Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Leopardstown Care Centre
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Ballyogan Road, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	30 June 2026
Centre ID:	OSV-0008692
Fieldwork ID:	MON-0050290

About the designated centre

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

Leopardstown Care Centre is situated in South County Dublin and is close to a local shopping area. It is a purpose-built facility currently registered for 150 residents. 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 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 supported by a senior management team, 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:	142

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 30 June 2026	07:20hrs to 15:40hrs	Aisling Coffey	Lead
Tuesday 30 June 2026	07:20hrs to 15:40hrs	Aoife Byrne	Support
Tuesday 30 June 2026	07:20hrs to 15:40hrs	Helen Lindsey	Support

What residents told us and what inspectors observed

Overall, residents were happy living in Leopardstown Care Centre; however, some residents told the inspectors they were dissatisfied with the laundry service, and there were complaints from residents about food, as set out in this report.

This unannounced inspection was conducted by three inspectors of social services over one day. During the inspection, the inspectors spoke with 22 residents and three visitors to gain insight into residents' lived experiences in the centre. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

Residents were complimentary of the centre, the person in charge, and the staff who cared for them, telling the inspectors that the centre was "like a hotel", "the staff can't do enough for you", and "the staff are wonderful". Visitors who spoke with the inspectors provided positive feedback, noting the high level of care and attention their loved ones received, as well as the communication with them as family members. The inspectors found that staff and management were knowledgeable about residents' needs. The inspectors observed numerous friendly, compassionate, warm, dignified, and respectful interactions between residents and staff over the inspection day.

Leopardstown Care Centre is a purpose-built premises located in South County Dublin. The centre is a three-storey building set out over the three floors. The ground and first floors provide long-term residential care, with the first floor designated as a memory care unit. The second floor offers short-stay residential services, including rehabilitation, respite and convalescence care. Two passenger lifts facilitate travel between the floors.

Bedroom accommodation comprised 150 single-occupancy rooms with en-suite facilities, including showers, toilets, and wash-hand basins. The size and layout of the bedroom accommodation were appropriate for residents' needs. Bedrooms had comfortable seating and were personalised with items from home, such as family photographs and artwork. The bedrooms had a television, locked storage, and call-bell facilities.

The centre is located in a busy urban area, in very close proximity to schools, colleges, offices and a large shopping centre. On arrival at the centre, inspectors noted privacy film on the ground-floor windows, protecting the privacy and dignity of residents on that floor. However, the privacy of residents on the first and second floors was not upheld, as inspectors were able to view into a sample of these bedrooms from the surrounding car park. This is a repeat finding from the February 2025 and August 2025 inspection reports and will be discussed further under Regulation 9: Residents' rights.

Within the centre, the design and layout supported residents in moving throughout the floor on which they resided. There were wide corridors, sufficient handrails, furniture and comfortable seating in the various communal areas. There remained keypad access controls to enter or exit the ground and first-floor resident accommodation; however, inspectors noted the presence of butterfly codes to support residents with decision-making capacity to enter and leave their floor. The person in charge informed the inspectors that the provider continued to progress their compliance plan commitment regarding access control within the building, including the plan to install keypad-controlled access at the exit door in the main foyer, which was due for installation in January 2026. The addition of this access control in the main foyer would enable residents to have unrestricted access throughout the centre whilst maintaining security at the building's main entrance. While noting the provider was progressing with this work, the delay in completing it within the compliance plan timeframe will be discussed under Regulation 23: Governance and management.

In terms of outdoor space, the centre had two internal courtyard areas and a garden facing out into the community located on the ground floor, as well as two outdoor terrace areas on the second floor. These areas were pleasantly landscaped and had outdoor furniture for residents and their visitors to use. Residents on the first floor, who did not have access to outdoor space, were seen being supported by staff as they walked to the garden to pick flowers.

Residents could receive visitors in the centre within communal areas, gardens, or in the privacy of their bedrooms. Multiple families and friends were observed visiting their loved ones during the inspection days.

