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:	Sugarloaf Care Centre
Name of provider:	Spridale Limited
Address of centre:	Kilmacanogue South, Kilmacanogue, Wicklow
Type of inspection:	Unannounced
Date of inspection:	04 March 2026
Centre ID:	OSV-0008793
Fieldwork ID:	MON-0049686

About the designated centre

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

Located at the foot of the majestic Sugarloaf mountain in the village of Kilmacanogue, the Sugarloaf Care Centre can provide comprehensive care for 119 residents, accommodating both male and female residents. The centre can provide care for residents ages 18+. Each room is thoughtfully designed to create a warm and welcoming atmosphere. The units are named appropriate to its surroundings as follows : Lower Ground Floor is named Powerscourt accommodating 18 residents. 15 single en-suite, 1 single accessible en-suite and 1 twin en-suite. Ground Floor is divided into two units Glendalough and Mount Usher accommodating a total of 49 residents. Glendalough: 17 beds comprising of 15 single en-suite, 1 twin ensuite. Mount Usher: 32 beds comprising of 29 single en-suite, 3 single accessible en-suite First Floor is divided into two units Silver Strand and Laragh accommodating a total of 52 residents. Silver Strand: 17 beds comprising of 15 single en-suite, 1 twin ensuite Laragh: 35 beds comprising of 32 single en-suite, 3 single accessible en-suite. Sugarloaf Care Centre is designed to meet the health & social care needs and risk assessment of residents of all dependency levels. There are currently no limits or restrictions on the care needs the centre is intended to meet, and all prospective and current residents are assessed using a standard assessment, the Barthel Assessment Tool. Staffing levels are determined by the management of the centre having reviewed the resident's current dependency levels.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	113

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 4 March 2026	08:05hrs to 16:25hrs	Niamh Moore	Lead
Wednesday 4 March 2026	08:05hrs to 16:25hrs	Aoife Byrne	Support
Wednesday 4 March 2026	08:05hrs to 16:25hrs	Kathryn Hanly	Support

What residents told us and what inspectors observed

Inspectors observed a relaxed and friendly atmosphere in Sugarloaf Care Centre. Staff were observed to promote and protect residents' privacy and dignity. On the day of the inspection, staff were seen to be responsive and attentive to residents' requests and needs. However, a small number of residents said that staff did not always respond to call bells in a timely manner. One resident said this delay particularly related to requiring the assistance of a second staff member to assist with their needs. Another resident said recently there had been a high turnover of staff.

This was an unannounced risk inspection which took place over one day by three inspectors, including one inspector who focused on the provider's compliance with infection prevention and control (IPC) oversight, practices and processes.

On arrival to the centre, inspectors met with members of management and completed an opening meeting, following this, inspectors walked through the centre. Sugarloaf Care Centre is a purpose-built care facility with capacity for 119 residents, comprising 113 single bedrooms and three twin bedrooms over three floors. On the day of the inspection there were 113 residents residing in the centre.

The location, design and layout of the centre was suitable for its stated purpose and met residents' individual and collective needs. Finishes, materials, and fittings struck a balance between being homely and accessible. The aesthetics and interior design of communal areas were also of a high standard.

There was a variety of comfortable communal spaces including, a coffee dock, 'quiet rooms', open plan day rooms and dining rooms available to residents. Corridors were wide and clear of items, with appropriately placed grab rails in place to allow residents to mobilise safely around the centre.

All of the bedrooms had en-suite shower and toilet facilities. The privacy and dignity of the resident's accommodated in the twin rooms was protected, with adequate space for each resident to carry out activities in private and to store their personal belongings. The majority of residents had personalised their bedrooms with photographs, ornaments and other personal memorabilia. Residents said they were very happy with their bedrooms.

