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:	Tara Winthrop Private Clinic
Name of provider:	Tara Winthrop Private Clinic Ltd.
Address of centre:	Nevinstown Lane, Pinnock Hill, Swords, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	13 August 2025
Centre ID:	OSV-0000183
Fieldwork ID:	MON-0047148

About the designated centre

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

Tara Winthrop private Clinic is situated close to the village of Swords, Co Dublin. The centre provides nursing care for low, medium, high and maximum dependency residents over 18 years old. The centre is organised into five units made up of 136 beds of which 112 are en-suite bedrooms. There are eight sitting room areas and six dining room areas and at least 15 additional toilets all of which are wheelchair accessible. The centre is set in landscaped grounds with a visitor's car park to the front of the building. It is serviced by nearby restaurants, public houses, library, cinemas, community halls, the Pavilions Shopping Centre, a large variety of local shops, retail park and historical sites of interest and amenity such as Swords Castle, Newbridge House and Demense, Malahide Castle and Demesne.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	118

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 13 August 2025	17:00hrs to 22:00hrs	Aisling Coffey	Lead
Thursday 14 August 2025	07:40hrs to 17:00hrs	Aisling Coffey	Lead
Wednesday 13 August 2025	17:00hrs to 22:00hrs	Laura Meehan	Support
Thursday 14 August 2025	07:40hrs to 17:00hrs	Laura Meehan	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they were content living in Tara Wintrop Private Clinic; however, a number of factors were negatively impacting their day-to-day lives in the centre, as outlined in this report. The residents spoken with were generally complimentary of the centre, with one resident informing the inspectors: "I find it great; it's very nice here". Residents spoke in favourable terms about the kind and considerate staff that cared for them, with the staff being described as "excellent," "friendly," and "very helpful." While acknowledging the positive attributes of individual staff members, some residents spoken with referred to there "not being enough staff" and staff members being "very busy", with two residents describing long wait times for assistance, while another explained how staff do not have the time to allow them to communicate their needs.

This unannounced inspection was conducted by two inspectors over two days, commencing with an evening inspection on the first day and followed by a second day of inspection on the following morning. During the inspection, the inspectors spoke with 20 residents and five visitors to gain insight into the residents' lived experience in the centre. The inspectors also spent time observing interactions between staff and residents, as well as reviewing a range of documentation.

Bedroom accommodation comprised 86 single-occupancy and 25 twin-occupancy rooms. Residents had access to either an en-suite bathroom facility or shared bathroom facilities within their unit. Bedrooms had comfortable seating, and were personalised with treasured items from home, such as family photographs, artwork, bedding and ornaments. The bedrooms had a television, locked storage, and call-bell facilities. On the first evening of the inspection, the inspectors reviewed call-bell access and found that some residents did not have access to their call-bell, meaning they could not summon assistance if required. Inspectors also observed that two toilet facilities on Shennick were locked, meaning residents could not access these facilities. These findings were brought to the attention of the person in charge, and the staff promptly rectified these matters.

Inspectors reviewed aspects of the communal space available to residents and found variations in the standard of communal space available to residents. The library, the oratory, and the day spaces on Lambay were accessible, pleasantly decorated, comfortable, and well-laid out. However, day spaces 1 and 2 on Shennick required an improved layout, contained damaged furniture, and had minimal therapeutic or sensory equipment for residents to engage with. These findings are further detailed under Regulation 17 of the report and were discussed with the provider. Inspectors also viewed the "snoezelen" room, a facility designed to provide a comfortable, multisensory environment for the well-being of residents who are distressed or agitated. However, this room required attention as it was not fit for purpose. It contained no seating, limited multisensory equipment to support a distressed resident, and was being used inappropriately for the storage of bulky activity equipment, such as a whiteboard.There was documentary evidence that the

provider had sought consultation and advice from an external staff member to guide the improvement of communal areas throughout the centre. While this consultation was positive, action was now required to improve the day-to-day living experience of residents using these communal areas.

In addition to layout and decor, access to communal areas was also found to require robust review. For example, on the first evening and second morning of the inspection, until 10:00am, communal spaces 1 and 2 were not accessible to residents living in Erris and Shennick due to locked doors into these communal areas.

There was a tidy, well-organised on-site laundry located on the ground floor where residents' personal clothing and towels were laundered. Bed linen was laundered off-site. The infrastructure of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process.

In terms of outdoor space, residents had unrestricted access to three enclosed courtyard gardens within the Lambay, Erris, and Shennick units, as well as two additional outdoor spaces located outside dining area 1 and the library. Inspectors observed that residents were smoking in a number of the outdoor areas. While ashtrays were available, other safety equipment, such as call-bells and fire blankets, were not present. This was brought to the attention of the person in charge on the first day of inspection, and management were seen to be installing the necessary equipment on the second day of inspection.

Residents could receive visitors in the centre within communal areas, gardens, or in the privacy of their bedrooms. Multiple families and friends were observed visiting their loved ones during the inspection days. The inspectors spoke with two visitors. Overall, they expressed their satisfaction with the quality of care provided to their relatives living in the centre and the communication between staff and families. However, some visitors raised concerns that there were insufficient staff on duty, based on their observations, including that their loved ones were not brought to activities.

On the first evening of the inspection, at 5:30pm, 10 residents attended a virtual tour in the library. Other residents relaxed in their bedrooms, where they read, watched television, or hosted a visitor. Some residents took a stroll with a staff member. However, many residents were seen to have little activation on the first evening. These residents were observed walking through the corridors of their unit or sitting for lengthy periods in the sitting rooms, with the television on, but without any other meaningful activity.

On the second inspection day, Mass took place in the morning in Lambay. The hairdresser was also present, and residents proudly displayed their new hairstyles. Similar to the first inspection day, many residents were seen sitting for lengthy periods in the sitting rooms with the television on but without other meaningful activation.

