



# 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:	26 November 2025
Centre ID:	OSV-0000183
Fieldwork ID:	MON-0047996

## 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:	113
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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 26 November 2025	16:15hrs to 21:05hrs	Aisling Coffey	Lead
Thursday 27 November 2025	07:30hrs to 15:15hrs	Aisling Coffey	Lead
Wednesday 26 November 2025	16:15hrs to 21:05hrs	Laura Meehan	Support
Thursday 27 November 2025	07:30hrs to 15:15hrs	Laura Meehan	Support
Wednesday 26 November 2025	16:15hrs to 21:05hrs	Sinead Corbett	Support
Thursday 27 November 2025	07:30hrs to 15:15hrs	Sinead Corbett	Support

## What residents told us and what inspectors observed

Overall, residents reported being content living in Tara Wintrop Private Clinic; however, some factors, including food and care provision, were impacting the day-to-day lives of a number of residents in the centre, as outlined in this report.

The residents spoken with were complimentary of the centre, the staff and the care received. Residents spoke favourably about the centre, with one resident telling the inspectors: "its lovely here". Residents were predominantly positive about the kind and considerate staff who cared for them, with the majority of staff being described as: "nice", "cheerful" and "jolly". While praising the staff overall, two first-floor residents and one first-floor visitor informed the inspectors of concerns regarding staff supervision and attentiveness and outlined gaps in care from their perspective. Inspectors discussed these matters with the person in charge.

This unannounced inspection was conducted by three inspectors over two days, commencing with an evening inspection on the first day and continuing following morning. During the inspection, the inspectors spoke with 29 residents and 15 visitors to gain insight into residents' lived experiences in the centre. The inspectors also spent time observing interactions between staff and residents and reviewing a range of documentation.

The designated centre is set out across two floors, accessible by stairs and a passenger lift. The ground floor contained the kitchen, laundry, staff changing rooms, canteen, and office facilities. The laundry, where residents' personal clothing and towels were laundered, was seen to be tidy and well-organised. The layout supported the functional separation of the clean and dirty phases of the laundering process.

Resident accommodation was set out across five units. Lambay, Shennick and Erris were located on the ground floor, while Columba and Iona were on the first floor. The centre comprised 86 single-occupancy and 25 twin-occupancy bedrooms. 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. 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. One resident did not have a call bell, and other residents had theirs out of reach, for example, on the floor or wrapped around the call bell plate. These findings were brought to the attention of the person in charge, and the staff promptly rectified these matters.

In terms of communal space, each unit had its own dining room, sitting rooms and day spaces. There was also a ground-floor library and an oratory for quiet reflection. Inspectors found improvements in accessibility and upkeep of communal areas within and adjacent to Shennick since the last inspection. Communal spaces 1 and 2

adjacent to Shennick were found to be fully accessible and used by residents throughout both inspection days. Day spaces 1 and 2 on Shennick had furniture of a suitable standard and therapeutic equipment for residents to engage with, such as books and games. Inspectors also viewed improvements to the "snoezelen" room, a facility designed to provide a comfortable, multisensory environment for the well-being of residents who are distressed or agitated. This room contained comfortable seating and multisensory equipment, including lighting and scents, to support a distressed resident.

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. These gardens were clean, tidy, and pleasantly decorated, with comfortable seating, potted plants and flowers. Inspectors observed residents smoking in several outdoor areas. These areas were seen to have the necessary protective equipment for residents who chose to smoke. However, these areas were used at night by residents but were not adequately lit for their safety.

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. Overall, visitors spoken with expressed their satisfaction with the quality of care provided to their relatives living in the centre and the communication between staff and families. However, one visitor raised concerns regarding staff supervision on the first floor and outlined gaps in care from their perspective.

