Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Leopardstown Care Centre
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Ballyogan Road, Dublin 18
Type of inspection:	Unannounced
Date of inspection:	25 August 2025
Centre ID:	OSV-0008692
Fieldwork ID:	MON-0047149

About the designated centre

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

Leopardstown care centre is situated in south county Dublin and is in close distance to a local shopping area. It is a purpose built facility that is currently registered for 101 beds but can accommodate 150 residents in the future. It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Care is provided for people with a range of needs: low, medium, high and maximum dependency. The registered provider is Mowlam Healthcare Services Unlimited. The person in charge of the centre works full time and is support by a senior management team and a team of healthcare professionals and care and support staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	127

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
Monday 25 August 2025	15:55hrs to 21:15hrs	Aisling Coffey	Lead
Wednesday 27 August 2025	07:20hrs to 16:00hrs	Aisling Coffey	Lead
Monday 25 August 2025	15:55hrs to 21:15hrs	Sharon Boyle	Support
Wednesday 27 August 2025	07:20hrs to 16:00hrs	Sharon Boyle	Support

What residents told us and what inspectors observed

The overall feedback from residents was that they were content living in Leopardstown Care Centre; however, several factors were negatively impacting their day-to-day lives in the centre, as outlined in this report.

Residents spoke in favourable terms about the kind and considerate staff that cared for them, with the staff being described as "very good", "very pleasant", and as "treating us very well". Inspectors similarly observed many compassionate, warm, dignified and respectful interactions with residents and their visitors throughout the two days of the inspection by staff and management. Some residents spoken with referred to staff being busy, leading to long wait times for assistance if they rang their call bell or made a request for food or other assistance.

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 two days later. During the inspection, the inspectors spoke with 36 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.

Leopardstown Care Centre is a purpose-built premises located in South County Dublin. The centre is a three-storey building and registered to accommodate 150 residents over the three floors. The ground floor and the first floor provide long-term residential care, with the first floor being designated a memory care unit. The second floor offers short-stay residential services, including rehabilitation, respite and convalescence care. Two passenger lifts facilitate travel between the floors.

Bedroom accommodation comprised 150 single-occupancy bedrooms with en-suite facilities, including a shower, toilet, and wash-hand basin. The size and layout of the bedroom accommodation were appropriate for residents' needs. Bedrooms had comfortable seating, and were personalised with items from home, such as family photographs and artwork. The bedrooms had a television, locked storage, and call-bell facilities. On the morning of the second inspection day, the inspectors reviewed call-bell access and found that some residents did not have access to their call-bell. These findings were brought to the attention of the person in charge, and the staff promptly rectified these matters. The person in charge noted that some of the call-bell clips, which would have secured the call-bell in position, were broken.

Internally, aspects of the centre's design and layout supported residents in moving throughout the floor on which they resided. There were wide corridors, sufficient handrails, furniture and comfortable seating in the various rest areas and communal areas.

In terms of outdoor space, the centre had two internal courtyard areas and a garden facing out into the community, located on the ground floor, as well as two outdoor terrace areas on the second floor. These areas were pleasantly landscaped and had outdoor furniture for residents and their visitors to use.

Overall, despite some decorative wear and tear noted in some bedrooms, the premises were well maintained internally and externally; however, aspects of the premises, such as keypad code locks and heavy doors, posed as restrictions to residents enjoying the amenities within the centre, including access to the outdoors. These matters are discussed further under Regulation 7 of the report. Additionally, inspectors observed that residents were smoking in the terrace areas on the second floor. While ashtrays were available, other safety equipment, such as call bells and smoking aprons, was not present. This was brought to the attention of the person in charge on the first day of inspection, and management had installed temporary protective measures by 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 five visitors. There was mixed satisfaction expressed by family members in relation to the quality of care provided to their relatives living in the centre. While there was high praise for the staff providing individual care, there was mixed feedback in relation to the quality and quantity of food and refreshments available, access to activities, opportunities to go outdoors, and aspects of environmental hygiene, including the cleanliness of residents' equipment, such as wheelchairs.

On the first evening of the inspection, the inspectors walked the premises. While it was a bright, warm evening, no residents used the ground-floor courtyards or garden area. The evening meal was served from 4:30pm, and inspectors found that residents expressed mixed feedback regarding the fish served that evening and meals served more broadly. While some residents were complimentary or expressed a neutral response when asked about the food, describing it as "adequate", "fine" and "ok"; the majority of residents strongly expressed their dissatisfaction with the quality of the food, portion sizes, choices available, timing of meals, how the food was cooked, and the nutritional value of meals received.

After this meal, residents were seen to sit for long periods in the day rooms, which were supervised by a staff member, with the television on. While some residents retired to their bedrooms to read, watch television, or host a visitor, many residents, particularly in the memory care unit on the first floor, were seen to sit for prolonged periods with no activation, except for the television. Inspectors also noted that some of the day rooms, for example, day room 1 on the first floor, had minimal therapeutic or sensory equipment for residents to engage with.