Ancillary facilities were well-ventilated and generally supported effective infection prevention and control. There was a dedicated medical/ clinical store on each floor for the storage and preparation of medications, clean and sterile supplies and dressing trolleys. Staff also had access to dedicated cleaners stores on each floor for storage and preparation of cleaning trolleys, equipment and sluice rooms with bedpan washers for the reprocessing of bedpans, urinals and commodes. However,

the detergent in some bedpan washers had expired and gloves were not available within some sluice rooms.

Based on inspectors' observations and discussions with staff and residents, it was evident that planned staffing levels were not consistently maintained. Staff reported that absences were frequently not covered which resulted in reduced capacity to meet residents' assessed needs. During the morning of this inspection, inspectors observed one staff nurse who was responsible for the supervision of eight residents with advanced dementia and high dependency needs, was also responsible for completing the medication round. During this time, the nurse was required to leave the medication round on multiple occasions to respond to residents, this posed a risk of a potential medication error.

There were information boards available which highlighted different activities available, including pictures of the visiting therapy dogs Bonnie and Toby and the resident rabbit Sugar who lived in the centre. An activities schedule showed a timetable of activities planned across seven days. However, the versions on display in the lower ground and ground floors had not been updated to reflect the current week's schedule. In addition, inspectors also observed differences in the level of activities and meaningful engagement provided on each floor. For example, on the day of the inspection, there was an activity staff member assigned to the first floor, where some residents participated in a quiz in the morning, and arts and crafts scheduled for the afternoon in preparation for the upcoming St Patrick's Day. There was also one-to-one engagement seen to occur on this floor. This contrasted with the experience of the residents on the lower ground and ground floors, where a much less stimulating environment was observed. For example, residents were observed sitting in the day rooms or in their bedrooms with the television on watching mass or a movie with limited staff interaction or engagement; numerous residents were seen sleeping during the afternoon movie.

The infrastructure of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process. However, due to the large volume of used linen awaiting washing, the 'dirty' side of the laundry was congested and poorly organised.

Visitors were observed to be welcomed by staff, and it was evident that staff knew visitors by name and actively engaged with them. Visitors also complimented the quality of care provided to their relatives by staff, who they described as kind and respectful. However, in conservations with inspectors, one common area of dissatisfaction raised was the laundry service. Inspectors were told that concerns had been raised previously about laundry not being returned to residents. Two visitors informed inspectors that there were no trousers in their loved ones wardrobes on the day of inspection. Inspectors saw that management had implemented a new process in response to the feedback regarding the laundry system. This included the introduction of a designated box for visitors to drop in new items of clothing for labelling. In addition, a communal space contained a ''lost and found'' area where unlabeled belongings were stored to facilitated the identification of the owners.

During this inspection, a lunchtime meal service was observed. Written menus were displayed on each table, outlining the meals available for the day, with a choice of salmon or chicken lasagne. Dessert options included berry cheesecake or jelly and ice-cream. Inspectors saw there were enough staff on duty to support residents in the dining rooms. Residents were generally complimentary of the home cooked food and the dining experience in the centre. Some residents attended the dining rooms for their meals while others choose to have lunch in their bedrooms. Staff served meals to the residents from a bain-marie in the dining rooms on each floor. This created a smooth and efficient serving, allowing the meals to be served quickly and in portions that suited resident's individual preferences and dietary requirements. Some residents said that noise from televisions or radios occasionally affected their overall dining experience. In addition, on the ground floor, inspectors saw that due to the volume of mobility equipment such as, wheelchairs within some dining rooms, the space was limited and required some residents to be moved from their tables to allow other residents to pass by them. In addition, the weekly planned fire alarm test occurred during this meal-time service, which was notably loud.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted 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

Inspectors found that overall this was a well-managed centre where residents were supported and facilitated to have a good quality of life. Inspectors found that improved levels of compliance were demonstrated by the provider since the previous inspection. Notwithstanding this, resources did not align with those outlined in the centres statement of purpose and audit findings were not consistently utilised to drive improvements.

