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:	Dundalk Care Centre
Name of provider:	Tempowell Limited
Address of centre:	Inner Relief Road Marsh South, Marshes Upper, Dundalk, Louth
Type of inspection:	Unannounced
Date of inspection:	15 April 2026
Centre ID:	OSV-0008237
Fieldwork ID:	MON-0048072

About the designated centre

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

Dundalk Care Centre is nestled on the edge of the peaceful townland of Haggardstown. It is registered to accommodate 130 residents all in single ensuite bedrooms and offers an extensive range of short term, long term and focused care options to residents. The ethos of Dundalk Care Centre is to provide quality person centred care, where residents are offered choice in how they live their life and are consulted and participate in decisions regarding their care. The nursing home is set in landscaped gardens with exceptional views across fields of outstanding beauty. There are a number of enclosed outdoor areas ideal for anyone wishing to spend time in nature, suitable for outdoor pursuits and recreational activities as well as providing tranquil space.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	118

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 15 April 2026	07:00hrs to 17:00hrs	Sheila McKevitt	Lead
Wednesday 15 April 2026	07:00hrs to 17:00hrs	Maureen Kennedy	Support

What residents told us and what inspectors observed

On the day of inspection, the inspectors spoke with many residents to gain insight into their experience of living in Dundalk Care Centre. Residents spoken with were complimentary in their feedback and overall expressed satisfaction about the standard of care provided. They felt safe living in the centre and told inspectors that their rights were upheld.

Inspectors were in the centre at 7a.m. and conducted a walk around both floors of the centre observing practices and speaking more in-depth with some residents and relatives during this inspection. Residents described the centre as a good place to live, one resident described it as "like a hotel".

Residents reported that they were 'happy with everything' and that 'staff are brilliant', 'they come when you ring the bell'. Inspectors found that there were adequate staffing numbers with the appropriate skills and knowledge to meet the needs of residents on both night and day duty, with a staff nurse on each unit during the day and night. Inspectors observed that call bells were accessible to residents and were answered promptly.

Residents' families and friends were observed to visit residents on the day of the inspection. Visitors confirmed they were welcomed into the home at any time and praised the care.

The inspectors observed some person-centred and discreet staff interventions during the inspection. Residents were observed being encouraged and facilitated to maintain their independence such as, to walk to and from the dining room. Staff confirmed that they had received safeguarding training and those spoken with had a good knowledge of how to safeguard residents. However, a small number of staff had not received up-to-date training and inspectors observed some practices which did not uphold residents' right to privacy.

Residents were well-groomed and both residents and relatives spoken with felt that residents received a good standard of nursing care. However, inspectors found that some nursing care practices, specifically in relation to the management of pressure area care were not of a high standard, and that the supervision of care and nursing documentation was not robust enough. This will be further detailed in the report.

The inspectors observed the lunch time meal experience in the home. Some resident's choose to dine in the centre's dining rooms, while other residents dined in their bedrooms. The dining rooms were bright, spacious, clean and nicely decorated. Mealtimes were observed to be relaxed and calm with music playing in the background. There was a picture menu available on each dining table reflecting the choice of meals available. Inspectors observed a variety of drinks being offered to residents and staff offering encouragement and assistance to residents. Staff spoken

with had good knowledge of residents' dietary needs to include likes, dislikes and relevant modified diets. The meals served on the day of inspection were wholesome and nutritious. However, the feedback from residents was mixed; some said the food was not always to their taste and they found the choice available limited, while others said the food was was good.

Residents had access to daily newspapers, televisions, radios and internet services within the centre. Some residents were observed reading the daily newspapers provided. Residents told the inspectors that activities were provided on a daily basis and that they were usually good fun. The inspectors observed a lively music session in the afternoon which was enjoyed by many residents. Some residents who spoke to inspectors in their bedroom confirmed that they did not wish to attend activities but staff had offered them the choice.

