



**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:	09 July 2026
Centre ID:	OSV-0008793
Fieldwork ID:	MON-0050900

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:	118
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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
Thursday 9 July 2026	08:05hrs to 16:25hrs	Niamh Moore	Lead
Thursday 9 July 2026	08:05hrs to 16:25hrs	Frank Barrett	Support

What residents told us and what inspectors observed

The overall feedback from residents was that Sugarloaf Care Centre was a nice place to live. Feedback received by inspectors from residents was that activities were good and the staff were very nice, however many residents acknowledged that staff were under more pressure recently. Similar poor feedback in relation to food, laundry provisions and response times to call bells were raised during this inspection which will be further discussed within this report.

This was an unannounced risk inspection, which took place over one day by two inspectors of social services, including one inspector who focused on the provider's compliance with the requirements relating to premises and fire precautions, including the oversight systems in place for these areas.

On arrival to the centre, inspectors met with the person in charge and completed an introductory meeting. Following this, one inspector conducted a walk around of the centre. The centre is registered for 119 residents, with 118 residents on the day of the inspection. The premises is set out across three floors, with five units where residents' bedroom accommodation was located. Inspectors noted that some areas of the building was quite warm and required mobile fans to cool the temperature.

The Powerscourt unit is located on the lower ground floor and has occupancy for 18 residents and is a dementia-friendly unit. Residents' bedroom accommodation was in 15 single bedrooms, one single bedroom which was larger to facilitate mobility requirements and one twin bedroom. The ground floor contains two units, Glendalough and Mount Usher for 49 residents. The Glendalough unit was for 17 residents comprised of 15 single bedrooms and one twin bedroom. Mount Usher was for 32 residents comprised of 29 single bedrooms and three larger single bedrooms to facilitate mobility requirements. The first floor contains two units, Silver Strand and Laragh for 52 residents. The Silver Strand unit for 17 residents comprised of 15 single bedrooms and one twin bedroom. The Mount Usher unit for 35 residents comprised of 32 single bedrooms and three larger single bedrooms to facilitate mobility requirements. All bedrooms had en-suite facilities. Bedrooms were clean, and had sufficient space to safe keep their belongings. Residents spoken with said they were happy with their bedrooms. The larger bedrooms had a sink fitted near the exit door, and this created issues with the planned bed evacuation of these rooms. This will be further discussed in this report.

There was adequate communal and quiet space for residents, which were well-laid out and decorated. However, inspectors noted that some rooms such as the quiet rooms contained closed-circuit television (CCTV) which may impact on residents' privacy. The oratory also contained residents' clothing which were unlabelled and seeking owners, which had also been in place at the last inspection of March 2026. While inspectors were told the new labelling system has improved, the backlog of clothing and the complaints received on laundry provisions remained an issue.

Residents had access to secure outdoor spaces, however some of these spaces required review to ensure they were safe and suitable for residents use.

Overall, the inspectors saw that residents were provided with kind care. Inspectors saw that residents were reassured relating to healthcare needs and staff were responsive and attentive to residents' concerns. Feedback received from residents and a visitor were that there had been many changes to experienced staff and on the day of the inspection, staff nurse vacancies were covered by clinical nurse managers. Inspectors saw there were delays in staff responding timely where on one occasion a call-bell was not responded to for over seven minutes. A call bell audit which audited five response times found that on two of the five occasions, the call bell had not been responded to in under three minutes. In addition, one resident told the inspectors that they had to press their bell twice to make sure staff responded, and a visitor spoke of one occasion where staff did not respond to provide personal care for ten minutes despite two follow up requests. The person in charge told the inspectors that they were reviewing the process of pagers for staff so they could be alerted to call-bells straight away and provide a faster response time.

There was information available to residents and visitors throughout the building on notice boards which provided details on the complaints process, advocacy services and activities. On the day of inspection, residents were observed participating in gardening, mass was available on the television, live music was held and an external provider hosted an exercise class. Residents told inspectors that they enjoyed the activities that were on offer to them. The person in charge said they were reviewing the activity provision to provide more dementia-focused activities in line with feedback received.