The aim of this unannounced inspection was to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 to 2025 (as amended) in the centre. Inspectors followed up on information received in statutory notifications from the provider, and the compliance plan from the last inspection in July 2025.

Sugarloaf Care Centre is operated by Spridale Limited, which is part of the Silverstream Healthcare group. There are two company directors. The management structure supporting the designated centre comprised of the company directors and a Clinical Governance Support, who was a person participating in the management of the service and provided support to the person in charge.

The person in charge facilitated the inspection and was supported in their role by an assistant director of nursing and two clinical nurse managers. Additional staff available included staff nurses, healthcare assistants, activity staff, catering, housekeeping, laundry and maintenance. Inspectors were told of some staff vacancies, which included one whole time equivalent (WTE) activity coordinator, one WTE laundry staff, five WTE healthcare assistants and two staff nurse vacancies, with active recruitment ongoing for these posts. However, inspectors found that some of these vacancies were not covered on a temporary basis.

Records were maintained in the centre in a secure but easily accessible format. The inspectors reviewed a sample of staff members' records and found not all of the required prescribed information was available, as set out in Schedules 2 of the Regulations.

An Infection Prevention and Control Committee had recently been established to oversee effective infection prevention and control activities within the centre. Overall responsibility for infection prevention and control and antimicrobial stewardship within the centre rested with the person in charge. The provider had also nominated a clinical nurse manager to the role of infection prevention and control link practitioner, to support staff to implement effective infection prevention and control and antimicrobial stewardship practices within the centre. A schedule of infection prevention and control audits were in place. Infection prevention and control audits covered a range of topics including hand hygiene, equipment and environment hygiene, waste and laundry management. Audits were scored, tracked and trended to monitor progress. High levels of compliance had been achieved in recent audits and this was reflected on the day of the inspection.

A review of notifications found that the person in charge of the designated centre had notified the Chief Inspector of outbreaks of notifiable infection as set out in paragraph 7(1)(d) of Schedule 4 of the regulations. Simultaneous outbreaks of Respiratory Syncytial Virus (RSV) and influenza were detected in early January 2026. A review of documentation found that appropriate infection control measures had been implemented. However, the prolonged (six week) duration of the outbreaks indicated that early interventions may not have been fully effective in containing the spread. A review of the management of the outbreaks to ensure preparedness for future outbreaks had been completed.

There were examples seen of effective management systems in place; however further oversight of auditing and residents' feedback was required. In addition, there was not always sufficient resources to ensure the effective delivery of care; particularly to ensure supervision of communal areas, activities and laundry provisions.

There was an accessible complaints procedure in place. The procedure was on display in the reception area. Inspectors also saw evidence that residents that supported to raise areas for improvement and to make complaints through residents' meetings. There were eight open complaints on the day of the inspection.

Inspectors saw that these complaints were all within the appropriate timeframes set out in the registered provider's policy.

Regulation 21: Records

Incomplete information was identified in the documentation of Schedule 2 staff files. For example:

- a full employment history together with satisfactory history of any gaps in employment was not available for two out of four files reviewed.
- while each file contained two written references, for two out of the four files reviewed they were not from the person's most recent employer as required by the regulations.

Additionally, information required to be kept in the centre in respect of each resident under Schedule 3 of the regulations were not available as evidenced by:

- the records for one resident's wound assessment had not been completed for a period of two weeks.