Residents and visitors had mixed views on the provision of activities. Some residents were complimentary and informed the inspectors that they were taken on outings

and attended day services of interest to them. Other residents told the inspectors that there were insufficient activities geared towards their interests and capacities. Some residents and families also informed the inspector that they were not informed about the activities taking place and were not supported in attending. Inspectors reviewed the activity schedule displayed and noted that, although activities were scheduled daily, the location of the activities and details on what they entailed were not provided to guide residents in choosing which activities to participate in. These findings were discussed with the provider. Similar to the planned improvement of communal areas, there was also documentary evidence that the provider had engaged the expertise of an external staff member to guide the improvement of activities provision throughout the centre, particularly for those who would require support to engage in activities. While this engagement is positive, action is now required to raise awareness of the activities on offer, support greater attendance, and improve the range of activities to cater to broader residents' interests and capacities.

The lunchtime experience was observed. Residents choose to dine in the dining areas or in their bedrooms. Meals were prepared on-site in the centre's kitchen and overseen by the head chef. Residents confirmed they had been offered a choice of meals. Notwithstanding these aspects, there was mixed resident feedback regarding the quantity of food. While some residents were very pleased and enjoyed their meals, others expressed dissatisfaction, particularly with the nutritional content of the evening meals and the availability of fresh fruit, salad and vegetables. Inspectors found immediate and urgent actions were required to ensure the dietary needs of residents were safely, effectively and accurately met. This is discussed further in the capacity and capability section of the report and under Regulation 18: Food and nutrition.

The following two sections of the report present the findings of this inspection concerning 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

This inspection found that significant focus was required to improve the management and oversight of service delivery, as there had been a substantial decline in regulatory compliance since the previous inspection of November 2025, which was impacting the quality and safety of care for residents.

This centre has been inspected on six occasions in the period June 2023 to August 2025. The four inspections of June 2023, November 2023, March 2024 and July 2024 identified ineffective governance and management structures, insufficient supervision of staff and poor oversight of the care of residents. The Chief Inspector

attached a restrictive condition requiring the registered provider to stop admissions from 10 June 2024 until the registered provider had implemented a revised governance and management structure, defined staffing levels and ensured regulatory compliance with nine specified regulations. Following the improvement in regulatory compliance found in November 2024, the restrictive condition was amended to permit the admission of new residents while continuing to require the registered provider to sustain the revised governance and management structures, defined staffing levels and regulatory compliance with nine specified regulations. However, the findings from this inspection are that the improvements in regulatory compliance found in November 2024 have not been sustained. In particular, the monitoring and oversight systems in place with regard to governance and management, training and staff development, food and nutrition, premises, infection control, residents' rights and managing challenging behaviours needed to be significantly enhanced.

This was an unannounced risk inspection to assess the registered provider's ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended) and to review the registered provider's compliance plan arising from the previous inspection of 18 November 2024. The provider had recently applied to remove the restrictive condition that was placed on the centre's registration following the last inspection. This inspection was used to inform decision-making in relation to the provider's application to remove the restrictive condition. The inspectors also followed up on three pieces of unsolicited information that had been submitted to the Chief Inspector of Social Services since the last inspection relating to staffing, food, premises, activities, falls management, and care and welfare of residents. The overall findings of this inspection indicated that some of the concerns highlighted to the Chief Inspector by way of unsolicited information were substantiated, and actions have been identified for the provider under the relevant regulations within the report.

The provider was seen to have implemented the compliance plan they submitted following the last inspection in November 2024. A practice development nurse had been recruited, and there were improvements in staff training. While acknowledging that these actions had been progressed, this inspection demonstrated a significant decline in the overall governance and management of the service and new areas of non-compliance were identified as requiring robust improvement as set out in this report.

Specific deficits required immediate and urgent action by the provider. Arrangements concerning food and nutrition were ineffective. Consequently, immediate actions were issued to the provider on the second day of inspection regarding the proper and safe serving of food, ensuring that the dietary needs of residents, as prescribed by healthcare or dietetic staff, were met, and that sufficient staff were available to assist residents at mealtimes and when refreshments were served. The provider had addressed these immediate issues by the end of the inspection. In addition to the immediate risks identified, the registered provider was also required to take significant further urgent action concerning food and nutrition to ensure that the dietary needs of residents were safely, effectively and accurately

met. Following the inspection, an urgent action plan request was issued regarding non-compliance with Regulation 18: Food and Nutrition. The provider reverted with an interim plan to manage the risks identified during the inspection and committed to a series of actions to ensure that these risks were controlled and mitigated going forward.

Tara Winthrop Private Clinic Limited, the registered provider, operates Tara Winthrop Private Clinic. This company is comprised of two directors. One of these directors, the chief executive officer, represented the provider for regulatory matters and was present on both inspection days to support the inspection process and receive feedback at the end of the inspection. This centre is part of a larger group, Grace Healthcare, which owns and manages several designated centres in Ireland.

The provider had a senior management team consisting of senior personnel who supported the person in charge in their operational management and clinical oversight of the centre. This senior management team provided support to the person in charge on a 0.4 whole-time-equivalent (WTE) basis through the following group functions: operations, human resources, finance, facilities and clinical quality and compliance. The person in charge reported to the regional manager, who in turn reports to the chief executive officer. Within the centre, a clearly defined management structure operated the service on a day-to-day basis. The person in charge was supported by three assistant directors of nursing, six clinical nurse managers, a practice development nurse, and a team of nurses, healthcare assistants, housekeeping, catering, activities, administration, physiotherapy, medical, hairdressing, and maintenance staff.

The registered provider had systems in place to monitor the quality and safety of care. There were communication systems in place between the registered provider and management within the centre, as well as between the person in charge and staff working in the centre. Records of clinical governance meetings that had taken place since the previous inspection were reviewed. The provider maintained a risk register to monitor known risks within the centre. Auditing of key aspects of service provision was occurring. The provider had also conducted two night checks in the previous six weeks to review the quality of resident care at night. Notwithstanding the presence of these oversight systems, further robust action was required to ensure the service provided to residents was safe, appropriate, consistent, and effectively monitored, as the provider's oversight mechanisms had not identified key deficits and risks, as found during this inspection. These matters are discussed under Regulation 23: Governance and management.

An annual review of the quality and safety of care delivered to residents took place in 2024 in consultation with residents and their families. Residents and families had been consulted in the preparation of the annual review through surveys and the residents' forum meetings. Within this review, the registered provider had also identified areas requiring quality improvement.