On the second inspection morning, there were delays in providing food and refreshments to some residents. The person in charge explained that there had been interruptions to public transport that morning, impacting staffing levels among care staff, housekeeping, and catering departments. The inspectors found that immediate actions were required to ensure the dietary needs of residents were met

on the second morning of the inspection. This is discussed further under Regulation 18: Food and nutrition.

Lunchtime on the second inspection day was observed to be a sociable and relaxed experience, with residents choosing to dine in the dining areas or in their bedrooms, aligned with their preferences. Meals were freshly prepared on-site in the centre's kitchen and overseen by the head chef. Residents confirmed they had been offered a choice of main meals.

In terms of activities seen, Mass was shown on television in the morning of the second inspection day. Six residents were supported to attend the local library. The hairdresser and a beauty therapist were present, and residents proudly displayed their new hairstyles and manicured nails. Similar to the first inspection evening, many residents were seen sitting for lengthy periods in the day rooms with the television on but without other stimulating activities or meaningful interaction from staff.

Residents and visitors had mixed views on the provision of activities. Some residents were complimentary, and there was high praise expressed for the live music, exercise programmes, and arts and crafts classes, such as dessert-making, flower arranging, and pottery classes. Some residents appreciated that Roman Catholic Mass was celebrated in the centre every week, as this was of importance to them. However, other residents told the inspectors that they were "bored" as there were insufficient activities geared towards their interests and capacities, or that they were not informed about, or supported to attend, activities taking place throughout the centre. Similar findings in respect of activities were seen in residents' and family questionnaires and in residents' committee meetings.

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.

Capacity and capability

This inspection found a need for significant improvement in the management and oversight of service delivery to residents. The decline in regulatory compliance since the previous inspection in February 2025, as detailed in this report, was impacting the quality and safety of care for residents.

This centre was first registered on 07 December 2023 by the Chief Inspector of Social Services to operate as a designated centre for older persons. The three inspections of 2024 identified poor governance and management structures resulting in poor oversight and poor care practices. There was an improvement in regulatory compliance found in February 2025, and the provider was permitted to

open an additional 49 beds in the centre following the submission of an application to vary condition one to the Chief Inspector, bringing occupancy from 101 to 150 residents. However, the findings from this inspection are that these improvements in regulatory compliance 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, residents ' rights and medicines and pharmaceutical services needed to be significantly enhanced.

This was an unannounced inspection to monitor ongoing compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended) and to review the registered provider's compliance plan arising from the previous inspection of 05 February 2025. The inspectors also followed up on unsolicited information that had been submitted to the Chief Inspector. This information was related to medication management, food and nutrition, activities and residents' access to the outdoors. 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.

While the provider had progressed with the compliance plan following the last inspection, and this inspection found improvements in regulatory compliance concerning the directory of residents, care planning and visits, this inspection also demonstrated deficits in the overall governance and management of the service, with new areas of non-compliance identified as set out in this report.

On the second morning of inspection, arrangements concerning food and nutrition were found to be ineffective. Consequently, an immediate action was issued to the provider to ensure that the dietary needs of residents were met. The provider's response was prompt and provided assurance that the immediate risk had been mitigated. This is discussed further under Regulation 18: Food and nutrition.

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

The person in charge oversees the daily running of the centre. The person in charge worked full-time in the centre and was supported in their management role by four assistant directors of nursing, six clinical nurse managers and a general services manager. Other staff members included nurses, healthcare assistants, activities coordinators, physiotherapists, occupational therapists, therapy assistants, medical staff, catering, housekeeping, maintenance and administration staff.

The provider had deputising arrangements in place whereby the assistant directors of nursing (ADONs) deputise for the person in charge; however, upon arrival at the centre, inspectors found that not all staff clearly understood these arrangements.

Since the last inspection, the provider had opened an additional 49 beds and had enhanced staffing levels by increasing the number of nursing staff and access to multi-disciplinary team services.

Notwithstanding these staffing enhancements, inspectors found the provider's whole-time-equivalent (WTE) staffing levels were not in line with the statement of purpose for which the centre is registered. These matters are discussed under Regulation 23: Governance and management and Regulation 16: Training and staff development within the report.

The registered provider had systems in place to monitor the quality and safety of care. Communication systems were in place between the persons participating in management and the person in charge in key areas, such as governance and regulatory compliance. The person in charge also prepared a monthly written report, an action register, for review by the persons participating in management, covering key issues.

Within the centre, the person in charge held a governance quality and safety meeting monthly with the heads of departments. On a day-to-day basis, further communication in relation to residents' care and wellbeing was facilitated through huddles and handovers. The inspectors observed a management clinical huddle facilitated by the person in charge and an end-of-shift handover meeting among staff. Notwithstanding these good practices, the inspectors found inconsistency in the staff communication systems. While regular staff meetings were taking place on the second floor, these meetings were not taking place on the ground or first floors in the centre. This is discussed under Regulation 23: Governance and management within the report.