On the morning of the inspection, the atmosphere in the centre was calm and relaxed. On arrival, inspectors met the clinical nurse manager in charge of the centre at night. As it was early morning, most residents were sleeping. Staff informed inspectors that residents chose when to get up. As residents woke, breakfast was served in the dining rooms and bedrooms, according to resident preference. Options served were cereal, porridge, eggs and toast, with refreshments such as tea and juices, and condiments such as butter and jam. Inspectors observed that some of the dining tables, crockery, and servery areas were unclean, which will be referenced under Regulation 18: Food and nutrition. This matter was discussed with the person in charge on the morning of the inspection, and cleaning was observed thereafter.

As the morning progressed, residents were dressed in their preferred attire and seen to engage in activities on offer. Inspectors admired the residents' pottery on display in the entrance lobby. In the morning, inspectors observed residents partaking in a physiotherapy class followed by Tai Chi. Residents who did not wish to partake in group activity were seen watching television, reading the newspaper, knitting, drawing, and chatting with other residents and staff. The hairdresser was also in the centre on the inspection day, and residents were seen enjoying having their hair cut and blow-dried in a fitted-out salon. In the afternoon, residents engaged in arts and

crafts, a reminiscence session and played bingo. The inspectors observed staff and residents having good-humoured fun during these activities.

There had been improvements to the facilities for occupation and recreation since the August 2025 inspection, and communal spaces were seen to have a variety of equipment for residents, including puzzles, jigsaws, ball games, books, and sensory items such as blankets. The provider had three activity staff on duty on the day of inspection. Activities were scheduled to take place over seven days and throughout the centre. Residents spoken with said they were very happy with the activities programme, which was displayed on notice boards and whiteboards on each floor.

Lunchtime was observed to be a sociable and relaxed experience, with the majority of residents choosing to dine in the dining areas over the three floors. Some chose to dine in their bedrooms. Meals were freshly prepared on-site in the centre's kitchen, under the head chef's supervision. Residents confirmed they had been offered a choice of main meal on the inspection day: Spanish-style chicken or a parmesan-crusted fillet of white fish. The food served appeared nutritious and appetising. However, residents had mixed views on the meals available. While some residents were complimentary, stating "the food is really good" and "I like it", others were neutral, stating "the food is passable", "it's alright", it's middling", and "sometimes it's ok". Similarly, some residents complained, telling the inspectors that "the food is bland", while others informed the inspectors that the breakfast time meal could be cold by the time it reaches their bedroom, there can be excessive sauces on food not requested by the resident and that the meat can be tough.

The following two sections of the report present the findings of this inspection regarding the centre's governance and management arrangements and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

This inspection found significant improvement in the management and oversight of service delivery to residents since the previous inspection in August 2025.

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended) and to review the registered provider's compliance plan arising from the previous inspection of 25 August 2025. The inspection also informed the provider's application to renew registration. Inspectors followed up on four pieces of unsolicited information submitted to the Chief Inspector of Social Services. This information was related to falls management, food, staffing levels, privacy, activities provision, governance and supervision. The overall findings of this inspection indicated that residents received good-quality care; however, concerns

regarding food and residents' rights to privacy were upheld and are discussed under the relevant regulations.

While the provider had progressed their compliance plan following the last inspection, and there were improvements in compliance across several regulations, including training and staff development and medicines and pharmaceutical services, the provider's compliance plan commitment regarding access control at the front door remained outstanding.

The registered provider is Mowlam Healthcare Services Unlimited Company. The company is part of the Mowlam Healthcare group, which operates several centres nationally. The company has two directors, one of whom serves as the chief executive officer and represents the provider for regulatory matters. There are two persons participating in management, a director of care services and a healthcare manager. These are senior personnel who support the person in charge in their operational management and clinical oversight of the centre.

There was a clearly defined management structure which identified lines of accountability and responsibility for the service. The person in charge is responsible for the centre's day-to-day operations and reports to the regional healthcare manager, who in turn reports to the director of care services, who reports to the chief executive officer.

The person in charge was an experienced nurse manager who had worked in the centre since it opened in 2023. The person in charge worked full-time and was supported in their management role by four assistant directors of nursing, nine clinical nurse managers and a general services manager. Other staff members included nurses, healthcare assistants, activities coordinators, physiotherapists, occupational therapists, therapy assistants, medical staff, catering staff, housekeeping staff, maintenance staff, and administration staff. The provider had deputising arrangements in place whereby one of the assistant directors of nursing (ADONs) deputised for the person in charge.