In terms of staff training and development, newly recruited staff received an induction covering key aspects of care and procedures in the centre, followed by a probationary period. A suite of mandatory training was available to all staff in the

centre. Records provided did not evidence that all staff had completed training on safeguarding vulnerable persons from abuse, fire safety, manual handling, and medication management. Improvements were also required concerning staff supervision to ensure the assessed needs of residents were supported and to oversee that staff practices aligned with the provider's policies. These matters are discussed under Regulation 16: Training and staff development.

While the provider had a system for recording, monitoring, and managing incidents and related risks, this inspection found that not all notifiable incidents had been reported to the Chief Inspector as required by the regulations. This is discussed under Regulation 31: Notification of incidents.

The provider displayed the complaints procedure prominently in multiple locations throughout the centre. Information posters on advocacy services to support residents in making complaints were also displayed. The centre had an up-to-date complaints management policy. Residents and families said they could raise a complaint with any staff member, but two residents and one family member stated that they were reluctant to do so, as they were concerned about possible repercussions. Staff were knowledgeable about the centre's complaints procedure. The complaints officer and review officer had undertaken training in complaints management. While records were maintained of complaints received, the inspectors identified some gaps in complaint management recording practices, and action was required to comply with Regulation 34: Complaints Procedure.

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

The registered provider had applied to remove a restrictive condition attached to the designated centre's registration in accordance with the requirements in the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015. At the time of inspection, this application was under review.

Judgment: Compliant

Regulation 15: Staffing

During the inspection days, it was observed that sufficient staff were present, including staff nurses and healthcare assistants; however, the provided rosters did not accurately reflect the staffing levels present within the centre. The provided rosters did not include some areas of staffing, such as the governance and management team.

The number of staff on the roster also did not correlate with the staff recorded on training records. For example, the roster stated the first names of five activity staff;

however, the training records only reflected three. This did not allow for a full review of staffing within the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider's arrangements for staff supervision were not sufficiently robust to ensure the assessed needs of residents were being met, for example:

- Some residents were found to be without access to their call-bell, meaning they were unable to summon assistance if needed.
- Some residents reported not being provided with the required support during mealtimes, a concern also observed by inspectors throughout the inspection.

The provider's supervision arrangements had failed to identify poor adherence to the provider's policies and procedures in several areas, including the administration of covert medications and the use of restraint, as discussed under Regulation 23: Governance and management.

Records reviewed showed that staff had access to a suite of training programmes to support them in their roles; however, the training records provided did not evidence that all staff named on the rosters had completed mandatory training.

Judgment: Not compliant

Regulation 23: Governance and management

Significant focus was required to improve the management and oversight of service delivery, ensuring that the service provided to residents was safe, appropriate, consistent, and effectively monitored, for example:

- The management systems provided inadequate assurance with respect to food and nutrition. Due to health and safety concerns, immediate actions were issued to the provider on the second day of the inspection, followed by an urgent action plan request after the inspection. This will be discussed under Regulation 18: Food and Nutrition.
- The provider's oversight systems had not identified risks and deficits concerning individual assessment and care planning, managing challenging behaviour, residents' rights, premises, protection, complaints management, infection control, and fire safety, as found during this inspection.
- The oversight of incident reporting did not ensure that all notifiable incidents were identified and reported to the Chief Inspector within the required time frames.

- The provider systems for ensuring oversight and effective communication of up-to-date information regarding residents required improvement, as the provider provided inaccurate information to the inspectors regarding occupancy levels, the number of residents in the hospital, and the number of residents with an infection.

Management systems had failed to ensure that practices were guided by, and fully aligned with, the provider's policies, for example:

- The assessment and care planning process in place for administering covert medication required review to ensure it was aligned with the provider's policies and professional guidelines issued by the Nursing and Midwifery Board of Ireland (NMBI). For example, the provider's policies required an assessment of the covert medication administration practice, to include the rationale and alternatives trialled. Additionally, the provider's policies and professional guidelines required an assessment of the resident's capacity to understand their care and treatment. However, these assessments had not taken place. This practice was brought to the provider's attention for prompt action.
- The assessment and care planning in place for the practice of using therapeutic holds required review to ensure it was aligned with the provider's policies and national policy on the use of restraint. This is discussed further under Regulation 7: Managing behaviour that is challenging.
- The management of infection control required review to ensure all practice was aligned with the provider's policies. This matter is discussed under Regulation 27: Infection control.
- The complaint's management practices required review to ensure they were aligned with the provider's policies. For example, the provider's policy states that a written complaint should be escalated to a senior manager in the organisation if the complainant is not satisfied; however, this did not occur in the case of one recent written complaint. The records reviewed also found that complaints were not evidenced to be acknowledged or reviewed in line with the provider's processes.

Judgment: Not compliant

Regulation 31: Notification of incidents

Inspectors found that not all notifiable incidents concerning alleged neglect and the use of restraint had been notified to the Chief Inspector as required by the regulations. Two notifications concerning alleged neglect were submitted retrospectively following the inspection. The provider was required to conduct a full review of all complaints and retrospectively submit any further notifications that met the threshold for an allegation of abuse that should be notified to the Chief Inspector.

Judgment: Not compliant

Regulation 34: Complaints procedure

Improvements were required to ensure compliance with the regulation.

- While there was a policy to guide residents staff and families on the complaints process, including how all complaints were to be managed, it was not being followed in practice. While inspectors found that where complaints were acknowledged this was done in a respectful manner, however, there was not consistent evidence of complaints being acknowledged within the required timeframe. Some gaps existed in the provider's records regarding whether the timelines set out under the regulation for responding to the complainant had been met.
- Where a resident was not satisfied with the outcome of the complaint this was not escalated to senior management in line with the provider's procedure.
- A number of residents and a family member spoke of their apprehension in submitting complaints due to potential repercussions.

The provider had not recognised some complaints as allegations of neglect, and this is discussed further under Regulation 8: Protection and Regulation 31: Notification of incidents.