The provider maintained a risk register to monitor known risks within the centre. Auditing of key aspects of service provision was occurring, for example, call bell response times, hand hygiene and medication management. Notwithstanding the presence of these oversight systems, 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.

The provider was progressing with the annual review of the quality and safety of care delivered to residents for 2024. The inspectors saw that the review had been discussed at the quality and safety meeting, and there was evidence of consultation with residents and families reflected in the review, as well as a quality improvement plan for 2025. However, the review document had not been finalised at the time of inspection and had not been made available to residents as required by the regulations.

In terms of staff training and development, records reviewed found a suite of mandatory training was available for nursing, healthcare assistant, activities and administrative staff in the centre, and this training was mostly up to date. The provider had dates booked to address any gaps in training within the week following the inspection. While acknowledging this good practice regarding training and staff development, further action was required to provide assurance in respect of all staff members being in compliance with mandatory training. Additionally, significant action was required to enhance the supervision of staff and ensure that the assessed needs of residents were adequately supported. These matters are discussed under Regulation 16: Training and staff development.

The provider displayed the complaints procedure prominently in the reception area and in other areas within the centre to ensure residents, staff, and families were aware of the procedure. The centre had an up-to-date complaints management policy. Information posters on advocacy services to support residents in making complaints were also displayed. The inspectors reviewed the records concerning several verbal and written complaints received. The inspectors found some gaps in complaints management practices when complaints were raised during residents' committee meetings, as outlined under Regulation 34: Complaints procedure.

Regulation 15: Staffing

The number and skill-mix of staff on the morning of the second inspection day required review, having regard to the needs of the residents, assessed in accordance with Regulation 5. Interruptions to public transport on the second morning of the inspection were seen to impact staffing levels for the breakfast service. The inspectors found that this had a direct impact on residents receiving food and refreshments in a timely manner which is discussed further under Regulation 18: Food and nutrition.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider's arrangements for staff supervision required improvement as the provider was not in compliance with the nursing management structures committed to the chief inspector, which impacted the person in charge's ability to supervise staff effectively, for example:

- The arrangements for staff supervision at night were not aligned with the provider's commitments made to the chief inspector on 17/11/2023, regarding the provision of two night supervisor staff at the clinical nurse

manager grade. Inspectors found that senior staff nurses were undertaking the night supervisor role.
- The provider had also committed to having five whole-time-equivalent (WTE) assistant directors of nursing (ADON) positions; however, one such role had not been filled by the provider.

Inspectors were not assured that all staff were appropriately supported and supervised to protect and promote the care and welfare of all residents. Several concerns identified by inspectors had not been escalated for resolution in a timely manner, for example:

- Inspectors found one of the exit doors in day room 2 on the ground floor, which was also a fire exit, to be out of order on the first inspection evening. This door could not be fully opened or closed that night. Staff were aware of the fault, but it had not been escalated to management as an urgent maintenance request.
- Inspectors found that the food and nutrition requirements of several residents had not been met on the second inspection morning. The delays in providing breakfast food and refreshments to residents were known to staff but were not escalated to the centre's management for urgent resolution.
- Medicinal products were not being administered in accordance with the directions of the prescriber to residents on the ground and first floors. These matters were known to staff but were not escalated to the centre's management for urgent resolution.
- Residents smoked on the second-floor terrace areas. While ashtrays were available, other safety equipment, such as call bells and fire aprons, was not present. Staff were aware of the residents smoking in these areas, but the lack of protective equipment for residents had not been escalated to the centre's management for urgent resolution.

Further assurances were required regarding staff compliance with mandatory training, including fire safety, managing behaviours that challenge, and safeguarding vulnerable adults from abuse. Training records for nurses, healthcare assistants and administration staff were provided; however, assurances were not provided in relation to other categories of staff, who were outsourced by the provider.

Staff are not aware of the legislation relevant to their roles and responsibilities. Copies of the Health Act 2007 (as amended), associated regulations, standards and other relevant guidance published by government, statutory agencies or professional bodies were not readily available to staff. The person in charge addressed this promptly on the second day of inspection.

Judgment: Not compliant

Regulation 19: Directory of residents

The provider had updated their paper-based directory of residents in the designated centre since the February 2025 inspection. This directory was seen to have recorded the information required under Schedule 3 of the regulations, including the resident's admission date, contact details for next of kin and general practitioner.

Judgment: Compliant

Regulation 22: Insurance

There was an appropriate contract of insurance in place that protected residents against injury and against other risks, including loss or damage to property.

