekly management meetings with the centre's management team to review Key Performance Indicators (KPIs) and to agree quality improvement actions.

• The Director of Care Services will meet with the HCM, Head of Quality and PIC each week and the wider management team will be included each month, to review governance and management of the centre. They will review KPIs, identified risks and operational issues in the centre to ensure sustainability of progress, to identify areas in need of improvement, agree corrective actions and implement quality improvements as required.

• There is a clearly defined management structure in the centre that identifies the specific roles and responsibilities for all areas of care provision, including night duty. There are approved templates for the induction of all staff groups, including agency staff which ensure that every staff member understands what is expected of them in their role.

• While we are implementing quality improvements to restore regulatory compliance in the centre, the HCM will continue to be on site at least 2 days per week and will work with the management team to provide support and to ensure they are undertaking their roles and responsibilities according to expected standards. The HCM will conduct management walkabouts with the PIC to monitor staff practice and conduct, care delivery, call bell response times and IPC standards in the centre.

• The PIC will actively seek feedback from residents, observe mealtimes and the general cleanliness of the centre. The HCM and PIC will ensure that all safeguarding plans required are in place and that any safeguarding concerns are fully addressed and resolved.

• The QCC will be on site two days per week and will work with the management team and staff to ensure that the detailed quality improvement plan is being implemented effectively and to ensure that all staff have all the information required to care for the residents in accordance with their assessed care needs and preferences. The QCC will report back to the PIC, HCM and the management team.

• Weekly senior governance meetings and QIP reviews are in place and will continue until the centre has stabilized and compliance improves.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

• The PIC will ensure that all safeguarding concerns will be recorded on the electronic record system, notification will be submitted to the Authority and any other external agencies as appropriate; an investigation will be completed and recorded, and a referral to the SIMT will be completed by the PIC. All allegations, findings and learning outcomes will be communicated with the resident/ nominated representative as appropriate, and centre staff.

• The HCM will review all incident reports weekly with the PIC and will ensure that all notifiable incidents are notified in writing to the Chief Inspector within the required timeframe.

• The HCM will provide oversight and advice to the PIC and will ensure that all notifiable incidents are escalated appropriately and notified in line with legislative and regulatory requirements.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• The PIC will ensure that residents have access to a variety of appetizing, nutritionally balanced food and fluids in accordance with their dietary preferences and clinical condition.

• The PIC, in collaboration with the catering service provider, will ensure that there is a quality improvement plan in place in respect of the feedback around the issues identified in relation to food and nutrition. A review of the issues around the quality of the food, portion sizes, choices available and the nutritional value of meals has been completed and addressed. The PIC will monitor the food service, and residents will be asked to complete satisfaction surveys around the food/dining services periodically.

• The PIC has completed a comprehensive review with the Catering Manager and can confirm that not all pureed diets are fortified.

• The PIC/AADON/CNMs will ensure that residents who are on a modified diet are provided with the correct consistency in line with Speech and Language therapy recommendations

• Residents who have dietetic needs and require fortified meals will be provided with these meals in accordance with their choice, preference and as per the SALT recommendations.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• The PIC will ensure that residents' care plans are person-centred and developed in consultation with the resident and/or their nominated representative.
• The care plan will focus on what matters to the resident and will incorporate the Age Friendly Health System, using the 4Ms framework (What Matters to Me, Medication, Mentation and Mobility).
• The PIC/CNM will complete a care plan audit monthly and develop a QIP as necessary, the results of which will be shared with nurses and used as an opportunity for learning.
• The PIC will ensure that care plans are developed in consultation with the resident/family member after a serious of evidence-based clinical assessments have been completed.
• The PIC will complete a weekly review of clinical documentation to ensure that information following review by Dietician is captured and the care plan is appropriately updated to effectively guide the delivery of care.
• For those residents with actual/potential skin integrity issues, the PIC will ensure that appropriate assessments are carried out and an individualized wound care plan will be developed to ensure that the care interventions adequately outline the required care.
• Findings and recommended improvements will be discussed at nursing staff meetings, daily handover/safety pause and at monthly management team meetings. Any changes or developments in the resident's condition or plan of care will be updated as they occur.
• The PIC will develop a QIP as necessary, the results of which will be shared with nurses and used as an opportunity for learning.
• The PIC and CNM will review the assessments and care plans with the named nurses to ensure that assessments accurately inform the plan of care, that the care plan is individualised and person-centred, considering the resident's current medical conditions, health and lifestyle status.
• The PIC and nursing management team will provide support, guidance and direction to nursing staff on clinical documentation, and will monitor the accuracy and quality of the clinical records. Where deficits are noted, they will work with the individual nurses to ensure that the overall quality of documentation improves.
• The PIC will ensure that residents are consulted when care plan is being developed.
• The PIC will complete a review of care plans and all historical information will be archived.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:

• The PIC will ensure that the residents' care plan is developed in line with their assessed care needs and updated to include any changes to their condition.
• The PIC and wider management team will ensure that all residents have timely and appropriate access and referrals to healthcare as required.