In terms of activity provision, there were two activities staff on duty daily. On the first evening of the inspection, some residents attended a virtual tour in the library, while others enjoyed chats and jokes with activity staff on Lambay. Residents who were not engaged in group activities relaxed in their bedrooms, where they read, watched television, or hosted a visitor. On the second inspection day, a Roman Catholic Mass was held on Lambay in the morning. The hairdresser was present, and residents proudly displayed their new hairstyles. In the afternoon, residents were seen enjoying art and crafts, nail care, and hand massage. Residents were predominantly positive when asked about the provision of activities. Inspectors observed a new activity schedule prominently displayed in resident areas, but the locations of the activities were not recorded to allow residents to know where to attend if they chose.

The inspectors observed breakfast, the main meal, and the evening meal over the two-day inspection, as well as refreshments provided throughout the day. Meals were freshly prepared on-site in the centre's kitchen, under the head chef's supervision. Residents had access to drinking water and other refreshments at meal times and throughout the day. Residents were offered a choice at each meal. Staff were observed providing discreet and respectful assistance to residents who required it at mealtimes. The majority of residents were complimentary when asked about the food. However, three residents expressed dissatisfaction with the portion sizes and the nutritional quality of the food provided in the evening. Residents reported an over-reliance on foods high in saturated fat. A small number of residents also informed the inspectors that meals and refreshments were not

properly served to them, with condiments on the side so residents could enjoy their meals according to their preferences. Instead, two residents informed the inspectors that cups of tea were served with milk already added, which they did not enjoy.

The following two sections of the report present the findings of this inspection regarding the centre's governance and management arrangements and how these arrangements impacted the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

## Capacity and capability

This centre has been inspected on seven occasions between June 2023 and November 2025. The four inspections in June 2023, November 2023, March 2024, and July 2024 identified ineffective governance and management structures, insufficient supervision of staff, and poor oversight of resident care. 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. The 13 August 2025 inspection found that improvements in regulatory compliance identified in November 2024 had not been sustained. Significant focus was required in relation to improving the monitoring and oversight systems concerning 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 inspection found that, overall, the management systems had strengthened since the August 2025 inspection. While improvements were observed in the provider's oversight of quality assurance, additional actions were required as the provider continued to work towards improved regulatory compliance, as outlined in this report.

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). The inspectors also followed up on two pieces of unsolicited information submitted to the Chief Inspector of Social Services since the last inspection, relating to family communication at the end of life and hospital transfers. The overall findings of this inspection indicated that these concerns were not substantiated and that the provider was in compliance with regulatory requirements in these areas.

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 the second inspection day 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 comprising senior personnel who supported the person in charge in 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 two 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. Deputising arrangements were in place when the person in charge was absent.

While staffing levels were appropriate to meet residents' needs on the inspection day, the staff resources available were not in line with those committed to in the staffing plan submitted to the Chief Inspector of Social Services when the centre was registered. The provider had committed to having three assistant directors of nursing (ADON) available. One ADON post became vacant at the end of October 2025, and recruitment efforts were underway.

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. Records of clinical governance meetings held since the previous inspection were reviewed. Records found the provider had also established several staff committees examining matters including falls reduction, infection control and restrictive practice. The provider maintained a risk register to monitor known risks within the centre. The person in charge monitored key performance indicators across multiple areas, including wound care, infection control, and nutrition, weekly. Auditing of key aspects of service provision, including hand hygiene, care planning, and wound care, was ongoing. Notwithstanding the presence of these oversight systems, further action was required to ensure the service provided to residents was safe, appropriate, consistent, and effectively monitored, as the provider's oversight mechanisms had not identified some deficits and risks found during this inspection. These matters are discussed under Regulation 23: Governance and management.

The provider had completed the annual review of the quality and safety of care delivered to residents for 2024. The inspectors saw evidence of consultation with residents and families reflected in the review. In this review, the registered provider had also identified areas requiring quality improvement.