Judgment: 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 a potential risk to residents' health and safety, immediate actions were issued to the provider on the second morning of the inspection with respect to ensuring residents had access to adequate food and hydration.
- The provider's auditing and oversight systems had not identified risks and deficits concerning staff supervision, medication management, call-bell access, residents' rights and complaints management, as found during this inspection.
- The provider's systems for ensuring effective communication among all staff regarding residents' care and safety, governance and oversight arrangements in the centre required review, to ensure all staff knew how and where to raise concerns.
- The number of unwitnessed falls had increased in the centre in the two months before the inspection. While acknowledging that tracking and trending of falls were occurring, these reviews did not explore the causal and contributory factors leading to the falls, to effectively identify deficits and risks in the service and increase resident safety.
- The oversight systems in place had not ensured that appropriate action was taken in response to resident feedback. A number of issues raised at residents' meetings were not managed as complaints.
- While there was documentary evidence that the provider was progressing with the annual review of the quality and safety of care delivered to residents

for 2024, the review document had not been progressed since the inspection in February 2025.

- The provider's staffing WTEs were not in line with those set out in the statement of purpose against which the provider was registered to operate. For example, the provider had committed to having five WTE ADON positions; however, one such role had not been filled.

Judgment: Not compliant

Regulation 34: Complaints procedure

While acknowledging good practices in adherence to complaints procedures, the inspectors found some gaps in complaints management practices when complaints were raised in resident committee meetings. For example, complaints raised by residents at the residents' committee meetings of 30/07/2025 and 27/05/2025 regarding inadequate support to attend activities, meat quality, food temperatures, timing of meals, food variety and environmental hygiene, particularly in dining areas, were not being recorded in the provider's electronic complaints system nor were they being managed in line with the provider's complaints policy.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

The policies required by Schedule 5 of the regulations were in place, updated in line with regulatory requirements and made available to staff in the centre.

Judgment: Compliant

Quality and safety

While the inspectors observed kind and compassionate staff and management 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, medication management and residents' rights. Other areas also requiring improvement included managing behaviour that is challenging.

Records reviewed found that restraints used in the centre were risk-assessed, and there was evidence that alternatives had been trialled. Notwithstanding these good practices, restrictions posed by keypad-coded locks and heavy doors continued to restrict residents' movement within the centre, including first-floor residents' access to the outdoors. These findings are discussed under Regulation 7: Managing behaviour that is challenging.

Staff were observed to be respectful and courteous towards residents. The centre had religious services available. Residents had access to radio, television, newspapers, telephones and internet services throughout the centre. Residents also had access to independent advocacy services. Notwithstanding these good practices, inspectors found that aspects of residents' rights were not upheld in the centre and improvements were required as discussed under Regulation 9: Residents' rights.

Regulation 10: Communication difficulties

Some residents in the centre had additional communication needs, such as sensory needs. These residents had their communication needs assessed and documented in their care plan. Staff were knowledgeable about the communication devices used by residents and ensured residents had access to these aids to enable effective communication and inclusion.

Judgment: Compliant

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 comfortable communal spaces, indoors and outdoors, for residents to host a visitor.

Judgment: Compliant

Regulation 18: Food and nutrition

The registered provider had not ensured that food and nutrition were delivered in accordance with regulatory requirements, as evidenced by the findings below.

Immediate concerns for residents' nutrition and hydration needs were identified on the second morning of the inspection:

- Residents did not have access to meals at reasonable times. Inspectors observed that multiple residents on the ground and first floors who chose to eat breakfast in their bedrooms had not been served breakfast by 09:45am, despite several residents having been awake from 07:30am.
- Residents did not have access to a safe supply of fresh drinking water at all times. Two residents who were being cared for in a day room did not have access to water, other fluids, or food for two hours after waking.

Given the potential risk to resident health and safety associated with these findings, immediate actions were issued to the provider on the second morning of the inspection regarding the nutrition and hydration needs of residents. The person in charge addressed these immediate issues promptly.

Inspectors were not assured that all residents were receiving adequate support and assistance at mealtimes. For example, the inspectors observed a resident who needed assistance at breakfast time on the second day of inspection was not receiving this support. This was immediately addressed during the inspection when the inspectors brought this to the attention of the nursing staff.

The inspectors were not assured that hot food was served at the appropriate temperature. Hot food, such as porridge, was being served to residents below the desired temperature when checked by catering staff in the presence of the inspectors.

Multiple residents spoken with over the course of the two-day inspection expressed their dissatisfaction with the quality of the food, portion sizes, choices available, timing of meals, how the food was cooked, and the nutritional value of meals received. Similar concerns were recorded in the minutes of resident committee meetings and noted in residents' and family surveys.

Judgment: Not compliant

Regulation 27: Infection control

The provider had processes to manage and oversee infection prevention and control (IPC) practices within the centre. Surveillance was conducted for healthcare-acquired infections and antibiotic usage. Nursing, healthcare assistant, activities and administrative staff had completed IPC training. Assurances required in respect of other categories of staff having completed this training are discussed under Regulation 16: Training and staff development. The provider was due to train a staff member to take on the infection prevention and control link practitioner role.