The inspectors observed the lunch-time service on the day of the inspection, and the meals appeared appetising and of good size. Residents had a choice of main courses, which included corned irish beef with parsley sauce, chicken and leek pie with buttered carrots, turnip, cabbage and mashed potatoes. There was also a vegetarian option of vegetable pie. For dessert, there was a choice of strawberry cheesecake or jelly and ice-cream. Residents had the choice to dine in the dining rooms, or in their bedrooms. There was ample staff available to assist residents, and they were seen to do so in a respectful manner. Residents spoken with reported to be happy with the temperature of meals and the amount of food available, some also reported to be happy with the choice of meals and the taste. However, some residents reported dissatisfaction and described the food as "desperate", and two residents said they did not enjoy the chicken that was available on the day. Some concerns were also raised on the evening-meal choices, and how toast arrived in the morning, already pre-buttered and jam spread on top. This will be further discussed in this report.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect 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

There was a stable management team in place with some systems to ensure the service was monitored. However, inspectors found that the overall findings of this inspection indicated that some of the concerns highlighted to the Chief Inspector by way of unsolicited information were substantiated, specifically in relation to supervision of staff practices to ensure residents' needs are met, nutrition, and complaints management.

This was an unannounced inspection. The purpose of the inspection was to assess the provider's compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 to 2025 (as amended). The inspectors reviewed documents and evidence in relation to information received since the last inspection in March 2026.

The registered provider for Sugarloaf Care Centre is Sprigdale Limited. The designated centre forms part of a wider organisational structure of Silver Stream Healthcare, an organisation which operates a number of other designated centres throughout Ireland under different entities. There are two company directors. The senior management team included a person in the role of Clinical Governance Support, whom the person in charge reported into. The person in charge was supported by two assistant directors of nursing, four clinical nurse managers, nursing staff, healthcare assistants, activity staff, housekeeping, catering, maintenance and administrative staff.

At the time of the inspection, the registered provider was recruiting for several staff positions. While some clinical staff posts were in the final recruitment stages, not all posts had been filled. As a result, temporary staff and managers were sourced for some of these vacancies, which was not in line with the staffing resources outlined within the statement of purpose.

Staff had access to mandatory and other relevant training to support them in their roles. However, on the day of the inspection the training matrix provided to inspectors highlighted gaps in mandatory training for safeguarding and managing behaviours that is challenging.

The registered provider had some good oversight systems in place. For example, inspectors found the management of a recent fire event was effective, with the staff response and the subsequent management follow up thorough and appropriate. Governance meetings were occurring weekly where key items in relation to the service were discussed, such as clinical care to residents. Inspectors saw that trending of wounds, falls and care was being discussed. However, this inspection identified that the oversight and supervision systems in place of the delivery of direct care to residents was not fully adequate. For example, records of nursing care provided to residents with impaired skin integrity and at high risk of developing

pressure damage to their skin were not consistently maintained in line with the resident's care plan. Staff meetings were occurring regularly and inspectors reviewed evidence where residents' feedback was being highlighted such as call-bell response times and their dining experience, however these issues had not been addressed at the time of this inspection. This and other concerns are further discussed under Regulation 23: Governance and Management.

Regulation 16: Training and staff development

Gaps were seen in attendance at mandatory training in line with the provider's policy. Some staff had not yet received training, and for others training had expired. For example:

- 18 percent of staff did not have up-to-date safeguarding training
- 26 percent of staff did not have up-to-date responsive behaviour training

During this inspection, there was insufficient clinical supervision and support to ensure staff delivered care in line with residents' care plans. Due to staff nurse vacancies, clinical nurse managers were required to work in the role of staff nurses, reducing supernumerary management oversight. For example, inspectors saw care plans for residents who were at risk of unexplained absences and safeguarding incidents outlined they required hourly safety checks, however the records of these safety checks were not being recorded as completed as per this assessed need. This was of particular concern given the onboarding of new staff and the use of temporary staff who lacked familiarity with local policy, processes and residents' needs and preferences.

Judgment: Not compliant

Regulation 23: Governance and management

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

- The resources for the laundry were not sufficient. While it is acknowledged recruitment for one post was complete with a new person starting induction the week of the inspection, there remained one staff vacancy. Complaints relating to the laundry provision remained an issue since the last inspection in March 2026.
- Clinical nurse managers were not supernumerary at the time of the inspection as they were working as staff nurses. This was seen to have an impact on the supervision of residents' care.