In terms of staff training and development, records reviewed found evidence of an emerging induction programme for all staff grades. The inspectors saw that the provider's newly recruited staff and agency staff received an induction covering key aspects of care and procedures in the centre. Records reviewed found that staff had access to a suite of mandatory training in areas such as safeguarding, infection control and fire safety to support them in their role. Notwithstanding this good practice, some gaps in adherence to mandatory training requirements required attention, and improvements were needed in staff supervision to ensure the assessed needs of residents were supported. These matters are discussed under Regulation 16: Training and staff development.

The provider displayed the complaints procedure prominently in multiple locations throughout the centre. Information posters on advocacy services to help residents make 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. Staff were knowledgeable about the centre's complaints procedure. The complaints officer and review officer had undertaken training in complaints management. While some records of complaints received were maintained on the provider's electronic records management system, the inspectors identified gaps in the recording of complaints management practices, as discussed under Regulation 34: Complaints Procedure.

### Regulation 15: Staffing

Based on a review of the worked and planned rosters and on speaking with residents, it was evident that there was sufficient staff with an appropriate skill mix on duty each day to meet the residents' assessed needs. There were five registered nurses in the centre at night, including one clinical nurse manager.

Judgment: Compliant

### Regulation 16: Training and staff development

While staff had access to a suite of training programmes to enable them to perform their respective roles, multiple gaps in adherence to mandatory training requirements required robust action, for example:

- 11 staff had not completed training in managing behaviour that is challenging.
- Seven staff had not completed safeguarding training.
- 17 staff had not completed fire safety training, while a further 24 staff were overdue for an annual refresher of this training.

- 12 staff had not completed infection control training, while six staff were overdue for an annual refresher of this training.

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. This was a repeat finding from the previous inspection.

Judgment: Not compliant

## Regulation 23: Governance and management

While the provider had management systems to monitor the quality and safety of service provision, these oversight mechanisms were not sufficiently robust to effectively identify deficits and risks in service provision, and to continuously drive sustained quality improvement when risk was identified, for example:

- The provider's assurance systems had not been fully effective in identifying risks in staff supervision, infection control, food and nutrition, and premises, as found on this inspection.
- The management team had not taken timely action to address the known gaps in mandatory training.
- The secure storage of prescribed thickening agents was not fully effective, as the inspectors found that such products were accessible and not secured in Shennick and Erris on the first evening of inspection. These findings were brought to the attention of nurse management, who arranged for these products to be stored securely. These products must be used under supervision. Insecure storage of such thickening agents poses a risk of asphyxiation from accidental ingestion.

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

- While the provider had introduced new assessment documentation to be completed before administering covert medication, this practice continued to require review to align with the provider's policies. For example, the updated assessment documentation seen did not record the medication to be administered covertly, the indications for these medications, alternative measures taken, or evidence of discussion with the resident's representative, as required by the provider's policy.
- The complaint's management practices continued to require review to ensure they were aligned with the provider's policies, as outlined under Regulation 34: Complaints procedure.

Judgment: Substantially compliant

### Regulation 31: Notification of incidents

Incidents and reports, as set out in Schedule 4 of the regulations, were notified to the Office of the Chief Inspector within the required time frames.

Judgment: Compliant

### Regulation 34: Complaints procedure

Records reviewed found improvements in complaints management continued to be required to ensure compliance with the regulation and the provider's complaints management policy, for example:

- There was not consistent written evidence stored on the provider's electronic records management system of complaints being acknowledged and managed within the required time frames.
- Records of complaints management were not fully and properly recorded on the provider's electronic records management system. Much of the information required to review a complaint was not available for review on the day of the inspection as it was stored in emails of staff members not on duty.
- A number of complaints had not been closed within the required time frame and had not been escalated for review in accordance with the provider's policies.

These were repeat findings from the August 2025 inspection.