The inspectors observed house-keeping staff busy cleaning residents' bedrooms and communal areas. Residents told inspectors their bedrooms were cleaned most days, and they felt that the standard of cleanliness was high.

The inspectors observed that some areas of the centre were showing signs of wear-and-tear, however these areas had been identified by the maintenance team who had a plan to address the highlighted issues.

The inspectors saw that changes had been made to the function of four rooms within the centre. On the first floor an activity room had been changed to the director of nursing office and the physio room was changed to a medication store room with a clinical wash hand sink. A further two changes had been made on the ground floor; the director of nursing office had changed to the assistant director of nursing office and the treatment room was changed to the physio room. The provider had applied to the Chief inspector to regularise these changes.

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

Capacity and capability

This unannounced inspection was conducted with a focus on adult safeguarding and for the purpose of reviewing the measures the registered provider had in place to safeguard residents from all forms of abuse.

Inspectors also followed up on the compliance plan from the last inspection in May 2025 and on four pieces of unsolicited information brought to the attention of the Chief Inspector in 2026, some of which were partially substantiated. Although residents reported feeling safe living in the centre, the inspectors found that the

level of regulatory compliance had deteriorated since the last inspection in May 2025, when the centre was found to be predominately in compliance.

Tempowell Limited is the registered provider of Dundalk Care Centre, and part of the Silver Stream Healthcare group. The person in charge was responsible for the day-to-day operation of the centre in addition to providing oversight of clinical practice. They were supported by two assistant directors of nursing, clinical nurse managers, a team of nurses and health care support staff. This clinical team was supported by the senior management structure for SilverStream, which included a director and team of clinical governance and quality staff, a chief operating officer, a group facilities manager, human resource staff, and administrative supports. Despite these governance supports the inspectors found the that some care practices were not of a high standard and that some nursing care documentation practices were poor.

Established management systems monitoring these areas were ineffective in ensuring the centre was operating in compliance with the regulations. Although key performance indicators (KPIs) and auditing of practices had been completed which identified poor practices, an appropriate plan had not been put in place to bring about change and address these practices in a timely manner. For example, several assessment and care plan audits had showed poor results, with little improvement audit after audit. There was no comprehensive plan in place to address the issues identified. Furthermore, the number of residents developing pressure ulcers in the centre had increased and this was reflected in key performance indicators, however a full review of this area of care had not taken place to determine why this was the case. This is further outlined under Regulation 6: Healthcare and Regulation 5: Individual assessment and care plan.

There were sufficient staffing resources in place in the centre to ensure effective care delivery. However, in the absence of appropriate oversight, staff were not consistently providing residents with a high standard of nursing care, specifically in respect of pressure area care management.

The training provided to staff required review to ensure they all had the skills and knowledge to care for the residents being admitted to the centre.

The recruitment processes were found to be reflective of the centre's policies and all the required documents were available in the sample of staff files reviewed on inspection.

Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration

The inspectors observed that the changes made to the premises were in line with the application to vary submitted to the Chief inspector in advance of this inspection. The statement of purpose dated 21 Oct 2025 (version 33) and floor plans received on 22 Oct 2025 reflected the changes made.

Judgment: Compliant

Regulation 15: Staffing

The staffing levels on the day of the inspection were appropriate to the size and layout of the centre and the current residents and their dependency needs.

Judgment: Compliant

Regulation 16: Training and staff development

Some staff had not completed refresher training in the safeguarding vulnerable residents against abuse.

Some staff had not completed training in how to manage residents with responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment), despite a number of residents having displayed aggressive behaviours over the past eleven months.