The centre was experiencing an outbreak of COVID-19 during this inspection period. The provider had an outbreak preparedness plan in place, based on national

guidance in relation to infection control and outbreak management. The provider was seen to be implementing this plan and following advice received from the Department of Public Health. There were readily available supplies of personal protective equipment (PPE) for visitors and staff. The person in charge had completed a review following a recent COVID-19 outbreak. Within the review, relevant protocols and guidance were documented as having been adhered to, and learning was identified in the event of a future outbreak.

The centre's interior was observed to be very clean on the two days of inspection. The provider had increased cleaning hours during the inspection period due to the outbreak of COVID-19.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

Inspectors were not assured that medication practices were in line with the safe administration of medicines professional guidance as evidenced by the findings below.

Inspectors found that medicinal products were not being administered in accordance with the directions of the prescriber.

- Records reviewed found three residents had not been administered the correct dosages of medications at prescribed intervals, for example:
    - One resident missed four doses of one prescribed medication.
    - One resident did not receive their medication to treat an infection for two days after it was prescribed.
    - One resident had their first dose of a medication and then missed three doses.

- Records reviewed found that some medications were administered in a crushed format without a prescription for crushed medicines signed by a doctor.

The storage of medicinal products required review as prescribed oral nutritional supplements were observed to be accessible within the first and second floor dining rooms, in day room 2 on the first floor and residents' bedrooms over the course of the inspection. These findings were brought to the attention of the person in charge, who arranged for them to be stored securely.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

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

Judgment: Compliant

Regulation 6: Health care

Residents had access to a doctor of their choice. Residents who required specialist medical treatment or other healthcare services, such as speech and language therapy, tissue viability nursing, dietetics, and physiotherapy, were supported to access these 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

Restrictions posed by keypad-coded locks and heavy doors were overly restrictive and did not reflect national policy guidance. For example:

- The doors leading to the lifts on the ground and first floors were keypad-controlled. During the two inspection days, inspectors noted that the keypad code was not displayed for residents who wished to attend social activities on another floor or watch the comings and goings in the entrance foyer.
- Inspectors observed that one of the two doors to access terrace 1, the door opposite bedroom 218, had a magnetic lock requiring a keypad code to access the terrace area.
- The inspectors reviewed a sample of doors leading to secure courtyard garden areas within the centre. Inspectors found that a sample of these doors, for example, the door to courtyard A on the ground floor opposite bedroom 14, was very heavy and could not be easily opened to facilitate residents accessing these secure outdoor areas independently.
- Inspectors found the doors to the dining areas were closed during mealtimes. While acknowledging the provider's intention to respect protected mealtimes

and enhance residents' dignity, inspectors observed residents using wheelchairs and mobility aids, who were unable to access the dining rooms as they could not independently open the doors.

Inspectors were not assured that first-floor residents had access to the outdoors, aligned with their wishes, as evidenced below.

- While residents of the ground and second floors had access to secure outdoor areas on these floors, residents on the first floor, the memory care unit, were restricted from freely accessing outdoor spaces. Residents of the first floor who wished to go outdoors had to wait for a staff member to be available to bring them to the ground or second floors to access the outside spaces. This is a repeat finding from the February 2025 inspection report.
- Inspectors sought evidence, as referenced in the compliance plan following the February 2025 inspection report, that first-floor residents were being given access to outdoor spaces as often as they wished; however, this evidence was not available.

On the second inspection day, management of the centre provided a written plan to review and risk assess the removal of keypad-coded locks to the ground and first-floor units.

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.

- On the morning of the second inspection day, the inspectors found that several residents did not have access to their call bell, meaning they were unable to call for assistance if required. The call bells were seen to be out of the resident's reach, for example, in the holder some distance from the bed, on the floor or under a chair.
- The 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, for example:
    - While group-based activities were observed on the second inspection day, residents were also seen sitting for lengthy periods over the two inspection days, in the day and dining rooms, with the television on but without other meaningful activation. Inspectors reviewed the activity schedule displayed and noted that, although activities were scheduled daily, there was an over-reliance on the television, as a form of activation, with each weekend afternoon featuring movies and most evenings consisting of television-based entertainment, for example,

Monday evening's "sounds of jazz", was music played on the television in the dining room.
    - Some residents and families informed the inspectors that they were unaware of activities taking place in different units within the centre and had not been supported to attend.
- The provider's facilities for occupation and recreation required review, as some day rooms, including day room 1 on the first floor, were observed to have minimal therapeutic or sensory equipment for residents to engage with.
- The privacy of residents on the first and second floors was not upheld as inspectors were able to view into a sample of these bedrooms from the surrounding car park on the first evening of the inspection. This is a repeat finding from the February 2025 inspection report.
- The provider's response to resident feedback was not sufficiently robust to uphold residents' rights. While residents committee meetings were taking place regularly, records reviewed for the meetings of 27/05/2025 and 30/07/2025 found repeated concerns regarding food and activities were raised without a time-bound action plan to address these concerns. For example, residents expressed their dissatisfaction that lunch and tea time meals had been brought forward to 12:30pm and 4:30pm, when they had been 1:00pm and 5:00pm. While the provider had engaged with the catering department about this matter, the timing of the tea time meal had not been moved back to 5:00pm, as requested by residents.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 18: Food and nutrition	Not compliant
Regulation 27: Infection control	Compliant
Regulation 29: Medicines and pharmaceutical services	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Leopardstown Care Centre OSV-0008692