The registered provider had systems in place to monitor the quality and safety of care. There was documentary evidence of the communication systems in place between the registered provider and management within the centre. There were minutes of regular governance meetings, and the person in charge also prepared a weekly report for the persons participating in management, which included key clinical matters affecting residents in the centre.

There was evidence of communication between the person in charge and the centre's management team, as well as regular staff meetings. During these meetings, key issues related to the quality and safety of the service delivered to residents were discussed, including incidents, safeguarding, auditing and complaints management. Records found that the provider had also established several staff committees to examine matters, including falls reduction, restrictive practices and infection control. On a day-to-day basis, further communication regarding residents' care and well-being was facilitated through huddles and handovers. The inspectors

observed the end-of-shift handover meeting among staff on the morning of the inspection.

The provider maintained a risk register to monitor known risks within the centre. Auditing of key aspects of service provision was occurring, for example, call bell response times, hand hygiene and medication management. Notwithstanding the presence of these oversight systems, some further action was required to ensure the service provided to residents was safe, appropriate, consistent, and effectively monitored, as the provider's oversight mechanisms had failed to identify some deficits and risks, found during this inspection. These matters are discussed under Regulation 23: Governance and management.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2025. The inspectors saw evidence of consultation with residents and families reflected in the review. In this review, the registered provider also identified areas requiring improvement, for example, mealtimes and medication administration practices.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider applied to renew the designated centre's registration in accordance with the requirements in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015. At the time of inspection, this application was being reviewed.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge met the regulatory requirements. They were an experienced registered nurse with previous management experience and a post-registration management qualification. The person in charge demonstrated good knowledge and understanding of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 and their regulatory responsibilities.

The provider had four assistant directors of nursing available to deputise in the absence of the person in charge.

Judgment: Compliant

Regulation 15: Staffing

Based on a review of the worked and planned rosters and from speaking with residents, there were sufficient numbers of staff with an appropriate skill mix on duty each day to meet the residents' assessed needs. At night, there were seven registered nurses in the centre.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were appropriately supervised and clear about their roles and responsibilities. In terms of staff development, records reviewed found evidence of an induction programme covering key aspects of care and procedures in the centre. This induction was followed by probation meetings during which the staff member's performance was appraised, and a performance improvement plan was developed to support identified learning needs. The inspection also reviewed records relating to reflective practice discussions, in which staff members discussed recent incidents in the centre with their line manager, to support staff in understanding the incidents and developing the competencies required to provide high-quality care and support to residents. Records reviewed found that staff had access to a suite of mandatory training in areas such as manual handling, safeguarding, infection control, dementia awareness, and fire safety to support them in their roles.

Judgment: Compliant

Regulation 21: Records

A sample of five staff files reviewed by the inspectors contained all the information required by Schedule 2 of the regulations, including An Garda Síochána (police) vetting disclosures, references, and qualifications. Evidence of active registration with the Nursing and Midwifery Board of Ireland was seen in the nursing staff records viewed.

All other records requested were made available and were well-maintained.

Judgment: Compliant

Regulation 23: Governance and management

While established governance and management systems were in place to oversee the quality of care delivered to residents, some of the providers' oversight systems required action to ensure the service provided was safe, appropriate, consistent and effectively monitored. For example:

- Some of the providers' oversight systems had not been fully effective in identifying risks and driving quality improvement in areas such as personal possessions, individual assessment and care planning, and residents' rights, as set out in this report.
- Inspectors reviewed arrangements for the oversight of agency staff. Records reviewed found that, from a sample of 10 agency staff who had worked in the previous month, nine of the ten staff had worked at the centre without valid identification. This was contrary to the provider's policies and the service level agreement with the recruitment agency.
- Actions committed to in the provider's compliance plan, submitted following the previous inspection in August 2025, were not implemented within the provider's timelines; for example, reviewing the privacy for residents bedrooms on the first and second floor and the installation of a keypad-controlled access point at the exit door and in the main foyer, which was due for completion by January 2026 and remained outstanding on this inspection.

Judgment: Substantially compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of four residents' contracts and found that they set out the allocated bedroom number and occupancy. The contracts outlined the services to be provided and the fees to be charged, and referenced other services that residents may choose to avail of at an additional cost, such as chiropody and hairdressing.