Judgment: Substantially compliant

Regulation 23: Governance and management

Management and oversight systems in place did not ensure that all aspects of care provided were safe, appropriate, consistent and effectively monitored t. For example:

- The oversight of clinical care was not robust enough.
- The standard of pressure area care being provided was poor. It did not reflect the centre's own policy on pressure area care and poor pressure area care practices had not been identified on audits conducted by the management team.
- There were gaps in the management systems overseeing the quality of individual assessment and care planning, including poor recording practices that had been identified in audits completed in late 2025 and early 2026. However, no action was taken on foot of these audits' findings and consequently the practices had not improved.
  Institutional practices were observed in the morning on one floor, which did not ensure that residents' right to privacy were upheld and did not reflect a

culture of person-centredness. This is further described under Regulation 9: Residents' rights.

- The pre-admission assessment process did not consistently assess whether the proposed admission being considered would or could cause a risk to the current residents living in the centre. A small number of beds had been contracted for short-stay and the provider had failed to evaluate the impact of these admissions on the existing residents living in the centre and the capacity and capability of the staff team to meet their needs.

Judgment: Not compliant

Regulation 34: Complaints procedure

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

Judgment: Compliant

Quality and safety

Overall, residents and visitors voiced satisfaction with the care provided in the home and the inspectors observed that in general, residents were supported and encouraged to have a good quality of life. However, significant improvements were required in relation to the nursing care being delivered, the admission process and the quality of the nursing records being maintained.

The standard of nursing care for residents identified at risk or at high risk of developing pressure ulcers was poor. This had lead to an increase in the number of grade 2 pressure ulcers developing in the centre. The care outlined in these residents' care plans was not reflective of best practice or the local pressure area care policy and was not in line with recommendations made by tissue viability nurse who had assessed these residents. The issues identified are outlined under Regulation 5: Individual assessment and care plan.

Although residents had access to members of the multi-disciplinary team and referrals were made, residents were not always seen in a timely manner as there was no follow-up process in place. This left residents at risk.

The use of restraints in the centre was minimal and where deemed appropriate, the rationale was in accordance with national policy and the inspectors found good assessment and care planning around this area of care. Staff had access to relevant training on responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and a policy on caring for residents with these behaviours was available to staff. However, on review of the training matrix, the inspectors noted that not all staff providing care for these residents had this training completed. In addition, there were gaps in the updating of care records in the sample of care plans reviewed for the management of responsive behaviours.

The inspectors found that reasonable measures were taken to protect residents from abuse. There was a policy in place which covered all types of abuse, however, not all staff had completed refresher training in relation to detection, prevention and responses to abuse. There was a rigorous recruitment procedure in place. Staff had An Garda Síochána (police) vetting prior to starting work in the centre. The provider was a pension agent for a number of residents. The inspectors were assured that monies collected on behalf of residents were being lodged into a residents' account, in line with best practice..

Activities were provided in accordance with the needs and preference of residents and there were daily opportunities for residents to participate in group or individual activities. There was access to advocacy with contact details displayed in the centre and overall, residents' rights to choice were promoted and respected within the centre. However, the inspectors observed that residents' right to privacy was not always upheld and residents could not always identify the staff caring for them as outlined under Regulation 9: Residents' rights.

Regulation 10: Communication difficulties

Residents with communication difficulties had their communication needs documented in their care plan. The inspectors found that staff knew about these residents' communication needs and ensured residents had access to any aids or supports to enable effective communication and inclusion.

Judgment: Compliant

Regulation 17: Premises

Changes had been completed to the premises which reflected the application to vary condition 1 which had been submitted to the Chief Inspector. Two changes of room functions had been made on the first floor. The activity room had been changed to the director of nursing office and the physiotherapy room had been changed to a

medication store room with a clinical wash hand sink insitu.On the ground floor the director of nursing office had changed to the assistant director of nursing office and the treatment room was changed to the physiotherapy room.
The floor plans received on 22 Oct 2025 and SOP dated 21 Oct 2025 version 33, reflect said changes.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

The inspectors identified gaps and discrepancies in nursing records which negatively impacted the care being delivered to residents. For example:

- The nurses handover sheets contained inaccurate information in relation to residents. For example, inspectors observed that the age of a number of residents was not accurate and in one unit the handover sheet did not reflect that two residents living on that unit were living with grade two pressure ulcers. This posed a significant risk that these two residents were not receiving care in line with their care plan, local policy and best practice guidance and as recommended by allied healthcare professionals involved in their care.
- There had been an increase in the number of residents with grade two pressure ulcers. Inspectors observed that they all had pressure relieving mattresses on their beds. However, a sample of four mattresses checked were all set inaccurately. For example, one resident's mattress was set at 120kg while their actual weight recorded in April 2026 was 64kg.
- Residents' pressure ulcer care plan did not reflect the name of the pressure relieving mattress they were on or the weight the residents' mattress was to be set at.
- Residents identified with pressure ulcers, who had their wound reviewed by a tissue viability nurse (TVN) did not have a revised revised skin integrity risk assessment or have their pressure ulcer care plan updated to reflect the changes in grading of the pressure ulcer or the recommendations made by the TVN.
- Residents with pressure ulcers of grade two or above were not being re-positioned every two hour in accordance with the centre's own policy, recommendations made by the TVN or in line with the care outlined in some of these residents' pressure area care plans.
- The pre-admission assessments were not comprehensive and did not include details of the residents' medical and social history. This posed a risk of inappropriate admissions, including accepting residents into the centre that posed a potential risk to other vulnerable residents, staff and relatives.
- Residents with responsive behaviours did not have their needs reassessed using validated assessment tool when changes were noted to a resident’s condition.

Judgment: Not compliant

Regulation 6: Health care

A high standard of nursing care was not being delivered to residents who had been assessed as being at risk of developing a pressure ulcer. In the absence of a high standard of nursing care the number and appropriate preventative measures implemented by staff, the number and grading of pressure ulcers had increased in the centre.

A referral had been sent to a tissue viability nurse (TVN), as requested by the residents general practitioner (GP), however the resident had not been seen by the TVN. The referral sent in February 2026 had not been followed up on by staff. This resident was living with a grade two pressure ulcer.

Judgment: Not compliant

Regulation 8: Protection

There was a policy in place in relation to the detection, prevention and responses to abuse, it covered all types of abuse, and it was being implemented in practice. Reasonable measures were taken to protect residents from abuse. The inspectors saw that there were safe procedures in place to manage a small number of residents' pensions.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' right to privacy was not always upheld. Staff practices on one floor did not reflect a rights- based approach to care. For example, during morning handover staff turned on the light in a number of bedrooms when the residents' were asleep in bed and a number of staff proceeded to walk into each of these bedrooms without gaining consent.

Residents could not identify all staff caring for them as not all staff were wearing identification badges.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Dundalk Care Centre OSV-0008237

Inspection ID: MON-0048072

Date of inspection: 15/04/2026

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 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• A full review of the centre training matrix has been completed to identify all outstanding mandatory and refresher training requirements.
• Safeguarding refresher training has been scheduled for all outstanding staff and will be completed to ensure 100% compliance. To date, Safeguarding training sessions have taken place, with compliance currently at 86% for the online and 71% in person. Additional training sessions are booked for June, August and November to support full compliance.
• Responsive behaviour training requirements have been reviewed in line with the assessed needs of residents currently living in the centre. Additional training sessions have been arranged to ensure all staff caring for residents displaying responsive behaviours are appropriately skilled to meet their needs with dignity, compassion and respect. Current training compliance in responsive behaviour management is 70% with further training sessions booked in June.
• The PIC and ADONs will maintain weekly oversight of training compliance through review of the live training matrix. This enhanced review process will remain in place until full compliance is achieved and a structured training schedule is fully embedded to support ongoing compliance.
• Training compliance is now a standing agenda item at clinical governance and management meetings to ensure ongoing oversight, accountability and sustainability.
• Spot-check supervision and competency observations will be completed by CNMs and ADONs to ensure learning from training is embedded into practice and reflected in the delivery of person-centred care.
• New staff induction processes have been strengthened to ensure mandatory training requirements are completed within required timeframes.
• The Group Practice Quality and Innovation Lead has been supporting the centre to not only ensure staff receive appropriate training, but also to further enhance clinical knowledge, competence and evidence-based practice across the service.