Inspection ID: MON-0047149

Date of inspection: 27/08/2025

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: • The Person in Charge (PIC) will ensure that there are always appropriate staffing levels available to ensure the safe and effective operation of the centre and to ensure that residents; care needs are met. • The PIC will complete a risk assessment and add it to the centre's Risk Register in relation to the contingency planning for the management of unanticipated staff shortages at late notice. This contingency plan will focus on the need to prioritise resident care at all times. This will include information on immediate actions to take in the event of an unanticipated significant staff shortage (for example, if several staff were unavailable at the same time) which could result in a negative impact on residents' care, including members of the management team participating in direct care as required. • The PIC will ensure that nurses are aware of the appropriate escalation procedures in relation to staff shortages so that the contingency plan can be implemented without delay. • The PIC and Assistant Director of Nursing (ADON) will review any staff shortages to ensure that they identify risks and assign staff allocation appropriately throughout the centre whilst awaiting contingency cover arrangements to be put in place. • In the event of staff shortage, every effort will be made to provide replacement staff to ensure that there are sufficient staff numbers in place to ensure that all residents' care needs can be met. This will include booking of agency staff if it is not possible to fill the vacant shift from the centre's own staffing resources.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:

• The PIC will review the current supervision arrangements in the centre and will ensure that all members of the management team are focused on the leadership and supervision of the centre, providing strong oversight and supervising staff to ensure that the assessed care needs of residents are consistently and effectively being met.

• Night time supervision will be provided by Night Supervisor CNMs.

• The staffing structure in the centre has been reviewed since the registration of the additional beds on the second floor. To support the PIC, there is a designated fully supernumerary ADON on each floor for clinical and operational leadership and oversight; there is also a supernumerary CNM on each 25-bed unit (2 CNMs per floor), plus a CNM Night Supervisor in charge every night. We revised our original intention to have 2 Patient Flow ADONs and instead we have recruited a Patient Flow CNM to support the Patient Flow ADON. The Patient Flow team are focused on assessing referrals and supporting discharge planning, which is working very well for all referrals to the centre In addition, we have recruited a Social Worker for the therapy support team. The Statement of Purpose has been revised and updated to reflect these changes which will demonstrate a robust management structure for the centre.

• The mandatory training of all staff has been further enhanced with the introduction of the Mowlam Healthcare Online Academy. This will allow staff to complete online mandatory training courses, many of which are further enhanced by the provision of on-site tutor led training.

• The PIC will ensure that Fire safety induction training is completed on commencement for all new staff.

• As well as the training available on the Mowlam Healthcare Online Academy, on-site training workshops have been scheduled to deliver further training on managing behaviours that challenge and safeguarding vulnerable adults from abuse.

• In respect of the staff provided by outsourced service providers, training records are available on a shared drive to allow the PIC and General Service Manager (GSM) to monitor the completion of mandatory training. These staff are facilitated to complete their mandatory training along with the centre's own employees.

• The PIC will ensure that staff are aware that there are opportunities to escalate any issues of concern in relation to residents' health and safety, staffing or premises concerns to the management team at daily handovers, safety pauses and by electronic communication records. Daily walkarounds are conducted by the PIC and GSM and issues can be reported directly.

• A collaborative Quality Improvement Plan has been developed with the outsourced catering provider to address the issues identified in relation to food and nutrition. Clinical and catering oversight of mealtimes and food service has been revised and program of the dining experience audits has been commenced. The PIC and GSM will ensure that there is a seamless working relationship between the catering service who are responsible for the production aspects, and the clinical team who are responsible for the service of food. Catering and cre teams will collaborate effectively to ensure that the residents enjoy nutritious meals serviced at the appropriate temperature in a timely manner to ensure that they can enjoy an unhurried social occasion at mealtimes.

• There is a designated smoking area identified in the centre. Residents who wish to smoke will be guided to the designated area. The PIC will ensure that signage advising residents of the location of the designated area will be erected. Staff have been advised that residents who choose to smoke should be directed to the designated smoking area.