Judgment: Substantially compliant

Regulation 23: Governance and management

The registered provider did not ensure that there was sufficient resources to ensure effective delivery of care to all residents in line with the statement of purpose. This was evidenced by:

- In addition to the five healthcare assistant and two staff nurse vacancies, planned and unexpected leave was not always filled which was seen to impact on the residents. For example; on the day of the inspection, one healthcare assistant shift was not filled. Some staff spoken with told inspectors that there was not enough time to complete all assigned duties promptly, especially during busy times such as during morning care delivery. This was observed to occur on the lower ground floor where the staff nurse was allocated to supervise the residents in the day room while also tasked with administering medication, the nurse was interrupted from administering the medication multiple times to assist the residents who had high dependency needs.
- The registered provider had one activity staff vacancy, and on the day of the inspection, planned leave for an additional activity staff member had not been covered. While one activity staff member was on duty, they were assigned to care provision tasks across all floors in the morning time, for example assisting with the hairdresser. For the remainder of their shift, they were

allocated to the first floor only. This allocation did not ensure that residents across all floors were afforded opportunities for meaningful engagement and activities.
- Inspectors saw that staff vacancies were not always covered on a temporary basis which was observed to have an impact on meeting the residents' needs. For example, a vacancy for laundry was not covered, and there were high levels of complaints relating to the laundry provision.

Notwithstanding the governance and oversight arrangements in the centre, some management systems in place were not consistent and effectively monitored. For example:

- While call bell audits were undertaken to ensure they were responded to by staff within three minutes, these audits did not provide assurance that the residents' needs were being met at the time they were deactivated, for example; residents who spoke with inspectors said that although one staff member would respond to their call bell, they were often left waiting for a second staff member to attend in a timely manner.
- Monitoring and auditing of staff files were not in place to ensure that they included all the requirements of Schedule 2, this was a repeat finding of the last inspection.
- While it was evident some action was being taken to respond to complaints, inspectors found that there remained issues with a common theme of dissatisfaction provided to inspectors from residents and relatives related to noise levels at meal-times and for the laundry provision.

Judgment: Not compliant

Regulation 31: Notification of incidents

Notifications as required by the regulations were submitted to the Chief Inspector of Social Services within the required time-frame.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors viewed the complaints log which demonstrated that complaints were appropriately recorded and followed up in a timely manner by the person in charge. In a sample of closed complaints reviewed, there was evidence that written responses were given to complainants. Outcomes, whether the complaint was

upheld or not, learnings identified and the satisfaction of the complainant was recorded in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Residents were supported to have a good quality of life in Sugarloaf Care Centre which was respectful of their wishes and choices. On this inspection, the care planning arrangements, access to activities and infection prevention and control measures did not fully meet the criteria of the regulations.

Residents' had their needs comprehensively assessed on admission to the centre, and again at regular intervals and where there were changes in their condition. Care plans viewed by the inspectors were generally personalised, and sufficiently detailed to direct routine care with some exceptions, particularly relating to the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) and for end-of-life planning. Details of issues identified are set out under Regulation 7: Managing behaviour that is challenging and Regulation 13: End of life.

Residents' health and well-being was promoted and appropriate supports were in place to ensure residents had timely access to health professionals in order to address any identified health care needs, such as psychiatry of old age, physiotherapy, dietitian and speech and language, as required. The centre had access to GP's from local practices and the person in charge confirmed that GP's routinely attended the centre every Tuesday and Thursday and as required. Residents also had access to local dental, optician and pharmacy services.

There were systems in place to safeguard residents and protect them from the risk of abuse. Staff were supported to attend safeguarding training.

There were no visiting restrictions in place at the time of inspection. Visits and outings with family members were encouraged and facilitated. While inspectors observed kind and compassionate staff treating residents with dignity and respect, not all residents' choices, rights and activities were upheld, as discussed under Regulation 9: Residents' rights.

The general environment including residents' bedrooms, communal areas and toilets appeared well maintained and visibly clean. A maintenance person was employed in the centre three days a week. An online software platform was used to log, track and manage maintenance requests within the centre. This system supported timely resolution of maintenance issues and provided a clear record of actions taken. The provider had a Legionella management programme in place. Unused outlets were

regularly flushed and routine monitoring for Legionella in hot and cold water systems was undertaken.