Regulation 23: Governance and management	Not Compliant

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

• The governance structure and oversight systems within the centre have been comprehensively reviewed and adjusted to ensure the improvement plan developed following the inspection findings is effectively implemented, monitored and maintained.

• Enhanced support from the Clinical Governance Team has been implemented and will continue to be maintained within the centre. This includes on site support visits from the PPIM and Group Practice Quality and Innovation Lead to provide targeted training, and competency support to staff in identified areas requiring improvement.

• Weekly clinical governance meetings have been strengthened with a focused review of areas requiring improvement and ongoing monitoring of key clinical and operational KPIs including complaints, serious incidents, falls, pressure ulcers, care plan and training compliance.

• Daily clinical walkarounds by the PIC, ADON and CNM team have been implemented to provide enhanced oversight of care delivery, documentation standards, and resident experience.

• Auditing and monitoring systems have been reviewed and changes implemented with clear escalation pathways and accountability structures in place for identified risks, non-compliance or practice deficits.

• Immediate reviews were undertaken in relation to clinical care practices, documentation systems, admission processes and residents' rights practices, with targeted action plans developed and assigned to responsible persons with clear timeframes for completion.

• Admissions presenting complex clinical, behavioural or safeguarding risks are escalated to the Clinical Governance Team for review prior to acceptance to ensure the service can safely and appropriately meet residents' assessed needs.

• Ongoing HR support is in place where staff performance concerns are identified, with performance management, supervision and support processes implemented in line with company policy to ensure staff are supported to achieve and maintain required standards of practice.

The provider will continue to monitor the effectiveness of these measures through ongoing audits, KPI reviews, supervision and governance oversight to ensure compliance and that the centre reflects good standards of safe, effective and person-centred care.

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:

• A full review of residents' assessments and care plans has commenced to ensure records accurately reflect residents' current needs, preferences and the care being delivered.
• Once the full review is completed, monthly care plan audits on Viclarity will continue to monitor compliance, demonstrate improvement trends and ensure escalation pathways are implemented for identified deficits.
• All residents with pressure ulcers or identified as at high risk of skin breakdown have had:
o skin integrity risk assessments reviewed,
o care plans updated to include wound details, pressure relieving equipment and settings, multidisciplinary recommendations, repositioning frequency and dressing recommendations,
• Handover documentation templates have been revised to ensure accurate and up to date resident information is communicated effectively at each shift handover. The CNM on each unit is responsible for maintaining accurate and current handover information. In addition, monthly reviews of handover documentation are completed by the ADONs to ensure ongoing oversight, accuracy and compliance with documentation standards.
• A review of repositioning documentation was completed and staff received additional guidance regarding the accurate completion of repositioning records within EPIC in line with residents' assessed needs and the centre's policy.
• Residents reviewed by the Tissue Viability Nurse or any other allied healthcare professional have mandatory reassessment and care plan review completed following any MDT review to ensure recommendations are implemented promptly and accurately reflected in the care documentation.
• Residents displaying responsive behaviours will have reassessment completed using validated assessment tools following any significant change in presentation or behaviour, to ensure care provided remain appropriate and that residents' needs continue to be met with dignity and respect.
• A comprehensive pre-admission assessment is in place and completed for all admissions in line with the company's admission policy, to ensure residents' needs can be appropriately assessed and safely met within the service.
• Staff nurses have received additional support, supervision and guidance in relation to clinical documentation and care planning standards from the Group Practice Quality and Innovation Lead to strengthen documentation practices and promote consistent standards of care planning across the centre.