Judgment: Not compliant

## Quality and safety

The inspectors found that many improvements had been made to the residents' standard of care since the previous inspection. Inspectors continued to observe kind and compassionate staff treating residents with dignity and respect. There were improvements in premises, food and nutrition, infection control, fire precautions, protection, residents' rights, individual assessment and care planning, healthcare and managing behaviour that is challenging. While acknowledging the various

improvements made, some further actions were still required concerning food and nutrition, premises and infection control.

The premises' design and layout met residents' needs. The centre was appropriately decorated to provide a homely atmosphere. There were secure outdoor areas, which were pleasantly landscaped. Improvements were noted in the standard of accommodation and upkeep of the premises on Shennick, compared with the previous inspection. While acknowledging these positive aspects in relation to the premises, some further areas required maintenance and repair to fully comply with Schedule 6 requirements, which will be discussed under Regulation 17: Premises.

Residents were generally complimentary regarding food, snacks, and drinks. Food was prepared and cooked onsite. Choice was offered at all mealtimes, and food was available at reasonable times throughout the day and evening. Residents had access to fresh drinking water and other refreshments at mealtimes and throughout the day. There was adequate supervision and discreet, respectful assistance at mealtimes. There was evidence of written communication between the nursing and catering teams to ensure that the dietary needs of each resident, as prescribed by healthcare or dietetic staff, were met. Notwithstanding these positive aspects, areas for improvement regarding food in the centre will be discussed under Regulation 18: Food and nutrition.

There was a marked improvement in infection prevention and control (IPC) practices since the last inspection. The centre's interior was very clean. Surveillance of healthcare-associated infections and multi-drug resistant organism colonisation was being undertaken and recorded. The volume of antibiotic use was also regularly monitored. The provider had appointed a trained infection control link nurse to provide specialist expertise, and staff had access to IPC training. A targeted auditing system was in place to regularly review staff practices and environmental cleanliness. Staff observed were bare below the elbow and adhered to best-practice guidelines regarding hand hygiene. The on-site laundry infrastructure 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. Notwithstanding these good practices, further actions were required to protect residents from infection and to comply with the *National Standards for Infection Prevention and Control in Community Services* (2018) and other national guidance on IPC, as discussed under Regulation 27: Infection control.

## 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 private and communal spaces for residents to host a visitor.

Judgment: Compliant

### Regulation 13: End of life

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

Judgment: Compliant

### Regulation 17: Premises

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas required maintenance, repair and review to be fully compliant with Schedule 6 requirements, for example:

- Lighting was required in external courtyard areas, including smoking areas, which residents used at night.
- The temperature within the centre did not ensure residents' comfort. Some residents reported that the temperature in the centre on the first inspection evening was too warm.
- The seal around one bedroom window required review as a draft was noted in this resident's bedroom on the first inspection evening.
- Storage practices within the centre required review as inspectors found examples of inappropriate storage arrangements, for example, three hoists, a sara-steady, chair-scale, office chair and a number of wheelchairs were stored in the assisted bathroom on Shennick.
- A double door to the internal courtyard of Erris was seen to be damaged with one door nailed shut. The provider addressed this matter on the second inspection day and provided written assurance of the repair following the inspection.
- Arrangements for transporting catering trollies and other heavy equipment in the lift required review. Inspectors observed that such equipment entering and exiting the lift on the first floor created a loud noise, which was seen to impact residents relaxing in the sitting and recreational space adjacent to the lift over the course of the two-day inspection.
- The maintenance of closure mechanisms on the doors to the main kitchen and to Shennick required review as they were seen and heard to bang heavily.

Judgment: Substantially compliant

### Regulation 18: Food and nutrition

While many positive aspects of the mealtime experience were observed, some action was required to ensure compliance with the regulation's requirements. For example:

- Further assurances were required that residents had adequate quantities of food and drink, which were wholesome and nutritious. Three residents expressed dissatisfaction with portion sizes and the nutritional standard of the food provided in the evening. Residents reported an over-reliance on foods high in saturated fat. A similar finding regarding the saturated fat content of some meals was also observed in a recent review of meals by a dietitian.
- A small number of residents informed the inspector that they were not always afforded a choice in how meals were served to them. For example, two residents informed the inspectors that cups of tea were served with milk already added, which impacted their enjoyment of this beverage. Residents told inspectors they would prefer to choose which condiments they want rather than have them already added to their food or drinks.