The management systems in place to ensure that the service provided was effectively monitored were insufficient. For example:

- The oversight systems in place to ensure that repeat issues in relation to food and laundry provisions were appropriately addressed were ineffective. While complaints were being discussed in governance forums, there was no documented quality improvement plan in place and there remained a high amount of open complaints relating to these two areas during this inspection. This was a repeat finding from an inspection in March 2026.
- While the numbers of staff on duty were sufficient on the day of the inspection, inspectors found that further oversight of staffing allocations and call-bell response times was required to ensure residents care was provided in a timely manner and in line with their assessed needs and preferences. As outlined earlier in this report, poor call-bell response times were found.
- Identified learnings from a serious incident review which required to be actioned had not been fully implemented. For example, this review identified that missing persons drills had commenced and that increased safety checks of exit seeking residents was in place. Inspection findings evidenced that this had not occurred.
- Oversight measures did not identify that pressure-relieving mattresses were not set in line with resident's weight. For example, one resident weighing 38kg had a mattress incorrectly set to 110-130kg.
- The use of CCTV within resident communal space required review to ensure that residents privacy was upheld.

Judgment: Not compliant

Quality and safety

Inspectors observed that the staff endeavoured to treat residents with respect and kindness throughout this inspection, and most of the residents spoke about the kindness of staff. However, inspectors identified that actions were required to ensure a safe and good quality service was consistently provided for residents in relation to ensuring assessed needs were met, the premises, food and nutrition and fire precautions.

The inspectors reviewed a sample of care plans and saw that residents had pre-assessments prior to their admission and most had comprehensive assessments completed within 48 hours of admission. Validated assessment tools were used, and overall, these results were used to develop care plans. Most care plans including those for behaviours that challenge and end-of-life care were person-centred and sufficiently detailed to guide care. However, there were residents who had care plans developed without an appropriate assessment being completed, and some

care was not delivered in line with residents' assessed needs. This is further discussed under Regulation 5: Individual assessment and care plan.

Residents had good access to reviews from general practitioners (GPs) and timely access to a range of allied health professionals, including specialist medical and nursing services as necessary.

Inspectors observed that staff upheld residents' rights. Interactions between residents and staff were observed to be patient and kind, and residents reported overall being happy living in the centre, and feeling safe. Inspectors found improvements in the activity provision since the last inspection, where residents were provided with opportunities to participate in activities in accordance with their interests and capabilities. Minutes from a residents' meeting in May were reviewed. In this meeting, new residents and staff were introduced. Residents had the opportunity to feedback on the service in relation to topics such as activity provision, food, laundry and fire safety. Minutes from a relatives' meeting in July were reviewed. Relatives were informed about staffing levels, new activity programmes and recent external outings. Poor feedback in relation to the mealtimes including the evening tea menu and the laundry provision were raised at these meetings. Some actions were seen to be in progress in relation to the concerns, during the inspection, however as reported under governance and management a more proactive approach was required.

Residents were seen to have access to a safe supply of fresh drinking water. Menus were displayed for residents, and residents had a choice for their meals. Nutritional screening was in place for residents and records of three-day food and fluid intake was reviewed by inspectors. Where risk was identified, residents were referred to the appropriate services such as dietitians and speech and language therapy. However, numerous complaints were received on the food provision and there were gaps in mandatory training to ensure food was safely served. It is acknowledged that following the inspection, confirmation was received of catering staff attending relevant training, and this training was being delivered to clinical staff also.

The centre is laid out over a large footprint to cater for the numbers of residents living there. Some of the external areas had not been maintained and imposed a trip hazard along the edges of paths in some areas. Storage space was inadequate, as inappropriate storage was noted in some resident areas. These and further premises related issues are noted under Regulation 17: Premises.

Residents were protected from the risk of fire through the compartmentation of the building and the fire safety systems which were installed within it. Further action was required to ensure compartmentation was complete in all areas to prevent fire smoke and fumes spreading over compartment boundaries. Procedural elements also required further attention such as fire drills, and the use of bed evacuation in rooms where this may be required. These issues are discussed further under Regulation 28: Fire Precautions.

Regulation 13: End of life

Following up from the last inspection, inspectors saw that end-of-life care plans were in place and from a sample reviewed, they detailed information to address residents' wishes in relation to their physical, emotional, social, psychological and spiritual needs.