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
• A comprehensive review of all residents living with pressure ulcers has taken place to ensure appropriate MDT referrals, reviews and recommendations are in place and clearly documented within residents' care plans.
• The Registered Provider assures that residents requiring specialist input continue to have access to GP, tissue viability, dietetics and other allied healthcare services as clinically indicated.
• Pressure relieving equipment across the centre was checked to ensure mattresses were correctly set in accordance with residents' current weight and clinical requirements.
• Staff received immediate guidance and refresher education regarding:
o pressure ulcer prevention
o repositioning practices and recording system
o skin integrity monitoring
o wound documentation
o escalation procedures
• Enhanced monitoring systems have been implemented to support evidence-based nursing care including:
o daily skin integrity reviews at safety pause
o high risk residents highlighted at handover
o weekly pressure ulcer report analysis
o random mattress setting checks
o repositioning compliance checks through reports generated from EPIC and analysed by the management team.
• Findings from audits, checks and reviews are discussed at staff huddles, meetings and training sessions to promote shared learning, reflective practice and continuous improvement in care delivery.
• Tissue viability referrals are now tracked through EPIC to ensure all referrals are appropriately followed up and residents are reviewed within appropriate timeframes. Multidisciplinary recommendations, including GP recommendations, are reviewed weekly by CNMs to ensure they are implemented promptly and accurately reflected within residents' care plans.
• Clinical KPIs are reviewed monthly by the Clinical Governance Team, with high-risk areas identified and escalated to the PIC for further review and root cause analysis. Pressure ulcers are discussed weekly at clinical governance meetings, with enhanced oversight processes implemented to ensure MDT reviews, trends, outcomes and recommendations are effectively monitored.
• The effectiveness of implemented measures will continue to be monitored through audit, supervision and governance review processes to ensure continuous improvement in clinical care practices, oversight systems and resident outcomes.

Regulation 9: Residents' rights	Substantially Compliant

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

• Residents’ rights, dignity, privacy and person-centred care practices were reviewed with all staff following the inspection.
• Staff huddles have taken place to provide guidance regarding respectful morning care practices including:
o knocking before entering bedrooms
o obtaining consent
o minimising unnecessary disturbance
o ensuring residents’ privacy and dignity are upheld at all times
• Senior nurses and management will complete observational supervision rounds to monitor staff practices and ensure a rights-based approach to care is consistently maintained.
• Residents’ rights, dignity and privacy will continue to form part of staff induction, supervision and ongoing training programmes.
• All staff have been provided with and instructed to wear visible staff identification badges while on duty to ensure residents and visitors can identify staff caring for them.
• Spot checks will be completed by management to ensure compliance with identification badge requirements and repeated non-compliance will be managed in line with the company’s disciplinary and performance management policies.
• Residents are supported and encouraged to exercise choice in relation to daily routines, activities, meals and care preferences.
• Ongoing resident feedback through resident meetings, satisfaction surveys and direct engagement will continue to inform quality improvement initiatives within the centre.
• The most recent resident satisfaction survey was completed in November 2025. The next resident survey is planned for June 2026 and feedback received will be reviewed by the management team to identify opportunities for further enhancement of the resident experience and quality of life within the centre.
• Human Rights training has been provided in person within the centre by the Group Advocate BC, with 91% compliance to date. Additional training sessions are scheduled for 4 August and 3 November 2026 to support ongoing staff awareness and the promotion of a rights-based culture of care throughout the service.

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 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	27/05/2026
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	Orange	27/05/2026
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).	Not Compliant	Orange	27/05/2026
Regulation 5(4)	The person in charge shall formally review, at	Not Compliant	Orange	30/06/2026

	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.			
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 accordance with professional guidelines issued by An Bord Altranais agus Cnáimhseachais from time to time, for a resident.	Not Compliant	Orange	27/05/2026
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	27/05/2026

Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	27/05/2026
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Substantially Compliant	Yellow	27/05/2026
Regulation 9(4)	The person in charge shall make staff aware of the matters referred to in paragraph (1) as respects each resident in a designated centre.	Substantially Compliant	Yellow	27/05/2026