Judgment: Compliant

Regulation 3: Statement of purpose

There was an up-to-date statement of purpose that included the information set out in Schedule 1 of the regulations.

Judgment: Compliant

Quality and safety

The residents living in Leopardstown Care Centre were receiving a high standard of care and attention from a stable staff team, many of whom had worked at the centre since its opening and knew the residents well. It was evident that staff worked hard to ensure that residents' needs were met. The inspectors observed kind and compassionate staff treating residents with dignity and respect. Residents were being protected from abuse. There had been improvements in regulatory compliance for food and nutrition, medicines and pharmaceutical services since the last inspection. Notwithstanding these positive findings, the inspection found that some further actions were required in care planning, residents' rights, personal possessions, and information for residents, to align with the requirements of the regulations.

The inspectors reviewed a sample of care records, assessments and care plans on the day of the inspection. Inspectors found that residents were comprehensively assessed in the centre using a suite of evidence-based risk assessment tools to evaluate risks, including falls, pressure sore development, malnutrition, manual handling needs, and dependency levels. Care plans were developed based on these assessment tools. The care plans viewed by the inspectors were updated at required intervals. However, not all care plans were person-centred or contained sufficient detail to guide staff on each resident's current needs. This is discussed further under Regulation 5: Individual assessments and care plans.

Staff were observed to be respectful and courteous towards residents. The centre offered regular religious services, both in-house and broadcast on television. Residents had access to radio, television, newspapers, telephones and internet services throughout the centre. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by attending monthly residents' meetings and completing questionnaires. Residents also had access to independent advocacy services. There had been improvements to the activities provision and access to facilities for occupation and recreation since the August 2025 inspection. Notwithstanding these good practices, inspectors found that aspects of residents' rights were not upheld as discussed under Regulation 9: Residents' rights.

There were arrangements in place to support residents in accessing and retaining control over their personal property, possessions, and finances. Residents' clothes were laundered off-site by an external company. Residents had adequate space in their bedrooms to store and maintain their clothing and possessions, including access to locked storage facilities. Residents who spoke with the inspectors stated they were satisfied with the space in their bedrooms and storage facilities. However, several residents expressed their dissatisfaction with the external laundry service and its impact on their ability to retain control over their clothing. This matter is discussed under Regulation 12: Personal possessions.

There was mixed resident feedback regarding the food available. Food was prepared and cooked onsite. Choice was offered at all mealtimes, and adequate quantities of

food were seen to be provided during the inspection day. Residents had access to fresh drinking water and other refreshments throughout the day. There was adequate supervision and discreet, respectful assistance at mealtimes. There was evidence of written communication between the nursing and catering teams to ensure that the dietary needs of each resident, as prescribed by healthcare or dietetic staff, were met. Notwithstanding these positive findings, some aspects of the dining experience required action to comply with Regulation 18: Food and nutrition.

A residents' guide was available at the centre and contained information on the services and facilities available. It also contained a copy of the complaints procedure and contact details for independent advocacy services. However, it did not contain all the information required by the regulations. This is discussed under Regulation 20: Information for residents.

Regulation 12: Personal possessions

Not all residents were facilitated to retain control over their clothes. Several residents who had their clothing laundered off-site by an external agency, contracted by the provider, reported to the inspectors that there were often delays in the return of clothing, that some clothing had not been returned, that some clothing was returned damaged, and some was returned unclean. Some of this feedback regarding delays and clothing not being returned was noted in the residents' committee meeting minutes from April 2026.

Judgment: Substantially compliant

Regulation 13: End of life

A resident approaching the end of life had appropriate care and comfort based on their needs, which respected their dignity and autonomy and met their physical, emotional, social and spiritual needs. The resident's religious preferences were respected. The resident's family were informed of their condition in accordance with the resident's wishes and were permitted to be with the resident at the end of their lives. The resident's preferred location for care and comfort at the end of life was facilitated.

Judgment: Compliant

Regulation 18: Food and nutrition

While acknowledging significant improvement in food and nutrition since the August 2025 inspection, further action was required to ensure food was served safely, for example:

- The inspectors were not assured that food and refreshments were properly and safely served, as areas of the ground-floor dining area and the first-floor servery were seen to be unclean. For example, on the ground floor, some dining tables and crockery were seen to have dried food and liquid stains, as the residents were seated for their breakfast. Additionally, some of the crockery was seen to be damaged.
- Many residents spoken with during the inspection expressed dissatisfaction with how the food was served, its taste and temperature, how the meat was cooked, and the addition of unwanted sauces to meals.