Inspectors identified several examples of good practice in the prevention and control of infection. For example, staff applied standard precautions to protect against exposure to blood and body substances during handling of sharps, waste and used linen. Records confirmed that COVID, influenza and pneumococcal vaccinations were administered to eligible residents with their consent. Discrete symbols were displayed on bedroom doors to identify residents colonised with Multi-Drug Resistant Organisms (MDROs). This approach supported staff awareness and compliance with infection prevention and control measures while preserving residents privacy and dignity. Measures taken to protect residents from infection did not exceed what was considered necessary to address the actual level of risk. Notwithstanding the good practices observed, inspectors identified a small number of areas that required review to ensure that the registered provider complied with the national standards for infection prevention and control published by HIQA. Findings in this regard are presented under Regulation 27; infection control.

There was a medication management policy in place to guide nurses and carers on the safe management of medications; this was up to date and based on evidence based practice. Through observation, the inspectors could see medicines were administered in accordance with the prescriber's instructions in a timely manner. Medicines were stored securely in the centre and returned to pharmacy when no longer required as per the centres guidelines. A pharmacist was available to residents to advise them on medications they were receiving.

Regulation 11: Visits

Staff explained that restrictions during the recent outbreaks were proportionate to the risks. For example, inspectors were informed that visiting was facilitated with appropriate infection control precautions in place.

On the day of the inspection, there were no visiting restrictions in place and visitors were observed coming and going to the centre. Residents were able to meet with visitors in private or in the communal spaces through out the centre.

Judgment: Compliant

Regulation 13: End of life

Spirituality and end-of-life care plans reviewed did not outline resident’s wishes with regards to the arrangements to be put in place when they reached their end of life, nor did they set out the religious and cultural needs of the resident. This meant that

staff were not sufficiently guided for residents' end of life wishes, including their physical, emotional, social, psychological and spiritual needs.

Judgment: Substantially compliant

Regulation 17: Premises

The premises was designed and laid out to meet the individual and collective needs of residents. The centre was clean and well maintained and it met the requirements of Schedule 6 of the regulations.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

A review of documentation found that when residents were transferred to hospital from the designated centre, relevant information was provided to the receiving hospital. Upon residents' return to the designated centre, staff ensured that all relevant clinical information was obtained from the discharging service or hospital. Copies of transfer documents were filed in the residents electronic care records.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27 infection control and the National Standards for infection prevention and control in community services (2018). However, further action was required to be fully compliant. For example;

- The overall antimicrobial stewardship programme needed to be further developed, strengthened and supported in order to progress. There was no evidence of multidisciplinary targeted antimicrobial stewardship quality improvement initiatives or audits.
- Staff informed inspectors that they manually decanted the contents of urinals into toilets prior to manually cleaning. This increased the risk of environmental contamination and the spread of MDRO colonisation.
- There were no disposable gloves available within some sluice rooms. This may impact the implementation of standard infection control precautions.
- The detergent in some bedpan washers had expired. This may impact the efficacy of decontamination.

- The dirty laundry facility had a significant volume of used laundry awaiting washing, resulting in excessive build-up of dirty laundry in this area. This created a risk of cross infection.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

There was an appropriate pharmacy service offered to residents and a safe system of medication administration in place. Policies were in place for the safe disposal of expired or no longer required medications.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Overall, the standard of care planning was good and outlined person-centred care.

Judgment: Compliant

Regulation 6: Health care

There were good standards of evidence based healthcare provided in this centre. Allied health professionals also supported the residents on-site where possible and remotely when appropriate, for example the dietitian, and physiotherapist. Records showed effective oversight of residents' conditions, including regular review by GPs.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The provider promoted a restraint-free environment in the centre, in line with local and national policy. The provider had regularly reviewed the use of restrictive practises to ensure appropriate usage. However, a review of a sample of behavioural charts, found that de-escalation techniques and ways to effectively respond to behaviours that were challenging were not fully outlined to direct the

care of the resident. This meant that staff did not have access to up-to-date information to guide them to manage the behaviour that was challenging.