Judgment: Not compliant

Quality and safety

While the inspectors observed kind and compassionate staff treating residents with dignity and respect, enhanced governance and oversight were required to improve the quality and safety of service provision. Significant action was required concerning food and nutrition, managing behaviour that is challenging, residents' rights, premises and infection control. Other areas also requiring improvement included healthcare, protection, individual assessment and care planning, and fire safety.

The inspectors saw examples of comprehensive person-centred care plans based on validated risk assessment tools. Records reviewed found that residents and their families were involved in care plan reviews. Notwithstanding these areas of good practice in care planning, action was required to ensure that each resident's needs were comprehensively assessed and an up-to-date care plan was prepared to meet

these needs. This will be discussed under Regulation 5: Individual assessment and care plan.

Residents had access to a doctor of their choice and an in-house physiotherapy service. Residents who required specialist medical treatment or other healthcare services, such as mental health services, speech and language therapy, dietetics and palliative care, could access these services in the centre upon referral. The records reviewed showed evidence of ongoing referral and review by these healthcare services for the residents' benefit. Notwithstanding this good practice, the inspectors found that improvement was required to ensure all residents received timely access to appropriate professional expertise. This will be discussed under Regulation 6: Healthcare.

Robust action was required concerning the management of behaviour that is challenging. While the provider had ensured that nursing and healthcare assistant staff had training in managing challenging behaviours, other categories of staff required this training. Improvements were also required to ensure that when restraint was used, it was used in accordance with national policy and the provider's restraint policy. The provider was also required to review the impact of residents' responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) on other residents. These matters are discussed under Regulation 7: Managing behaviour that is challenging.

The provider had systems in place to safeguard residents and protect them from abuse. Staff had access to both online and face-to-face training to support them in protecting residents from abuse. A safeguarding policy provided support and guidance in recognising and responding to allegations of abuse. Staff spoken with were clear about their role in protecting residents from abuse. Residents reported that they felt safe living in the centre. From the records seen, the person in charge was investigating incidents and allegations of abuse. While acknowledging these good practices, the providers' systems for recognising and responding to abuse incidents and allegations had not correctly identified all safegurding incidents that had occurred in the centre as outlined under Regulation 8: Protection.

Staff were respectful and courteous towards residents. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents' meetings and completing residents' questionnaires. The centre had religious services available. Residents also had access to a pleasant oratory area in Lambay for prayer and quiet reflection. Residents had access to radio, television, newspapers, telephones and internet services throughout the centre. Residents also had access to independent advocacy services. However, inspectors also found that aspects of residents' rights were not upheld in the centre and improvements were required by the provider to ensure that residents had opportunities to participate in activities in accordance with their interests and capabilities and that residents' privacy was protected. This will be discussed under Regulation 9: Residents' rights.

Overall, despite some decorative wear and tear noted, the premises were well maintained internally and externally; however, there was a marked variation in the standard of accommodation and upkeep of the premises on Shennick compared with other areas in the centre. For the Erris, Lambay, Iona, and Columba Units, the design and layout met the residents' needs, and these areas were found to be bright and pleasantly decorated, providing a homely and comfortable atmosphere for the residents. These units also had multiple pleasant communal areas for residents and visitors to enjoy.

Residents expressed mixed feedback regarding food, snacks, and drinks. Food was prepared and cooked on-site and choice was offered at all mealtimes. However, robust action was required to ensure that food and nutrition were delivered in accordance with regulatory requirements, as discussed under Regulation 18: Food and Nutrition.

The interior of the centre was generally clean on the day of inspection, including sluice rooms. The infrastructure of the on-site laundry supported the functional separation of the clean and dirty phases of the laundering process. The person in charge had completed a review following a recent COVID-19 outbreak with learning identified in the event of a future outbreak.

The provider had robust fire safety processes in place. Preventive maintenance for fire detection, emergency lighting and fire-fighting equipment was conducted at recommended intervals. Staff had undertaken fire safety training, and there were monthly fire evacuation drills within each unit in the centre, which covered a range of scenarios. Each resident had a personal emergency evacuation plan to guide staff in the event of an emergency requiring evacuation. The procedures to follow in the event of a fire were clearly displayed, and the staff spoken with were knowledgeable about these procedures. Floor plans displayed on the walls indicated the compartment boundaries to guide staff. There was a system for daily and weekly checking of the fire alarm, means of escape, fire safety equipment, and fire doors. Laundry records of lint removal were available for review. Several fire doors were checked on the inspection day, and the majority were found to be in good working order. The inspectors checked the fire escapes and found them to be unobstructed. Notwithstanding these good practices, some further actions were required to ensure that residents and staff were adequately protected in a fire emergency. These findings are set out under Regulation 28: Fire precautions.

Regulation 11: Visits

The provider had a written visitor policy as required by the regulation. The inspectors observed that visits to the centre were encouraged. The visiting arrangements in place did not pose any unnecessary restrictions on residents. The registered provider had several communal spaces for residents to host a visitor.

Judgment: Compliant

Regulation 17: Premises

The standard of accommodation and upkeep of the premises on Shennick, which accommodated residents with complex care needs, including dementia and mental health diagnoses, was not to an acceptable standard and was inconsistent with the decorative attention, comfort and upkeep seen in other units. For example:

- Day space 2 was not laid out and furnished to meet the needs of residents. Inspectors observed that the room, which contained a large table, four plastic office chairs with no armrests, and two dining chairs, was not an inviting and homely communal area for residents to enjoy.
- Furniture in day space 1 required repair or replacement. For example, three armchairs had torn coverings, while two armchairs had sunken seat areas, and a dresser was damaged, with exposed chipboard visible.
- Flooring was observed to be damaged and had black masking tape applied.
- Lighting required review and replacement; for example, several light bulbs were not working in the day space 2.
- Mobility equipment was not kept in a good state of repair. For example, two residents were observed mobilising using steel-framed zimmerframes, which made a continuous high-pitched noise as the residents travelled. This noise was observed to cause agitation among other residents and was not conducive to creating a calm and comfortable environment for them.
- There was inappropriate storage within residents' communal areas, for example, a chair scale was stored under the television in day space 1, while a whiteboard was stored in the "'snoezelen" room.