Judgment: Substantially compliant

### Regulation 27: Infection control

While the interior of the centre was very clean on the day of inspection, and there was a marked improvement in IPC practices since the last inspection, some areas required attention to protect residents 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:

- Organisation within the sluice rooms required improvement as a number of pieces of equipment were not inverted after decontamination. Instead, this equipment was seen to be stacked on allocated racking and stored within the sluice room sinks.
- Jugs used for emptying urinary catheter bags were seen to be stored in a communal toilet facility.
- Some residents' equipment, such as crash mats, were seen to be unclean with dried-in liquid staining.
- Some resident seating was seen to be ripped, impacting the ability to clean this seating effectively.

- Gaps in mandatory IPC training are referenced under Regulation 16: Training and staff development.

Judgment: Substantially compliant

### Regulation 28: Fire precautions

The provider had good oversight of fire safety and had taken adequate precautions against the risk of fire throughout the centre. Sufficient arrangements were in place to detect, contain, and extinguish fires. Preventive maintenance for fire detection, fire-fighting equipment, and emergency lighting was conducted at recommended intervals. There was a system for conducting checks of the fire alarm, means of escape, fire safety equipment, and fire doors. Fire doors were observed to be in good working order. The inspectors found all means of escape kept clear. Procedures to be followed in the event of fire were prominently displayed for staff and visitors within the centre. Each resident had a personal emergency evacuation plan to guide staff in an emergency requiring evacuation. Smoking areas were seen to contain protective equipment for residents. A schedule of fire safety training for staff and monthly fire evacuation drills in each unit was provided.

Gaps in mandatory annual staff fire safety training are addressed under Regulation 16: Training and staff development.

Judgment: Compliant

### Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of nursing notes and care plans for residents. There was evidence that residents were comprehensively assessed upon admission using a suite of evidence-based risk assessment tools to evaluate risks, including falls, pressure sore development, malnutrition, manual handling needs, and dependency levels. Care plans were developed based on these assessment tools. Care plans viewed by inspectors were person-centred and specific to that resident's needs. Care plans were reviewed at required intervals, and there was evidence of consultation with the resident and, where appropriate, their family during these reviews.

Judgment: Compliant

### Regulation 6: Health care

The health of residents was promoted through ongoing medical review and in-house physiotherapy services. Residents also had access to a range of community-based and outpatient healthcare providers, including chiropodists, opticians, speech and language therapists, dietitians, occupational therapists, tissue viability nurses, and palliative care services. The records reviewed showed evidence of ongoing referral and review by these healthcare services for the residents' benefit.

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

The provider had a training programme in place for staff to acquire up-to-date knowledge and skills appropriate to their role in responding to and managing challenging behaviour. Records reviewed found the provider had been rolling out this training to non-clinical staff grades who had day-to-day contact with residents, as required by the provider's induction, orientation, and supervision policy. There remained some gaps in this mandatory training, which are referenced under Regulation 16: Training and staff development.

Residents predisposed to episodes of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had care plans and other documentation to guide staff. Records reviewed found that behaviour observation charts, such as the Antecedent, Behaviour and Consequence charts, were also used to understand the behaviour. The reviewed documentation was person-centred and described the behaviours, potential triggers, and de-escalation techniques to guide staff in delivering safe care. Since the last inspection, the provider had sought specialist review for a number of residents with responsive behaviours by a nurse specialist working in the local gerontology services. Inspectors also observed that residents exhibiting responsive behaviours were supported compassionately and respectfully by staff.

The centre's restraint usage was in accordance with national policy published by the Department of Health. Environmental restrictions on movement in Shennick seen during the August 2025 inspection had ceased, as had the practice of using therapeutic holds.