Judgment: Compliant

Regulation 17: Premises

The registered provider, having regard to the needs of the residents at the centre, did not fully provide premises which conform to the matters set out in Schedule 6 of the regulations. For example:

- Some areas of the centre were not reflective of the registered purpose such as store rooms 6 and 7.
- Internal courtyards were seen to have some concrete paths with edges which were not level, presenting a trip hazard for residents using them.
- One communal toilet was used to store incontinence wear.
- Some of the ventilation systems in the building did not appear to be functioning correctly. This could have resulted in the extensive use of mobile fans on corridors and communal rooms due to the increased heat on the warm day when inspectors visited.
- Residents sinks were not fitted with plugs resulting in the use of plastic basins within some residents sinks.
- Some of the thermometers did not appear to be in working order within resident bedrooms.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

There was limited evidence that food and drink which was properly and safely prepared and served to residents who required a modified diet, as staff had not received IDDSI (The International Dysphagia Diet Standardisation Initiative) training. This training equips staff with the knowledge and skills to safely prepare and serve texture-modified foods and thickened liquids for individuals with dysphagia. As a result of this lack of training, residents were at a higher risk of choking if their food was not prepared and served appropriately.

Inspectors were not assured that residents were provided with wholesome and nutritious food. For example, the menu outlined tinned and frozen foods at tea time and some residents expressed dissatisfaction with the food provided within the centre. Comments were in relation to meat being tough, food lacking flavour, toast arriving pre-made with all toppings and the tea-time choice. On the day of the inspection, this choice consisted of ham & cheese jambons with wedges and spaghetti hoops or cream of vegetable soup with soda bread. This feedback aligned with feedback in residents' meetings, relatives meetings, surveys and the complaints register.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The registered provider had not taken adequate precautions against the risk of fire, including providing suitable means of escape, emergency lighting, containment measures and ensuring staff were familiar with the actions to take in the event of a fire specifically when required to use the stairs. For example:

- There was no fire extinguisher in the laundry room, and this was a high risk of fire area.
- There were some service penetrations missing fire sealing within the PV inverter room. This room is a high-risk electrical room which was constructed as its own compartment, therefore, penetrations in the floor, walls or ceiling of this room could allow fire and smoke to spread across compartment lines.
- Vertical evacuation was not forming part of the fire drill programme. Considering the numbers of residents on upper floors, ensuring staff are familiar with the requirements of evacuation using the stairs was required.
- Some large rooms were designed for high dependency residents and the evacuation of the residents within these rooms on their bed was part of the design. However, a second resident sink was fitted on the wall near the door which prevented bed evacuations from being possible.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Inspectors found that assessments and care planning did not always align with the requirements of the regulations. This was evidenced by the following:

- A resident did not have their comprehensive assessment fully complete within 48 hours on admission. For example, the mobility section was blank three weeks following the initiation of the assessment. In addition, this resident's

manual handling assessment differed and reported assistance was required of one staff and then also referenced two staff, therefore it was unclear on the resident's actual needs.

- Two behaviour care plans outlined that PINCH ME assessments were completed at times where behaviours of concern were exhibited, however there was no record available for review of these completed assessments for these residents.
- A resident's care plan outlined they were on a regular toileting plan every two hours. However, there were days where there were no records of this toileting plan being adhered to. Inspectors saw that on some of these days; incidents had occurred.
- Two residents care plans outlined they were wearing incontinence wear, however there were no incontinence assessments completed for either resident to determine if the products they were using were appropriate or in line with their assessed needs.

Judgment: Substantially compliant

Regulation 6: Health care

There was good evidence of appropriate referral to and review of residents by health and social care professionals where required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Inspectors reviewed records for residents displaying responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment). Care plans were person-centred and detailed potential triggers and the de-escalation techniques to respond to behaviours. There was evidence of timely referral and medical review when changes to behaviours were noted.

Judgment: Compliant

Regulation 9: Residents' rights

The registered provider had ensured that residents had adequate facilities and opportunities to engage in activities. Residents had opportunities to be consulted

with on the service. For example, meetings were being held with the catering department and residents in relation to the food service and this was ongoing during the time of this inspection.