On Lambay, a door was causing damage to the flooring in the day room. It was also observed that the door entering the garden area was held open by the nozzle of a garden hose.

Action was also required to improve call-bell accessibility. On the evening of the first inspection day, inspectors found that four residents did not have access to their call-bell, meaning they were unable to summon assistance if required. The call-bells were seen to be out of the resident's reach, for example, on the floor at the end of their bed or wrapped around the overhead light fixture.

Judgment: Not compliant

Regulation 18: Food and nutrition

Robust action was necessary to ensure that food and nutrition were delivered in accordance with regulatory requirements, as evidenced by the findings below.

Action was required to ensure the dietary needs of residents, as prescribed by a health care professional, were met, for example:

- Food was not provided to residents aligned with their assessed dietary needs. For example, a resident who was prescribed a modified consistency diet was served an inappropriate diet, which posed a safety risk. This was immediately addressed during the inspection when the inspector brought this to the attention of the nursing staff and the person in charge.
- Complaint records reviewed found that one resident complained that lactose-free milk had not been made available to them for three days, contrary to their dietary needs.

Inspectors were not assured that residents were receiving adequate support and assistance at mealtimes. For example, the inspectors observed a resident who was not supported into the correct seating position to receive a meal, thereby increasing the risk of aspiration. This was immediately addressed during the inspection when the inspectors brought this to the attention of the nursing staff and the person in charge.

The inspectors were not assured that food was properly and safely prepared, cooked and served due to the following findings:

- Hot food, such as scrambled eggs, was observed by the inspectors to be wrapped in cling film, resulting in excess moisture on the food. This was brought to the attention of the inspectors by several residents.
- The provider's food safety policy was not available during the inspection. This was submitted after the inspection as requested.

Inspectors were not assured that residents were provided with adequate quantities of food and drink which were wholesome and nutritious. Over the course of the inspection, several residents complained about the nutritional standard of food provided, particularly in the evening. Residents reported an over-reliance on food that was cooked from frozen, such as chips, croquettes, and goujons, and sought increased quantities of fresh fruit, salad, and vegetables.

The mealtime experience on Lambay required review, as inspectors observed and residents reported that there was insufficient supportive seating with armrests in the dining room to enable residents to position themselves within the dining chair.

Residents did not have access to a safe supply of fresh drinking water at all times. While staff refilled water jugs in bedrooms, there was no accessible supply of fresh drinking water available to residents of Erris and Shennick on the first evening of inspection. One resident was observed to be seeking fresh drinking water. This was brought to the provider's attention, and drinking water was observed in communal areas during the second inspection day.

Given the potential risk to resident health and safety associated with these findings, immediate actions were issued to the provider on the second day of inspection regarding the proper and safe serving of food, ensuring that the dietary needs of residents, as prescribed by healthcare or dietetic staff, were met, and ensuring that sufficient staff were available to assist residents at mealtimes and when refreshments were served. The provider had addressed these immediate issues by the end of the inspection. In addition to the immediate risks identified, the registered provider was also required to take significant further urgent action. Following the inspection, the provider reverted with an interim plan to manage the risks identified during the inspection and committed to a series of actions to ensure that these risks were controlled and mitigated going forward.

Judgment: Not compliant

Regulation 27: Infection control

While the interior of the centre was generally clean on the day of inspection, there were some areas for improvement to ensure residents were protected from infection and to comply with the *National Standards for Infection Prevention and Control in Community Services (*2018) and other national guidance in relation to IPC, for example:

- The provider systems for ensuring oversight and effective communication of key information regarding infection control required review, as inspectors were provided with inaccurate information regarding the number of residents who were colonised with a multi-drug resistant organism (MDRO). It is essential for management to have full oversight of residents with MDROs so that appropriate precautions can be put in place when caring for these residents in order to prevent the spread of infection.
- There was ambiguity among staff in relation to the infection control needs of a resident with an infection, with inspectors inaccurately informed in respect of the precautions in place when caring for this resident. Additionally, the precautions described to inspectors were not aligned with the guidance contained in the provider's infection control policy.
- The provider's wound care policy to guide staff practice had not been updated to reflect pressure ulcer staging practices in the centre, as directed by members of the multi-disciplinary team.
- MDRO monitoring did not incorporate a robust review and actions to address any areas for improvement.

While environmental hygiene throughout the premises overall was maintained to a high standard, gaps were identified where the standard of hygiene required improvement, for example:

- The flooring within the Shennick and Erris required attention due to a strong malodour. This odour was most notable in Shennick. The presence of this

odour was not acceptable and did not promote the dignity of residents using this area.
- Residents' equipment, including crash mats and pressure cushions, was observed to be unclean with food and liquid staining and other debris.

Judgment: Not compliant

Regulation 28: Fire precautions

While the provider had strong fire safety processes in place, the oversight of fire safety within the centre required review, as the provider had not identified and managed some of the risks found during the inspection, for example:

- Precautions against the risk of fire required review, as residents were seen to smoke in a number of outdoor areas within the centre which lacked the necessary safety equipment, such as in the smoking area outside the hygiene office, which did not have a call-bell, fire blanket or fire extinguisher to respond in an emergency. These matters were brought to the attention of the person in charge on the first day of the inspection, and management was seen to be installing the necessary equipment on the second day of the inspection.
- The provider's arrangements for containment required review as some fire doors did not close fully when tested by the inspectors, for example, the double doors to enter Erris from the library.
- Each resident had a personal evacuation plan to guide staff in respect of their support needs in an emergency requiring evacuation. However, these plans did not state if the residents required supervision following an evacuation. This was important because some residents may be at risk of re-entering an unsafe area while staff evacuate other residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of nine residents' records. While there was evidence of personalised care planning based on validated risk assessment tools, action was required to ensure that each resident's needs were comprehensively assessed and an up-to-date care plan was prepared to meet these needs, for example:

- Not all identified healthcare needs, had a corresponding care plan in place to guide staff in providing person-centred, effective care to the resident. For example, a resident with a specific diagnosis did not have this diagnosis

referenced in their care plan, nor their related healthcare needs and interventions required to address them. Another resident with a mental health diagnosis did not have the emotional support needs associated with their condition documented in their care plan to guide staff.