Judgment: Substantially compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up to date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns. The centre did not act as a pension agent for any of the residents.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that residents on the first floor had good opportunities to participate in activities in accordance with their interests and capacities; and numerous examples of positive engagement was seen on this floor. However, inspectors found that for residents on the lower ground and ground floors, they did not have the same choice to access meaningful engagement. Inspectors observed residents sitting watching television with long intervals, and occasions where there was no staff present.

Residents' rights to exercise choice in relation to the meal-time experience was not consistently respected. For example, some residents told the inspectors that the presence of loud televisions or music at times disrupted their mealtimes. Inspectors also found that the weekly fire-alarm sounded during the mealtime service during this inspection.

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	
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Sugarloaf Care Centre OSV-0008793

Inspection ID: MON-0049686

Date of inspection: 04/03/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • A full audit of all staff files will be completed by 30/06/2026 to ensure compliance with Schedule 2 requirements. • Missing documentation, including full employment histories and appropriate references, has been requested and will be obtained as the audit progresses. • A standardised staff file checklist has been introduced and is now utilised at recruitment stage to ensure all required documentation, including explanations for any gaps in employment, is in place prior to commencement. • Clinical documentation improvements: o A full review of all residents with current wounds has been completed to ensure assessments are up to date and accurately documented. o A weekly wound audit has been implemented and will be completed by the CNM on each unit to ensure timely assessment and review. o Oversight of wound documentation and audit findings will be monitored by the ADON and PIC as part of the monthly KPI and governance review process	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • The provider assures that staffing levels, skill mix, and allocations within the centre have been reviewed in line with residents' assessed dependency levels and the Statement of Purpose. Recruitment has progressed as follows: o Healthcare Assistants: 6 staff recruited since inspection.	

o Nursing: staffing levels are currently in full compliance, with ongoing recruitment to maintain a stable staffing pipeline.
o Activity Coordinator: recruitment for a full-time Activity Coordinator is in progress, with interim cover provided by an assigned HCA.
o Laundry: service is currently covered 7 days per week. Recruitment is in progress with interim support from the HCA team.
Agency staff are utilised as required to ensure all planned and unplanned leave is covered and safe staffing levels are maintained.
• A daily review of staffing allocations is completed by the PIC/ADON to ensure continuity of care and appropriate supervision across all units, with escalation processes in place where deficits are identified.
• The provider assures that clinical risks identified during the inspection have been reviewed and addressed. Medication rounds are now protected to minimise interruptions and reduce the risk of medication error.
• Activity provision has been reviewed and restructured to ensure equal access across all units. Staff allocation has been adjusted to support meaningful engagement on all floors. Residents' and families' feedback is sought through daily interactions, residents' meetings, and satisfaction surveys for ongoing improvements.
• The provider assures that laundry systems and associated risks have been reviewed and is reflected in the centre's Risk Register. The backlog of laundry has been cleared, and the segregation process has been reviewed to support an effective and safe workflow in line with best infection prevention and control practices.
Regular spot checks are carried out by the ADON/PIC to ensure safe practices are maintained.
• Governance systems and audit processes have been strengthened:
o Call bell audits have been revised to measure both response time and resolution of residents' needs
o An improvement plan has been implemented to review staff files and ensure compliance with Schedule 2 requirements (refer to Regulation 21)
o Complaints analysis and trending are completed by the PIC monthly to identify recurring issues, with action plans developed, implemented, and monitored.
• Findings from audits, complaints, and KPIs are reviewed weekly at Clinical Governance meetings and monthly through the Governance Report to the RPR team, ensuring effective oversight, and to support continuous quality improvement.
The provider is satisfied that these measures will strengthen governance, oversight, and ensure the delivery of safe, consistent and person-centred care.