Judgment: 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 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Sugarloaf Care Centre OSV-0008793

Inspection ID: MON-0050900

Date of inspection: 09/07/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The register provider and PIC have reviewed the findings in relation to staff training, supervision and clinical oversight and has implemented the following actions: Mandatory training. Staff had previously completed safeguarding training through either in-person or online training. The training matrix identified that refresher training was required for a number of staff to ensure training remained current and in line with the provider's training requirements. Training is ongoing and a schedule is in place to address outstanding and refresher requirements. Additional responsive behaviour training has been provided since the inspection, with further sessions scheduled. At present, 99% of staff have up to date safeguarding training and 78% have up to date responsive behaviour training. Further training is scheduled in October. Compliance will continue to be monitored through the centre's training matrix until full compliance is achieved and sustained Four additional registered nurses have been recruited since the inspection and are now rostered within the centre. Further nurses are currently onboarding. An additional Senior Clinical Nurse Manager has also been recruited and is onboarding. The Senior CNM previously worked in Sugarloaf Care Centre and is familiar with the centre, residents and local systems. These additional clinical resources will strengthen clinical supervision and reduce the requirement for existing CNMs to routinely cover staff nurse vacancies, enabling them to provide greater oversight of care delivery. CNMs and ADONs will continue to oversee the delivery and documentation of planned care, particularly for residents requiring enhanced supervision, regular safety observations, skin integrity interventions and other scheduled care. New and temporary staff will continue to receive local induction and appropriate	

supervision, with particular focus on residents' assessed needs, care plans, centre procedures and safeguarding arrangements.

Regulation 23: Governance and management

Not Compliant

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

The registered provider and PIC have reviewed the governance and management issues identified during the inspection and have implemented a number of actions.

Additional clinical staff have been recruited, including two registered nurses and a Senior CNM, with further nurses currently onboarding. This will strengthen clinical supervision and reduce the need for CNMs to routinely cover staff nurse vacancies.

Laundry staffing has also been strengthened, with additional staff now working full time in the laundry. The service will continue to be monitored through complaints, resident feedback and governance meetings.

Call bell response times continue to be audited. An additional HCA is now rostered on the first floor for 12 hours per day, seven days per week, and a twilight HCA has been recruited for the Dementia Friendly Unit. A pager system is also being considered for trial.

Missing person drills are now completed monthly. Air mattress settings continue to be audited and the issue identified during the inspection has been raised with the supplier and is being addressed.

A QIP is in place for food and nutrition, with daily oversight of the dining experience by the senior nursing management team. Food, laundry, staffing, call bell response times, clinical audits, incidents and complaints will continue to be reviewed through the centre's governance meetings.

The use of CCTV in communal areas is currently being reviewed with the organisation's Data Protection Officer and in line with the Data Protection Commissions guidance on the use of CCTV in Residential Care Settings to ensure that its use is necessary, proportionate and appropriately protects residents' privacy, dignity and rights. Any actions or changes identified following this review will be implemented, monitored and kept under ongoing review.

Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: The register provider and PIC have reviewed the environmental issues identified during the inspection and has implemented or commenced the following actions: The Estates & Engineering Manager is reviewing the external garden areas and pathways to address any uneven surfaces or trip hazards identified. A suitable contractor has been contacted and will take the necessary corrective actions to remediate. The storage unit containing incontinence wear has been cleared and items are now stored in appropriate storage areas. The ventilation system and thermostats have been reviewed by Facilities Team to ensure they are working correctly. Temperatures will continue to be monitored and any issues identified will be followed up. Sink plugs will be provided in all resident sinks. The Facilities Team will complete a check of all resident bedrooms to ensure plugs are in place and suitable for use. Bedroom thermometers will continue to be checked and replaced where required. Premises issues will continue to be monitored through environmental audits and Facilities reviews. All identified defect items will be logged and tracked until closeout on the EPIC maintenance log.	
Regulation 18: Food and nutrition	Substantially Compliant
Outline how you are going to come into compliance with Regulation 18: Food and nutrition: A QIP has been implemented in relation to food, nutrition and the dining experience following residents feedback and the findings of the inspection. A Resident Nutrition Committee has been established to ensure residents are directly involved in reviewing the food service and menu options. Meetings are currently being held and led by the PIC, with particular focus on menu planning, resident choice and the overall dining experience. Menus have been reviewed and further amendments will be made in consultation with residents. Once the revised menus have been agreed with residents, they will be reviewed by a dietitian to confirm that they provide appropriate nutritional content. A new Head Chef has been recruited and is currently onboarding. The Head Chef will have responsibility for implementing the revised menus and supporting ongoing improvements in food quality, presentation, choice and consistency.	