- There were some discrepancies regarding a resident's risk of falls noted in a care plan. One care plan was seen to document the resident as being at high and low risk of falls within the same plan. Clarity on the resident's risk of falls is crucial to ensure staff can effectively mitigate falls risks and develop a robust care plan to enhance the resident's comfort and safety.
- Some residents' care plans were not updated at four-monthly intervals or sooner as required by the regulations, with one resident's infection care plan seen not to have been updated in nine months.

Judgment: Substantially compliant

Regulation 6: Health care

Notwithstanding residents' access to a range of healthcare professionals, some improvement was required to ensure that all residents had timely access to appropriate professional expertise based on their assessed needs. For example, a resident receiving wound care was not referred for further review by the tissue viability nurse (TVN) specialist as recommended, even though this resident's wound was not healing and the TVN was regularly in the centre.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The person in charge had not ensured that all staff had up-to-date knowledge and skills appropriate to their role to respond to and manage behaviour that is challenging. Records reviewed found that nursing and healthcare assistants had received training; however, this training did not extend to other staff grades who have day-to-day contact with residents, as required by the provider's induction, orientation, and supervision policy.

The registered provider had not ensured that where restraint was used, it was used in accordance with national policy and the provider's restraint policy as evidenced below:

- Residents on Shennick had their movements restricted as the double doors to some of their living areas, communal space 1 and 2, where the 'snoezelen'' room was also located, were observed to be locked on the first evening of

inspection and were not opened until 10:00am on the second day of the inspection.
- Two toilet facilities on Shennick were locked on the first evening of inspection, meaning they were inaccessible facilities for residents.
- Inspectors found that where therapeutic holds, a form of physical restraint, were being used to support a resident during personal care, this had not been risk assessed as required by the provider's polices and by national policy. Additionally, the resident's care plans did not detail a stepped approach to such practices, ensuring that the least restrictive response was used when supporting the resident in these complex circumstances and to maintain the safety of all parties.Staff had not received training in the implementation of therapeutic holds.

The inspectors observed that some residents living in the centre displayed responsive behaviours. It was further observed that at times, these behaviours impacted negatively upon other residents who voiced that they were anxious and frightened by the behaviours. Action was required to review the support needs of residents with responsive behaviours and to alleviate the impact of these responsive behaviours on other residents' quality of life, including a peaceful enjoyment of their living environment.

Judgment: Not compliant

Regulation 8: Protection

While the registered provider had taken measures to protect residents from abuse, the systems for recognising and responding to abuse incidents and allegations required some improvement. Complaints management documentation reviewed by the inspectors identified three incidents of alleged neglect, which had not been recognised as abusive interactions. As a result, these incidents had not been investigated and managed in line with the centre's safeguarding policy.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Action was required by the registered provider to ensure residents' rights were respected, as evidenced by the findings below.

For all residents of the centre, the current provision and organisation of activities did not ensure that all residents had an opportunity to participate in activities in accordance with their interests and capacities. While group-based activities were observed on the inspection days, residents were also seen sitting for lengthy periods

in the sitting rooms with the television on but without other meaningful activation. Some residents and families informed the inspectors that they did not know that activities were taking place and had not been supported to attend. Others told the inspectors that the activities on offer were not geared towards their interests and capacities.

Significant improvements were required to ensure activities offered to the residents living in Shennick were based on their assessed needs and aligned with recommendations documented in their care plans. Many of the residents of Shennick had a diagnosis of dementia and experienced responsive behaviours. These residents were seen to have comprehensive responsive behaviour care plans, often informed by specialist expertise from mental health and geriatrician services. These care plans outlined the benefits of therapeutic activities, such as gardening, playing cards, games, relaxation, arts and crafts, and using the multisensory room, for these residents to alleviate the agitation and unease that are symptoms of their condition. However, inspectors found that the named activities were not provided, and facilities in Shennick did not meet the residents' assessed needs nor align with recommendations documented in residents' care plans, for example, there was no evidence of gardening being offered to residents, despite it being referenced in their care plans.

Action was required to ensure the privacy of residents was respected at all times. For example:

- Handover was observed to completed in a communal space in front of residents and external individuals.
- Resident information was observed to be openly displayed in bedrooms.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 7: Applications by registered providers for the variation or removal of conditions of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Tara Winthrop Private Clinic OSV-0000183

Inspection ID: MON-0047148

Date of inspection: 14/08/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Staffing in the centre on the days of inspection was adequate to ensure the care needs of the residents were met and all rosters were made available to the inspectors on the day of inspection. Staff who are on long term sick/ maternity leave remain on the rosters and will complete outstanding mandatory training on return to work. • Rosters are done fornightly and closely monitored by the PIC, ADON and CNM to ensure appropriate skill mix is present daily. • Clinical team review roster and ensure sufficient staff are available at all times to meet the assessed needs of residents. • Staffing policies are reviewed regularly and reflect current best practices and regulatory requirements. • Staff are supervised by experienced clinical team and provide support, and opportunities for professional development. a positive working environment that supports staff well-being and retention.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • Floor supervision is now strengthened, led by the DON and ADON. Structured supervision rounds are now completed daily by the CNMs and staff nurses working in each unit, focusing on mealtime support, call-bell accessibility, and adherence to residents' care plans. Any findings are immediately corrected. • Staff who are on long term sick/ maternity leave remain on the rosters and will complete outstanding mandatory training on return to work.	