Judgment: Compliant

## Regulation 8: Protection

Systems were in place to safeguard residents and protect them from abuse. Staff were subject to An Garda Siochana (police) vetting before commencing employment in the centre.

Safeguarding training was provided online and face-to-face to staff, and a safeguarding policy provided support and guidance in recognising and responding to allegations of abuse. There were some gaps in this mandatory training, which is referenced under Regulation 16: Training and staff development.

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

While the provider did not hold small amounts of cash in safekeeping for residents, it acted as a pension agent for 12 residents living in the centre. Records reviewed found that these pensions were paid into a separate residents' client account to safeguard residents' finances. The provider had a transparent system in place for recording lodgements and withdrawals of residents' personal monies from their accounts.

Judgment: Compliant

## Regulation 9: Residents' rights

The inspectors found that residents' rights were promoted in the centre. Staff were respectful and courteous towards residents. Residents' privacy and dignity were respected. The centre had regular Roman Catholic religious services on-site, which residents could attend if they wished. Residents had access to radio, television and newspapers throughout the centre. Residents could communicate freely, having access to telephones and internet services throughout the centre.

Residents also had facilities for occupation and recreation. Rosters reviewed confirmed that at least two activities staff were on duty daily, supporting residents with opportunities to participate in activities in accordance with their interests and capacities. A previous practice in which activity staff manned the reception desk in the evening was observed to have ceased.

Residents had the opportunity to be consulted about and to participate in the organisation of the designated centre through regular residents' meetings and completing residents' questionnaires. There were also meetings with family representatives and surveys of family members to ascertain their views on service improvement. Residents also had access to independent advocacy services.

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
<b>Capacity and capability</b>	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
<b>Quality and safety</b>	
Regulation 11: Visits	Compliant
Regulation 13: End of life	Compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

# Compliance Plan for Tara Winthrop Private Clinic OSV-0000183

Inspection ID: MON-0047996

Date of inspection: 27/11/2025

## 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 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <p>The registered provider assures the chief inspector that:</p> <ul style="list-style-type: none"> <li>• A full review of all staff mandatory training records has been completed to identify outstanding and overdue training.</li> <li>• A prioritised training schedule has been implemented to ensure 100% completion of Managing Behaviour that is Challenging, Safeguarding Vulnerable Persons, Fire Safety, Infection Prevention and Control.</li> <li>• A centralised training matrix will be updated weekly by Practice Development Nurse and reviewed by PIC.</li> <li>• Refresher training compliance will be included as a standing agenda item at weekly management meetings.</li> <li>• Robust measures are in place to ensure all residents have access to their call bells.</li> <li>• RGN/CNM/ADONs review this on a regular basis and carry out visual checks and in addition staff complete an electronic checklist in to confirm checks and any issues identified are rectified promptly.</li> </ul>	
Regulation 23: Governance and management	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 23: Governance and management:</p> <p>To ensure delivery of quality and safe service, the registered provider assures the chief inspector that:</p>	

- The Clinical Nurse managers and Assistant directors of nursing are present on the floor for enhanced clinical oversight and supervision by completing daily walkabouts to support and manage the team.
- The clinical team will oversee the infection control practices and ensure staff strictly adhere to IPC practices on the floor.
- Food and nutrition review has been completed and gaps identified have been actioned. The Clinical team supervise the dining rooms and mealtimes to ensure residents have access to food and fluids, condiments and the dining experience is pleasant, clean and enjoyable.
- A centralised training matrix will be updated weekly by Practice Development Nurse and reviewed by PIC.
- The secure storage of prescribed thickening agents was addressed, and measures were implemented on the day of the inspection. All staff are made aware of the safe location of these products and the importance of keeping them safe and secure.
- All residents who receive medications covertly have been assessed, the new assessment form has been updated with medications to be administered covertly, the indications for these medications, alternative measures taken and evidence of resident/nominated representative discussion in line with medication management policy.
- The complaints process has been reviewed by PIC and ROM. PIC reviews the complaints on a regular basis to ensure complaints are acknowledged, addressed and documented in line with the home's policy, and this will be discussed in the Clinical Governance Meeting monthly.