Judgment: Substantially compliant

Regulation 20: Information for residents

The registered provider prepared a guide for residents, which was made available to each resident. However, the guide did not include the terms and conditions relating to residence in the centre, nor how to access inspection reports.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The provider had ensured that a pharmacist was available to each resident. There was a comprehensive centre-specific policy in place to guide staff in the safe management of medications. This policy was up to date and evidence-based. Medication administration was observed, and the inspectors found that the staff had adopted a person-centred approach. The records reviewed indicated that medicines were administered in accordance with the prescriber's directions. There were robust measures in place for the handling and storage of controlled drugs in accordance with current guidelines and legislation. There were appropriate procedures for handling and disposing of unused and out-of-date medicines. The inspectors noted that the medication trolley was secured at all times.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

While comprehensive person-centred care plans were developed, based on validated risk assessment tools, action was required concerning individual assessments and care plans to ensure that each care plan accurately reflected the resident's assessed needs and guided staff in meeting these needs, for example:

- Inspectors reviewed a sample of behaviour support care plans for residents who displayed responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment). The inspectors found that these care plans did not guide staff by outlining residents' responsive behaviours and detailing de-escalation and other therapeutic techniques to manage and respond to the behaviour.
- Inspectors found that a resident deemed at high risk of malnutrition when the provider's malnutrition screening tool was used had their risk of malnutrition incorrectly recorded as low risk in their most recent assessment. At the same time, their care plan incorrectly noted they were at medium risk. Underestimating a resident's risk of malnutrition could lead to missed opportunities to mitigate these risks and develop a robust care plan to enhance the resident's care and welfare.

Judgment: Substantially compliant

Regulation 6: Health care

The health of residents was promoted through ongoing medical review and access to a range of healthcare providers. Services such as palliative care, physiotherapy, speech and language therapy, occupational therapy, tissue viability nursing expertise and dietitian services were available to residents through a system of referral. The records reviewed showed evidence of ongoing referral and review by these healthcare services for the residents' benefit.

Judgment: Compliant

Regulation 8: Protection

Safeguarding training was provided, and a safeguarding policy provided support and guidance in recognising and responding to allegations of abuse.

From the records seen, it was clear that the person in charge had provided a robust and person-centred response when investigating and responding to allegations of abuse concerning residents.

The provider was not a pension agent and did not hold cash or personal possessions in safekeeping for residents.

Regarding systems in place to protect residents from abuse, the provider's failure to validate agency staff members' identification has been referenced under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 9: Residents' rights

The provider had not ensured that the dignity and privacy of residents were maintained at all times, for example:

- The privacy of residents on the first and second floors was not upheld as inspectors were able to view into a sample of these bedrooms from the surrounding car park on the inspection day. This is a repeat finding from the February 2025 and August 2025 inspection reports. While the provider had risk assessed this matter, the control measures in place to uphold residents' privacy were not being implemented and were therefore ineffective.
- There were symbols on all bedroom doors, visible from the corridor, outlining aspects of the resident's care needs, including, for example, their wishes regarding resuscitation.

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 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: End of life	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 20: Information for residents	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Leopardstown Care Centre OSV-0008692

Inspection ID: MON-0050290

Date of inspection: 30/06/2026

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 23: Governance and management	Substantially Compliant

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

• The Person in Charge (PIC) and the Healthcare Manager (HCM), will complete a review of the centre's governance and oversight systems in the areas identified on inspection, to include personal possessions, individual assessments and care planning, residents' rights, and the management of temporary agency staff.

• A Quality Improvement Plan (QIP) will be maintained for all actions arising from this inspection. Each action will have a named responsible person, target date for implementation of actions and evidence of completion. Progress will be reviewed at the centre's monthly Quality & Safety Management Meetings and reported to the governing body through the quarterly senior management governance meetings.

• Targeted audits will be completed of the areas identified during inspection. Audit findings, resident feedback and complaints are trended and reviewed to ensure that actions taken are effective and sustained.