• A complete review of training compliance records has been undertaken. All mandatory training including safeguarding, fire safety, manual handling, responsive behaviour, and medication management has been verified and recorded on the Training Compliance Matrix.
• PIC completed a review of the assessment and care plans of all residents currently receiving covert medication and on therapeutic hold to ensure compliance with providers policy and NMBI guidelines. There are no residents on therapeutic hold currently in the centre.
• Policy on Covert Medication Administration reviewed and updated to ensure full alignment with NMBI and national standards.
• All staff will have re-read and acknowledge understanding of the updated policies

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• A full review of Regulation 18 food and nutrition was completed, and actions are detailed under Regulation 18
• A strengthened local management team has since been re-established, chaired by the Director of Nursing and attended by the Assistant Directors of Nursing, Clinical Nurse Managers, and Heads of Department. This group meets weekly to review key performance indicators, incident trends, safeguarding reports, audit outcomes, and progress against outstanding action plan.
• Oversight of incident reporting and notifications has been strengthened through daily safety huddle and weekly incident review by the DON and ADONs. All incidents are now reviewed within 24 hours to determine notification requirements, ensuring compliance with regulatory timeframes.
• To improve the accuracy of operational data, occupancy, infection, and hospitalisation daily board update is now maintained and verified by the Director of Nursing on a daily basis.
• Monthly care plan audits will be completed and corrective actions are conveyed to staff at staff meetings.
• Policy alignment was reviewed across all key practice areas including covert medication, restraint management (therapeutic hold), infection control, and complaints to ensure that practice is consistent with the standards and policies.
• A daily complaints log oversight by the director of nursing has been introduced to ensure all complaints are timely acknowledged, investigated, and escalated where required, in accordance with policy. A monthly complaints summary is presented at the Governance meeting for review and learning.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• A retrospective review of all incidents has been completed, with missed NF-06s submitted.
• Incidents are reviewed in the weekly management meetings which is chaired by the PIC.
• PIC conducted a full review of complaints, incidents and restrictive practices in the centre.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
To ensure adherence to regulations and standards:
• The PIC has reviewed all open complaints and has ensured all complaints are acknowledged and resolved in line with the Centre's policy.
• The PIC, being the Complaints Officer is highlighted in all complaints poster across the centre's communal area.
• Resident forums discuss complaint escalation and safeguarding education session are conducted to promote transparency and reassure residents about the robust process that is in place in the centre. Evidence includes complaints tracker and resident meeting minutes.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
To resolve the identified issues, the following compliance plan has been put into action:

• A full environmental review of the Shenick, Lambay, and Erris units was completed to address the deficits identified.
• Day space 2 will be reviewed and all damaged furniture will be replaced.
• The black masking tape noted on the floor has been removed and the affected area resurfaced.
• Lighting fixtures across Shenick were reviewed, and all faulty bulbs and fittings have been replaced to improve visibility and ambience.

• The Snoezelen room was decluttered and reinstated as a dedicated multi-sensory environment. All inappropriate storage such as mobility equipment and weighing chairs in communal spaces has now been removed.
• Mobility equipment across all units was inspected and serviced. Faulty zimmer frames that generated excessive noise have been installed with rubber-foot device to minimise disruption and promote a calm environment for residents.
• In Lambay, the day-room door causing damage to the flooring has been repaired, and nozzle of garden hose holding the external garden door was removed to ensure safe access to the garden area.
• Call-bell access has been prioritised. A centre-wide call-bell audit was completed to ensure call-bells are securely mounted within residents' reach at all times. This check is now incorporated into the daily walkabout completed by CNMs or ADONS and or DON.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
A comprehensive review of mealtime systems and nutritional care was undertaken immediately following the inspection.

• All residents requiring modified diets now have up-to-date speech and language therapy assessments, and care plans have been updated to reflect the correct texture, consistency, and supervision requirements.
• Nursing and catering teams received refresher training on dysphagia management, safe feeding, and mealtime risk prevention, with emphasis on correct seating and positioning to mitigate aspiration risk.
• The Food Safety Policy was reviewed, updated, and communicated to staff.
• The Head Chef, in collaboration with the Dietitian, has implemented a new menu cycle incorporating fresh ingredients, increased availability of fruit and vegetables, and reduced reliance on frozen or pre-prepared items. All menus are reviewed by the Dietitian and Director of Nursing.
• Rosters were reviewed and staff allocation sheet has been updated to ensure sufficient support and oversight during mealtimes. Each dining area now includes designated staff responsible for ensuring that residents are comfortably and safely positioned before food service commences.
• Mealtime observation audits are carried out weekly by the CNM or ADON.
• Residents have access to drinking water at all times.
• Resident communication and involvement in dietary planning have been strengthened through documented discussions, resident food survey and inclusion in care-plan reviews.
• The mealtime experience on Lambay was reviewed which included supportive and comfortable seating arrangement, supervision and assistance and relaxing music.

Regulation 27: Infection control	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
Following the Inspection and with a view to assuring the concerns of the Inspector, the Registered Provider has taken the following actions:

• A revised handover structure has been introduced, requiring each CNM to provide an infection-control update at every shift change, including the current number of residents with active infections or MDROs and required isolation precautions. This information is verified daily by the ADON and reviewed by the DON during the morning safety huddle.
• Information shared with inspectors during the inspection has since been reviewed, and practice realigned with the provider's updated IPC policy to ensure consistency between knowledge and practice.
• The Wound Care Policy has been revised to incorporate evidence-based staging tool i.e.: Pressure Ulcer Scale for Healing or PUSH tool.
• Environmental standards have been reinforced through monthly IPC audits and enhanced cleaning schedules, focusing on odour elimination and the cleanliness of resident equipment such as crash mats and pressure cushions.
• Deep cleaning of Shennick and Erris units has been completed, and odour-control measures are now routinely reviewed.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The Registered Provider has taken the following steps you to achieve compliance:

• A review of fire safety oversight and risk management systems was completed to address the issues identified.
• All designated smoking areas were reviewed and equipped with appropriate fire safety apparatus, including fire blankets, fire extinguishers, and call-bells.
• Signage indicating "Designated Smoking Area" have been installed for the awareness of all staff and residents.
• The fire containment between the library and Erris were inspected and repaired.
• Each resident's PEEP has been reviewed and updated to explicitly record post-evacuation supervision requirements. This ensures that residents who may continuous assistance and supervision during and after evacuation are put in place following evacuation.

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

The Registered Provider has undertaken the following measures to achieve compliance:

• A full review of all resident care plans and risk assessments were completed to ensure that every resident has a comprehensive, up-to-date, and person-centred care plan reflective of their assessed needs.