The PIC will ensure that the appropriate safety equipment, such as call bells and fire aprons, are in place and ashtrays will be removed from all areas other than the designated smoking area. The PIC will provide 'NO Smoking' signs on areas such as balconies where residents have been smoking as a reminder that these are not designated smoking areas.
• Copies of the Health Act 2007 (as amended), associated regulations, standards and other relevant guidance published by government, statutory agencies or professional bodies, are now in place on each floor and are readily available and accessible to staff.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC has put in place measures to ensure that there is consistent and effective communication within the team in the Centre. This includes:
• the introduction of link nurses on each unit. These nurses will be responsible for holding monthly meetings and feeding back to the management team regarding aspects of care such as IPC, skin integrity etc.
• change of daily management meetings – the timing of these has been amended to ensure that ADONs and Clinical Nurse Managers (CNM) are focused on being available in the resident areas, overseeing and supervising staff to ensure that the assessed care needs of residents are being met consistently and effectively.
• increased staff awareness in relation to communicating and escalation of issues.
• The PIC will ensure that there is effective and consistent supervision and oversight of staff providing care in the centre; the PIC, ADONs and CNMs have increased their visibility and presence on the floor and are more accessible to residents and staff which will improve oversight, supervision, and communication.
• The management team have revised their daily workflow, to ensure that all members of the management team are monitoring practice and care delivery on each unit.
• The PIC will ensure that nighttime supervision is provided by a Night Supervisor CNM.
• The PIC completes a weekly KPI report that is accessible to the senior management team including the PPIMs.
• There is a monthly Quality & Safety management meeting attended by a member from each discipline in the centre, the HCM, following which an action register is developed. This is available to all members of the management team, the Healthcare Manager, Executive Team and the Board.
• There is a schedule of audits in place, and on completion of audits, action plans are developed to address any deficits identified. The PIC will ensure that all staff conducting audits are doing so correctly.
• As part of the staff supervision process, all nurses will be required to attend a monthly reflective practice review with the PIC/ADON. This review provides an opportunity for nurses and PIC/ADON to identify progress, learning needs or other development areas and agree a development pathway for the nurses on an individual basis.

• The Annual Review for 2024 was completed and has been shared with staff and residents.
• The findings in relation to food and nutrition have been addressed by the PIC, HCM and the outsourced catering service provider. A collaborative Quality Improvement Plan has been developed in collaboration with the outsourced catering service provider to address the issues identified in relation to food and nutrition. Clinical and catering oversight of mealtimes and food service has been revised and a program of dining experience audits has commenced. The PIC will ensure that there is strong cohesion between the catering and care teams so that food is served to residents promptly and in line with their expressed preferences.
• Multidisciplinary medication management review meetings have taken place with the pharmacy provider on-site with agreed action plans developed to ensure safe ordering, dispensing, storage and administration of medicinal products and an effective improvement plan has been implemented.
• The PIC will ensure that residents' rights will always be upheld and prioritised, including access to call bells, provision of scheduled activities, privacy and dignity, and a quality improvement plan has been developed to address the issues identified during the inspection. The PIC will ensure that this QIP is reviewed, updated and made available to staff.
• A quality improvement plan is in place to address the findings in relation to the management of complaints, including the screening of resident feedback, minutes of meetings etc. The PIC has scheduled a workshop on Safeguarding that will include complaints management, staff will receive training in recognizing, escalating and responding to complaints. The PIC/ADON will ensure that staff record all resident dissatisfaction in the electronic complaints log and follow the correct procedures to ensure resident complaints are resolved to their satisfaction.
• The staffing structure in the Centre has been reviewed since the registration of the additional beds on the second floor. The PIC is supported by 4 ADONs, including 1 Patient Flow ADON and there is a designated ADON on each floor to provide consistent leadership and oversight; there are 9 CNMs which include 1 Patient Flow CNM, 1 CNM per 25-bed unit (2 CNMs for each floor) and 2 CNM Night Supervisors. We have appointed a Medical Social Worker to the therapy support team. The Statement of Purpose will be revised and updated to reflect these developments. The appointment of a CNM to support the Patient Flow ADON has been a positive enhancement and they are focused on assessing referrals and supporting discharge planning.
• The falls prevention and management protocol in the centre has been reviewed and a plan developed to include a review of the root cause analysis and contributory factors associated with falls at the monthly Falls Prevention Committee meeting. The PIC will ensure that falls resulting in a serious injury will be referred to the Senior Incident Management Team along with a learning outcome / quality improvement plan, this will assist to ensure that actions are in place to minimize the risks and recurrence of falls.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The PIC has scheduled a workshop on Safeguarding that will include complaints management, staff will receive training in recognizing and responding to complaints. The PIC/ADON will ensure that staff are aware of what constitutes a complaint and the need to record all resident dissatisfaction in the electronic complaints log and follow the correct procedures to ensure resident complaints are resolved to their satisfaction.
• The management team will screen all records of resident feedback, including minutes of resident meetings, to ensure that all complaints are identified, logged and addressed in line with Company policy.