• The PIC will ensure that all agency staff reporting for duty have valid photographic identification and that this is verified before they commence work in the centre, in accordance with the policy. In addition, a procedure for the orientation and induction of agency staff has been introduced.

• An agency staff verification record will be maintained. The CNM/Night Supervisor in charge will record completion of the required checks before an agency staff member is allocated to duty.

• Compliance with agency identification requirements will be reviewed regularly to ensure that the management of agency staff is being maintained in line with company policies.

• A keypad access point has been installed at the main reception entrance and exit door and the access number is displayed internally. The PIC has undertaken a risk assessment to determine the safe implementation of this entry and exit system, and it has been agreed that, due to the size of the centre, this will be introduced on a phased basis using a risk-based approach.
The Second Floor has no restriction on entering and exiting the unit.
The Ground and First Floors will have a phased risk-based approach to the reduction in use of the access control points that are currently in place at the entrance and exit of each unit.
This phased approach is planned as follows:
1. The access code is displayed for any resident or family wishing to use the code to unlock the door. This action has been completed.
2. An environmental risk assessment will be undertaken to include the scope of the external environment and potential risks outside the building and surrounding areas. There have been environmental changes externally that are evolving due to local building works. The environmental risk assessment will be completed by 10/10/2026.
3. Residents who walk with purpose will be individually reviewed with the creation of a positive risk-taking plan of care, in collaboration with their will and preference, the view of their nominated representatives, the GP and any other Health & Social Care Professionals involved in the care of that resident. This will be completed by 31/10/2026.
4. New staff who have recently been recruited for reception, will be fully inducted and will complete training and education with the PIC and the General Service Manager on recognising and responding to residents that may be at risk due to walking with purpose. The newly appointed staff will be notified of the residents from each floor who may have higher risks because of living with a cognitive impairment and behaviours that may pose a threat to their wellbeing and safety. The date for completion of this action is 31/10/2026.
5. A review of the plan will be undertaken at the Quality & Safety Monthly Meeting by the PIC, the HCM and the team to finalise the last stage of the phased plan by the 30/11/2026.
6. The PIC and General Services Manager (GSM) will maintain specific oversight of the access control at the main foyer until fully completed.

• In relation to resident privacy on the first and second floors, there has previously been a comprehensive review of the privacy of all first- and second-floor bedroom windows. It was determined that the use of privacy screening on the windows was not suitable on the upper floors as it significantly reduced residents' access to daylight and their view from the bedroom. Therefore, the control measures that were introduced following a risk assessment will be maintained, with a more robust oversight by the PIC, ADONs and Clinical Nurse management team. We will review the privacy screening to consider whether the application of privacy screening to the lower half of the upper floors' windows would prevent residents from being seen by external observers without significantly darkening the rooms.

• A risk assessment with mitigating actions will remain in place pending completion of the works. The PIC will ensure that the implementation of the interim control measures is reviewed to ensure that these controls are being maintained.

• Progress of the QIP action completion dates will be reviewed on an ongoing basis until these are fully completed.

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:

• The PIC and GSM will complete a review of the external laundry service, with a focus on delayed return of clothing, missing items, damaged clothing and clothing returned unclean. This will be addressed at regular meetings with the outsourced service provider.

• Concerns regarding residents' clothing will be logged as complaints and followed through to resolution / satisfaction of the complainant. The record will identify the item, date reported, action taken, outcome and whether replacement or reimbursement is required.

• The outsourced service provider will be required to provide an action plan addressing the issues identified and compliance with agreed service standards will be monitored through regular service review meetings.

• Residents and their representatives will be reminded of the process for reporting missing, damaged or unclean clothing via internal communication and the web text service. Feedback on the laundry service will remain a standing agenda item at residents' meetings.

• The GSM will complete a monthly laundry audit, to include a sample check of turnaround times and returned clothing. Findings will be reviewed by the PIC, and any recurring issues will be escalated to the HCM and the outsourced service provider.

Regulation 18: Food and nutrition	Substantially Compliant

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

• A review of dining rooms, dining tables and crockery has been undertaken. Damaged crockery has been removed from use and replaced.

• A cleanliness check will be completed by the senior member of the catering staff team before each meal service. Any deficit identified will be rectified before residents are seated or food is served. The GSM will conduct daily checks of the dining service to include hygiene checks to ensure the standards are being maintained.