Regulation 34: Complaints procedure	Not Compliant
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Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

To ensure compliance with the complaints procedure, the registered provider assures the chief inspector that:

- All complaints are formally acknowledged and managed with evidence within the required time frames.
- Any complaint not resolved within the required timeframe will be escalated for review in accordance with the centre's policy.
- All open complaints are being reviewed weekly by the Person in Charge and the Regional Manager.
- Staff have been reminded that complaints must not be retained in email accounts and will be uploaded to the electronic system.

Regulation 17: Premises	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 17: Premises:</p> <p>The registered provider assures the chief inspector that:</p> <ul style="list-style-type: none"> <li>• A full review of lighting in all external courtyards and smoking areas has been completed, and an external contractor has been appointed to address the lighting. This was completed on the 15th of January 2026.</li> <li>• A review of the centre’s heating and ventilation systems has been completed, and adjustments to the heating controls have been made to ensure balanced temperature regulation.</li> <li>• The window handle of the identified bedroom has been replaced on the second day of inspection.</li> <li>• All equipment will be removed from assisted bathrooms and stored in designated storage areas.</li> <li>• Safe access to the courtyard has been restored.</li> <li>• Staff will be advised to minimise noise when using the lift adjacent to resident areas.</li> <li>• The maintenance of the door closure mechanism on the doors to the main kitchen and to Shenick has been reviewed and adjusted on the second day of inspection.</li> </ul>	
Regulation 18: Food and nutrition	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 18: Food and nutrition:</p> <p>To ensure compliance with food and nutrition, the registered provider assures the chief inspector that:</p> <ul style="list-style-type: none"> <li>• A full review of the evening menu will be completed in consultation with the dietitian to ensure meals are nutritionally balanced, meet residents’ dietary needs, and reduce reliance on foods high in saturated fat.</li> <li>• Portion sizes will be reviewed to ensure adequate for all residents, with flexibility to provide larger portions or second servings where requested.</li> <li>• Condiments (e.g. milk, sugar, sauces) are presented separately to residents wherever practicable, allowing them to choose according to preference.</li> <li>• Mealtime practices will be monitored regularly by the senior staff member to ensure resident choice is consistently respected.</li> </ul>	

Outline how you are going to come into compliance with Regulation 27: Infection control:

To ensure compliance with the infection prevention and control, the registered provider assures the chief inspector that:

- All staff have been reminded of correct decontamination and storage procedures, including the requirement that cleaned equipment is inverted and allowed to air-dry prior to storage.
- Sluice rooms have been organised in line with best IPC practice, reducing the risk of contamination.
- Jugs used for emptying urinary catheter bags were removed from communal toilet facilities immediately and stored in the designated area.
- All residents' equipment, including crash mats, will be inspected and cleaned in accordance with IPC cleaning schedules.
- A documented cleaning schedule for residents' equipment will be reviewed and reinforced with staff.
- Any equipment that cannot be adequately cleaned or ripped will be removed from use and replaced.
- All staff will complete IPC training, supporting safe and effective care delivery.

## 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.	Not Compliant	Orange	30/01/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	30/01/2026
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	30/01/2026
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	28/02/2026

	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	28/02/2026
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.	Substantially Compliant	Yellow	28/02/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Substantially Compliant	Yellow	28/02/2026
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	31/01/2026

Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is implemented in the designated centre, as required.	Substantially Compliant	Yellow	31/01/2026
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	30/01/2026
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	31/01/2026
Regulation 34(6)(a)	The registered provider shall	Substantially Compliant	Yellow	30/01/2026

	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.			
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