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:

• All residents' end-of-life care plans are currently being reviewed and updated to ensure they clearly reflect:

o Personal wishes and preferences
o Religious and cultural needs
o Psychological, emotional and spiritual supports
• Advance care planning discussions are initiated on admission and are reviewed quarterly, or sooner if required, in consultation with the resident and/or their family during care plan review meetings.
• Staff education sessions on end-of-life care planning, including effective communication and documentation of residents' wishes, have been scheduled and will be completed.
• Staff has been assigned to attend training facilitated by the Irish Hospice Foundation, and ongoing enrolment in the CARU programme to further enhance staff knowledge, skills, and best practice in end-of-life care.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• Antimicrobial stewardship is now tracked and a standing agenda item at monthly IPC committee meetings.
A multidisciplinary review process has been established in collaboration with GPs to ensure appropriate prescribing and use of antibiotics.
• Daily spot checks are completed by the CNM in each unit to ensure the availability of PPE, including gloves, across all clinical areas.
• Monitoring of detergent expiry dates has been incorporated into weekly spots checks.
• Laundry management:
o The backlog of laundry has been cleared, and segregation process reviewed to support an effective and safe workflow.
o The laundry process has been reorganised to ensure strict separation of clean and dirty areas, in line with best practice.
• The practice of manual decanting of urinals and commodes has ceased. All items are now placed directly into bedpan washers in accordance with infection prevention and control best practice.
• Face-to-face IPC training sessions have been scheduled to supplement online training and support consistent application of infection control practices.
• The frequency of IPC audits has increased from quarterly to monthly. Findings are reviewed and trended through the IPC committee, with action plans developed, implemented, and completion monitored.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
• Residents' care plans are currently being reviewed and updated to ensure they clearly outline:
o Individual triggers
o Early warning signs
o Person-centred and effective de-escalation strategies
• Monthly care plan audits are conducted using the Viclarity system to monitor compliance, identify gaps, and ensure timely actions.
• Staff training in responsive behaviours and dementia care is mandatory. Training sessions have been scheduled to enhance staff knowledge, skills, and confidence in identifying and managing behaviours that are challenging.
• Behavioural incidents are reviewed on a weekly basis, with regular staff huddles implemented to discuss findings, identify trends, and share learning to improve practices.
Oversight of residents' care plans and incident trends will be maintained by the management in the home, with escalation to the Clinical Governance Team through governance meetings and reports.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• A review of the activity programme structure has been completed to ensure residents across all units have equal access to meaningful and person-centred activities throughout the day. Activity staff allocation has been adjusted to support engagement on all floors. Healthcare Assistants are encouraged to support both individual and group engagement, where appropriate, when not providing direct care, promoting a holistic approach to resident wellbeing.
External providers are also utilised to enhance the range and variety of activities available.
• Mealtime experience improvements:
o TVs and radios are turned off during mealtimes unless otherwise requested by residents. Soft background music is available to enhance the dining experience and promote a calm, social environment.
o Fire alarm testing has been rescheduled outside of mealtimes to minimise disruption to residents.
• Resident engagement and feedback:
o Residents' meetings are held regularly, and feedback is actively sought and reviewed.
o Satisfaction surveys are completed periodically to monitor residents' experience, with findings reviewed by the management team and used to inform service improvements.
• The most recent survey completed in March identified high levels of satisfaction with

care and staff interaction.
• Daily supervision of communal areas has been reinforced to ensure residents are supported, engaged, and not left without meaningful interaction.

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	30/06/2026
Regulation 13(1)(b)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that the religious and cultural needs of the resident concerned are, in so far as is reasonably practicable, met.	Substantially Compliant	Yellow	30/06/2026
Regulation 21(1)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/06/2026

	records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	05/05/2026
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.	Substantially Compliant	Yellow	05/05/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	31/05/2026
Regulation 7(1)	The person in charge shall ensure that staff have up to date	Substantially Compliant	Yellow	30/06/2026

	knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/05/2026
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	05/05/2026