• In addition to the daily check, dining and service hygiene will be included in monthly catering audits, to be conducted by the GSM and findings will be addressed with the outsourced service provider's Catering Manager on-site, and reviewed with the PIC, GSM and Catering Manager at the monthly quality and safety governance meeting.

• The catering team will review resident feedback regarding food temperature, taste, tenderness of meat, presentation and the addition of sauces that have not been requested.

• Residents' individual food preferences and choices, including sauces and accompaniments will be clearly communicated to catering and care staff. Condiments and sauces will be served separately in accordance with residents' preferences.

• The Catering Manager will be required to ensure that food temperatures are monitored at the point of service, including meals delivered to residents who choose to dine in their bedrooms. Care staff have received training in relation to room service meal delivery.

• Food and Nutrition will remain on the agenda of the residents' meetings. Feedback, complaints and dining experience audits will be reviewed monthly and a QIP will be updated where improvement is required.

Regulation 20: Information for residents	Substantially Compliant

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

• The Residents' Guide will be revised to include the terms and conditions relating to residing in Leopardstown Care Centre and clear information on how residents and representatives can access HIQA inspection reports.

• The revised Residents' Guide will be checked by the HCM, Quality & Safety to ensure they are in accordance with the requirements of Regulation 20 before these are circulated.

• The updated guide will be made available to all current residents and representatives and will be provided to new residents on admission.

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

• The PIC, ADONs and Clinical Nurse management team will undertake a review of behaviour support care plans to ensure they clearly describe each resident's responsive behaviours, known triggers, early warning signs, de-escalation approaches and other interventions that are effective for that individual resident.

• Where a required improvement is identified, the resident's assessment and care plan will be updated and communicated to the staff team at handovers and safety pause meetings.

• The PIC will ensure that a sample of behaviour support care plans will be audited each month to confirm that plans are person-centred, sufficiently detailed and provide clear guidance to staff.

• The resident record identified on inspection was immediately reviewed and addressed to ensure that the MUST screening score, recorded the level of risk and a care plan consistent with the level of risk.

• The PIC, ADONs and Clinical Nurse management team will ensure that a review of residents identified as being at risk of malnutrition will be completed to verify that screening scores, risk identification and nutritional care plans correspond and that appropriate interventions and referrals are in place.

• Registered nurses will receive a reminder on the need for accurate completion and interpretation of the malnutrition screening tool and on ensuring that assessment findings are correctly reflected in care plans.

• Nutritional assessments and associated care plans will be included in the care plan audit schedule, with findings reviewed by the PIC/ADON team and corrective action taken where required.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• There has previously been a comprehensive review of the privacy of all first- and second-floor bedroom windows, it was deemed that the ground floor privacy screening that protects residents from external observation, was not suitable on the upper floors as it significantly reduced residents' access to daylight and their view from the bedroom.

Therefore, the control measures that were introduced following a risk assessment will be maintained with more robust oversight by the PIC, ADONs and Clinical Nurse management team.

• Implementation of the control measures will be checked daily by the management team. Privacy will thereafter be included in the review of residents' rights.

• The symbols displayed on bedroom doors have been removed.

• Information required by staff to support safe care will be communicated through the new system of ISBAR handover that has been developed and implemented to ensure staff awareness is maintained up to date at each handover. IPC signage will be displayed in line with HPSC Public Health Guidance.

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 12(a)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that a resident uses and retains control over his or her clothes.	Substantially Compliant	Yellow	30/09/2026
Regulation 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that his or her linen and clothes are laundered regularly	Substantially Compliant	Yellow	30/09/2026

	and returned to that resident.			
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Substantially Compliant	Yellow	30/09/2026
Regulation 20(2)(c)	A guide prepared under paragraph (a) shall include how to access any inspection reports on the centre.	Substantially Compliant	Yellow	30/10/2026
Regulation 20(2)(b)	A guide prepared under paragraph (a) shall include the terms and conditions relating to residence in the designated centre concerned.	Substantially Compliant	Yellow	31/10/2026
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.	Substantially Compliant	Yellow	31/12/2026
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where	Substantially Compliant	Yellow	31/10/2026

	necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.			
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	30/09/2026