Regulation 18: Food and nutrition	Not Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• An action plan has been put in place collaboratively with the catering service provider to ensure that hot food is served at the appropriate temperature. The issue during breakfast service has been assessed and to resolve the issues identified, a food service/station trolley has been introduced, a heated container for porridge and a toaster for hot freshly prepared toast will be available at the point of service. This has been risk assessed and will ensure that there is a selection of choice and the temperature of foods being delivered to residents who prefer to dine in their own rooms is appropriate.
• The PIC will ensure that the service to residents will ensure that they have access to adequate food and fluids.
• The PIC, in collaboration with the catering service provider, will ensure that there is a quality improvement plan in place in respect of the feedback around the issues identified in relation to food and nutrition. A review of the issues around the quality of the food, portion sizes, choices available and the nutritional value of meals has been completed and addressed. The PIC will monitor the food service and residents will be asked to complete satisfaction surveys around the food/dining services periodically.
• The chef manager on-site works in a supernumerary capacity to provide oversight of the catering service and the food being served to residents.
• A review of mealtimes will take place based on residents' feedback and adjustments have been made in accordance with residents' preferences.
• A dining experience audit tool will be completed by the management team in the centre. A quality improvement plan will be developed in response to identified deficits.
• The PIC will complete a review of the minutes of resident meetings and ensure that any negative feedback received from residents will be logged as complaints, investigated, addressed and resolved to the residents' satisfaction.

Regulation 29: Medicines and pharmaceutical services	Not Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

• A communication review will be undertaken to ensure that the information shared at handovers is used effectively to maintain continuity in respect of resident prescriptions.

• The PIC, along with the ADON on each floor, will ensure that there is no delay to commencement of treatment e.g. there is an adequate stock of commonly used and emergency medications held on site and will ensure that the nurses are aware of the stock items so that they can inform the prescriber what medications are available on-site as required.

• The PIC will ensure that there is effective monitoring of the storage of medicinal products. The PIC, ADONs and CNMs will conduct walkarounds to check and ensure that medication management practices are compliant.

• Multidisciplinary medication management review meetings have taken place with the pharmacy provider on-site with agreed action plans developed to mitigate against delays in commencement of prescribed medication treatment regimens. The meetings have included representatives from the pharmacy, the GP, the resident medical officer and the centre management team and an effective improvement plan has been implemented.

• The PIC, ADONs, and CNMs will oversee the use and storage of nutritional supplements and continue to monitor that these are stored in accordance with policy, prescribed and administered as required.

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:

• Access throughout the centre will be reviewed. This will include a review of keypad access controls and disability access. A survey will be completed to determine the most appropriate way of enhancing access throughout the centre and access to outside space e.g. the removal of keypad controls in all relevant areas, automatic door opening devices, to allow residents to move freely without restrictions throughout the centre whilst maintaining security.

• A keypad-controlled access point will be installed at the exit door in the main foyer, which will enable residents to have unrestricted access around the centre whilst maintaining security at the main entrance to the building.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will ensure that all residents have access to a call bell, this will be monitored as part of daily walkabout.
• The PIC will ensure that call bell audits will be completed to ensure that residents who require assistance are attended to in a timely manner.
• The program of activities will be reviewed and further developed to ensure that residents have access to a range of activities that are in keeping with their choices and preferences.
• The electronic activities support application (Altra) available in the centre will be used to supplement the activities provision and facilitate electronic communication between residents and their families.
• The therapeutic and sensory equipment available in the centre will be made more accessible to residents and spaces developed to allow residents to have a more meaningful engagement in line with their needs, interests, and capabilities.
• A premises survey will be conducted to look at how we can best address the issue of privacy in the rooms on the first and second floor. At present there are voile panels in each room and curtains that can be closed. The introduction of any additional screening may compromise the amount of daylight coming into the centre and this will require a risk assessment to determine the best solution.

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	31/01/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/12/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/11/2025
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Substantially Compliant	Yellow	31/10/2025

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.	Not Compliant	Orange	31/10/2025
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.	Substantially Compliant	Yellow	31/10/2025
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	31/10/2025
Regulation 18(2)	The person in charge shall provide meals, refreshments and snacks at all reasonable times.	Substantially Compliant	Yellow	31/10/2025
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.	Substantially Compliant	Yellow	31/10/2025
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre	Not Compliant	Orange	31/10/2025

	has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.			
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 23(1)(g)	The registered provider shall ensure that a copy of the review referred to in subparagraph (e) is made available to residents and, if requested, to the Chief Inspector.	Not Compliant	Orange	31/10/2025
Regulation 23(2)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Not Compliant	Orange	31/10/2025
Regulation 29(4)	The person in charge shall ensure that all medicinal products dispensed or supplied to a	Substantially Compliant	Yellow	31/10/2025

	resident are stored securely at the centre.			
Regulation 29(5)	The person in charge shall ensure that all medicinal products are administered in accordance with the directions of the prescriber of the resident concerned and in accordance with any advice provided by that resident's pharmacist regarding the appropriate use of the product.	Not Compliant	Orange	31/10/2025
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	30/11/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only	Substantially Compliant	Yellow	31/01/2026

	used in accordance with national policy as published on the website of the Department of Health from time to time.			
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/11/2025
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	31/10/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	31/10/2025
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	31/01/2025
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure	Not Compliant	Orange	31/10/2025

	that a resident may be consulted about and participate in the organisation of the designated centre concerned.			