• The PIC will ensure that referrals to Dietician are requested for those residents that have any change in weight management and will monitor records to ensure weights are recorded with appropriate frequency.
• The PIC/AADON/CNMs will attend daily handovers and will ensure that referrals to allied health services such as Dentist, Occupational Therapist and Psychiatry of Later Life are made where necessary. The resident care plan will be updated to include these referrals and subsequent recommendations will inform further changes to care plan.
• The PIC will ensure that all direct care staff attend a daily handover at the beginning of their shift utilising the ISBAR handover tool. At this meeting any concerns, risks and relevant resident information is shared. A mid shift daily safety pause will also be attended by all direct care staff to share information relating to resident care and to raise any concerns that may require further attention.
• The PIC will ensure that all Healthcare staff have access to the STOP AND WATCH assessment tool which is recorded on the electronic record keeping system- this alerts the Staff Nurse (SN) and CNM to a change in resident condition which requires their review. Healthcare assistants are also encouraged to inform the SN if they feel there is any change in a resident's condition.
• INEWS is recorded on the electronic record keeping system and this is an assessment tool where Nursing Staff can record and monitor a resident's condition. The tool aids the recognition of deterioration and guides the response pathway. Nurses are currently doing additional training on assessment of the deteriorating resident

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC will review all incident reports weekly and will ensure that all notifiable incidents are notified in writing to the Chief Inspector within the required timeframe.
• The HCM will also review incidents weekly with the PIC and will provide oversight and advice to the PIC, ensuring that all notifiable incidents are escalated appropriately and notified in line with legislative and regulatory requirements.
• The HCM will ensure that the PIC fosters an open and transparent culture so that all staff will escalate any incidents or concerns appropriately so that they can be fully investigated and addressed.
• We will provide regular Safeguarding workshops to ensure that all staff remain aware and vigilant regarding our collective responsibilities in protecting all residents. All safeguarding concerns will be notified in line with legislative requirements.
• Serious incident reviews are completed on all significant incidents in the home and referred to our SIMT in line with HSE guidance. A QIP is developed by the PIC and QCC and shared with staff.
• The HCM, Quality & Safety will facilitate an After-Action Review of recent significant incidents to highlight to the staff and the entire management team the importance of protecting residents and recognising, reporting, escalating, investigating and resolving any safeguarding concerns.

• The PIC ensures that all staff receive regular mandatory safeguarding training and refresher updates annually, including training in the National Standards for Adult Safeguarding.
• The PIC will review incidents and complaints each week to determine whether they allude to anything that could be construed as a safeguarding concern. The PIC will review the records of resident meetings to check whether any feedback concerning safety and safeguarding have been highlighted.
• A safeguarding Organogram is displayed for staff to highlight awareness of their personal responsibilities in relation to safeguarding residents.
• The PIC has completed a safeguarding audit and a QIP was developed in response to the findings. The QIP will be implemented by all staff and monitored by the PIC AADON and CNMs.
• Information on Independent Advocacy Services are displayed within the Centre and offered to residents.
• The PIC will ensure that Safeguarding is a standing item on the resident meeting agenda. Meetings take place at minimum quarterly.
• The PIC will check in with residents and their families regularly via walkabout and resident meetings to ensure that they are happy, safe and content with the care and to ensure that they are confident that they can discuss any concerns they may have about the centre with the PIC.
• Routine surveys are also conducted biannually, and responses are also screened for safeguarding concerns.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

• The PIC will ensure that resident preference with regard to bedtimes and waking up time is clearly documented in care plan and is adhered to by staff.
• The PIC will ensure that residents may exercise choice in so far that it does not interfere with the rights of other residents.
• The PIC will ensure that all staff complete Residents rights/ FREDA principles training.
• The PIC will ensure that residents' privacy and dignity will be upheld in the centre, curtains will be open or closed based on residents' choice. The PIC will monitor compliance as part of daily Manager walkabout audit.
• Regular call-bell audits will be carried out by the management team to identify any learning and improvements that may be required. As part of the CNM role in supervision, staff will be actively reminded to respond in a timely manner to call bells in their areas.
• The oratory has been painted, and all residents have been informed about its availability. The PIC will check oratory as part of daily manager walkabout audit to ensure it is available for resident use.
• The PIC/AADON/CNMs will ensure that all staff that work nights have been advised that no resident should be up and washed/dressed for the day unless it is the resident's expressed wish as documented in care plan.
• The increased supernumerary hours and improvements in supervision will allow us to be more assured that residents' preferences are always respected.

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 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.	Not Compliant	Orange	31/08/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Red	31/08/2026
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which	Substantially Compliant	Yellow	31/08/2026

	meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.			
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	31/08/2026
Regulation 23(1)(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Red	31/08/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Red	31/08/2026
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of	Not Compliant	Orange	31/08/2026

	Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/08/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Not Compliant	Orange	31/08/2026
Regulation 6(1)	The registered provider shall, having regard to the care plan prepared under Regulation 5, provide appropriate medical and health care, including a high standard of evidence based nursing care in	Not Compliant	Red	31/08/2026

	accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.			
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.	Not Compliant	Red	31/08/2026
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Red	31/07/2026
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Red	31/07/2026
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/08/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does	Not Compliant	Orange	31/07/2026

	not interfere with the rights of other residents.			
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	31/07/2026