• A care plan audit was conducted across all units, focusing on completeness, accuracy, and review frequency.

• All deficits identified during the inspection including missing care plans for specific diagnoses, inconsistent falls risk documentation, and outdated infection care plans have been rectified.

• To prevent recurrence, scheduled care plan audit is in place. Care plans are reviewed at a minimum every four months or sooner if the resident's condition changes.

• The ADONs and CNMs conduct monthly care plan audits, with outcomes reviewed by the DON and discussed at the local management meeting.

• Refresher education has been provided to all nursing staff on care planning standards, and the importance of accurate, consistent documentation.

Regulation 6: Health care	Substantially Compliant

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

• Referral and escalation processes review was undertaken to strengthen timely access to specialist input for residents with complex needs.

• All wounds are now reviewed weekly by the CNM and ADON, with mandatory escalation to TVN or GP if no measurable improvement is observed within the defined clinical timeframe.

• The process of care plan review, wound staging, and treatment regimen following any deterioration or lack of progress was also strengthened.

Regulation 7: Managing behaviour that is challenging	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
The Registered Provider has implemented the following actions to attain compliance.
• Responsive Behaviour Management and Restrictive practices were reviewed .
• Immediate action was taken to remove the use of therapeutic holds within the centre.
• The resident's care plan with therapeutic hold intervention has since been fully reassessed and currently no residents have therapeutic holes
• Non-Clinical Staff received training in positive behaviour support, ensuring that all responses are person-centred, proportionate, and least restrictive.
• All communal and toilet areas identified during inspection have been made accessible to residents at all times.
• The Doors on the dementia unit remain restricted this is clearly documented on the restraint register; however butterfly keypads are on all restricted doors.
• Care plans for residents with responsive behaviours have been reviewed and updated to include clear stepped interventions, ensuring that early communication and de-escalation strategies are prioritised before any restrictive measure is considered.
Incidents are now reviewed daily by the Director of Nursing to monitor trends, triggers, and outcomes.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• Following the inspection, the management team conducted a full review of safeguarding systems and reporting processes to ensure that all incidents and allegations of abuse including neglect are consistently recognised, investigated, and managed in line with the policy and the centre's own safeguarding procedures.
• An immediate review of all complaints and incident records was undertaken. The two incidents highlighted by inspectors have since been formally reviewed, reclassified under safeguarding, and submitted as NF06 notifications to HIQA. Appropriate internal investigations were completed and learning outcomes were shared across the nursing and management teams.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
Following the inspection, Activity Lead has completed a full review of the activities programme across all units to ensure that residents' rights to dignity, autonomy, and meaningful engagement are upheld.

• The centre has a comprehensive activity calendar which is available for all residents. This calendar is developed by the Activity Coordinators in consultation with residents, families and the care team. Individual activity assessments are completed for all residents on admission and reviewed quarterly or following any change in condition. Each care plan includes personalised preferences derived from the Key to Me assessments.
• On the day of inspection, some residents opted not to participate in group activities and preferred to remain in the sitting area watching television. This reflects residents choice. The centre also facilitates one to one activities as per residents need and requests.
• A dedicated Activities Lead has led the development and coordination of a centre-wide activities programme, supported by trained activities coordinators within the centre.
• The programme is based on residents' assessed interests, cognitive capacities, and therapeutic needs, with sessions incorporating music, art, reminiscence, gentle exercise, sensory stimulation, and one-to-one engagement for residents who prefer quieter interaction.
• Attendance and engagement are documented, and residents and families are invited to contribute suggestions through regular resident and family forums.
• Specific focus has been placed on Shenick, where activities have been realigned to reflect resident's care plan.
• Gardening, relaxation sessions, sensory room activities, and small-group card games continue to be part of the structured weekly plan.
• The Snoezelen room has been reinstated for sensory-based engagement, supporting the general wellbeing of residents with responsive behaviours.
• Activities schedule is now displayed clearly in all communal areas and communicated at morning staff handovers to ensure all residents are supported to participate according to their preferences.
• Handover was conducted in the nurses station, however the nurses station was near the communal area. All staff informed that handovers are not to be conducted infront of residents and external individuals.
• The information displayed in bedrooms, was reviewed and removed if required.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	13/08/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	13/08/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	13/08/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre,	Not Compliant	Orange	30/11/2025

	provide premises which conform to the matters set out in Schedule 6.			
Regulation 18(1)(a)	The person in charge shall ensure that each resident has access to a safe supply of fresh drinking water at all times.	Substantially Compliant	Yellow	30/11/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which are properly and safely prepared, cooked and served.	Not Compliant	Red	22/08/2025
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	30/11/2025
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional	Not Compliant	Red	22/08/2025

	assessment in accordance with the individual care plan of the resident concerned.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Not Compliant	Red	22/08/2025
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	30/11/2025
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.	Not Compliant	Orange	30/11/2025
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and	Not Compliant	Orange	30/11/2025

	control and outbreak management is implemented in the designated centre, as required.			
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	31/08/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	31/08/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the designated centre and safe placement of residents.	Substantially Compliant	Yellow	31/08/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within	Not Compliant	Orange	31/08/2025

	2 working days of its occurrence.			
Regulation 31(3)	The person in charge shall provide a written report to the Chief Inspector at the end of each quarter in relation to the occurrence of an incident set out in paragraphs 7(2)(a) to (e) of Schedule 4.	Not Compliant	Orange	31/08/2025
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.	Substantially Compliant	Yellow	31/08/2025
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident	Substantially Compliant	Yellow	30/11/2025

	concerned and where appropriate that resident's family.			
Regulation 6(2)(c)	The person in charge shall, in so far as is reasonably practical, make available to a resident where the care referred to in paragraph (1) or other health care service requires additional professional expertise, access to such treatment.	Substantially Compliant	Yellow	31/08/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	30/09/2025
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	30/09/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only	Not Compliant	Orange	30/09/2025

	used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Substantially Compliant	Yellow	30/09/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	31/08/2025
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Not Compliant	Orange	31/08/2025
Regulation 9(3)(b)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may undertake personal activities in private.	Substantially Compliant	Yellow	31/08/2025