The DON and two ADONs currently provide daily oversight of the dining experience. This includes monitoring meal service, food quality, presentation and residents' overall dining experience.

Room service and beverage/trolley services are also being audited and monitored.

Staff allocation within dining rooms has been reviewed. Kitchen Assistant allocation has also been reviewed so that staff with appropriate experience and skills are allocated to front-of-house and dining-room duties.

IDDSI training is mandatory for relevant staff and is included on the centre's training matrix.

Compliance with IDDSI training will continue to be monitored to ensure staff involved in preparing, checking or serving modified diets have the appropriate knowledge and competency.

Resident feedback currently indicates an overall improvement in satisfaction with the food, menu and dining experience.

A quarterly nutrition survey will be completed with residents to provide structured feedback and to monitor whether improvements are sustained.

Regulation 28: Fire precautions	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The register provider has reviewed the fire safety matters identified during the inspection and has implemented or commenced the following actions:

A fire point and appropriate fire extinguishers have now been installed within the laundry area.

The Estates & Engineering Manager have contacted an external Fire Safety Management company to undertake a review of the fire proofing and compartmentation requirements identified during the inspection.

Any remedial fire stopping works identified through this review will be completed in accordance with the recommendations of the competent fire safety consultant and tracked through the Facilities action plan.

Vertical evacuation has now been incorporated into the centre's internal fire drill plan. Previously, vertical evacuation formed part of training delivered by external fire safety trainers, while internal drills primarily focused on horizontal evacuation. The centre's internal programme has now been expanded to ensure staff routinely practise both horizontal and vertical evacuation arrangements.

Fire drills will continue to reflect different staffing levels and evacuation scenarios and will record learning and required follow-up actions.

Four sinks have been removed from the identified accessible bedrooms where their location obstructed safe bed evacuation.

This action has restored the planned evacuation route and enables bed evacuation from these rooms where this forms part of the resident's evacuation strategy.

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: Additional training in resident assessment and care planning has been provided to all nurses by the Practice Quality and Innovation Lead. The training reinforced requirements relating to comprehensive assessment, development of care plans, review of assessed needs and appropriate supporting documentation. Nurses are assigned for specific residents and are responsible for ensuring that their allocated residents' assessments and care plans are complete, current and consistent with their assessed needs. This includes ensuring that PINCH ME assessments, continence assessments and other relevant assessments are completed where clinically indicated. Admission documentation is audited by CNMs/ADONs following admission to ensure the comprehensive assessment and care plan requirements are completed within the required 48hour timeframe. Any gaps identified through these reviews are escalated to the responsible nurse and nursing management for prompt corrective action. CNMs and ADONs will continue to audit assessments, care plans and associated clinical records to ensure that assessed needs are clearly reflected within care plans and that planned interventions are documented as delivered. This includes scheduled toileting programmes, safety observations and other resident specific interventions. Nursing staff have access to the provider's policies in digital format. Algorithm posters covering key areas of care and other clinical requirements are also available at each nurses' station to support staff in accessing guidance during clinical practice. Care plan and assessment audits will continue as part of clinical governance. Findings will be discussed with relevant staff and corrective actions monitored by the management team.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/10/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/10/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	31/12/2026
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,	Substantially Compliant	Yellow	30/09/2026

	cooked and served.			
Regulation 18(1)(c)(ii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are wholesome and nutritious.	Substantially Compliant	Yellow	30/09/2026
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	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.	Not Compliant	Orange	21/09/2026
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	31/10/2026

Regulation 28(1)(d)	The registered provider shall make arrangements for staff of the designated centre to receive suitable training in fire prevention and emergency procedures, including evacuation procedures, building layout and escape routes, location of fire alarm call points, first aid, fire fighting equipment, fire control techniques and the procedures to be followed should the clothes of a resident catch fire.	Substantially Compliant	Yellow	21/09/2026
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/10/2026
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the	Substantially Compliant	Yellow	31/10/2026

	designated centre concerned.			
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