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:	Beechfield Manor Nursing Home
Name of provider:	Beechfield Manor Nursing Home Limited
Address of centre:	Shanganagh Road, Shankill, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	06 August 2025
Centre ID:	OSV-0000013
Fieldwork ID:	MON-0047782

About the designated centre

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

Beechfield Manor Nursing Home is a purpose built nursing home located in Shanganagh Road, Shankill Co. Dublin. It is registered to provide accommodation for 69 residents in 67 single and one double bedrooms. Each room is fully decorated and furnished. Residents are encouraged to bring personal belongings and small items of furniture where appropriate. The majority of the rooms have en suite facilities. Professional nursing care is provided to residents 24 hours a day by our dedicated team of qualified registered nurses, headed by our Director of Nursing and supported by Assistant Director of Nursing, two Clinical Nurse Managers, qualified staff nurses and experienced carers, with additional input from catering, housekeeping and laundry staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	63

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 6 August 2025	08:35hrs to 17:30hrs	Mary Veale	Lead
Wednesday 6 August 2025	08:35hrs to 17:30hrs	Aisling Coffey	Support

What residents told us and what inspectors observed

The overall feedback from all residents who spoke with the inspectors was that they were content living in Beechfield Manor Nursing Home; however, a number of factors were negatively impacting their day-to-day lives in the centre, as outlined in this report. Overall, the residents spoken with were complimentary of the staff and the care they received. One resident informed the inspectors that the staff were "as good as you'd get anywhere," while another resident told the inspectors ", the staff can be great." While there was complimentary feedback, two residents informed the inspector of improvements they would like to see in the centre, specifically regarding call bell response times, personal care, and moving and handling practices. These matters were referred to the person in charge.

Two inspectors of social services carried out this unannounced inspection over one day. The inspectors spoke with nine residents, staff, and four visitors to gain insight into the residents' lived experiences in the centre. The inspectors also observed the environment, interactions between residents and staff, and reviewed various documentation.

Beechfield Manor Nursing Home comprises a period house with a purpose-built extension, located in Shankill, Co. Dublin. Resident accommodation within the centre is set out over three floors. The centre is accessed through the ground-floor entrance lobby of the period house and includes a lower ground floor and a first floor. Two passenger lifts facilitate travel between the three floors.

Bedroom accommodation comprises 67 single-occupancy bedrooms and one twin-occupancy bedroom. The inspectors saw that 20 bedrooms had an en-suite shower, toilet, and wash-hand basin, while 41 bedrooms had an en-suite toilet and wash-hand basin. The remaining seven bedrooms shared communal bathroom facilities. 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. It was noted that one bedroom did not have a hand-wash basin present. The provider had a plan to install this sink by 31/08/2025.

Residents had access to several communal areas, including a large dining room and a sitting room on the lower ground floor, two sitting rooms and a visitor's area on the ground floor, and a sitting room on the first floor. Some residents were also observed sitting in smaller seating areas near the nurse's station on certain floors, watching the comings and goings.

On the day of inspection, the lower ground-floor activity room, which was registered as residents' communal space, was being used inappropriately for storage. The inspectors observed a catering fridge, two hot trolleys for food storage and meal

tray trolleys being stored in this area. This was a repeat finding from the June 2025 inspection.

There was an on-site laundry service located on the lower ground floor where residents' personal clothing, towels and bed linen were laundered. Inspectors observed that the door to the laundry had been repaired since the previous inspection. As inspectors walked the premises, it was noted that fire safety concerns, such as doors being propped open and hoist batteries charging in the corridors, had been addressed. Inspectors also spoke with contractors on-site, who confirmed they were upgrading some fire doors within the centre.

In terms of outdoor space, there were two enclosed terrace areas: one located at ground-floor level and the other accessible from the lower ground-floor dining area and lobby.

Residents could receive visitors in the centre within communal areas or in the privacy of their bedrooms. Multiple families and friends were observed visiting their loved ones during the inspection day. Visitors whom the inspectors spoke with, expressed their overall satisfaction with the quality of care provided to their relatives living in the centre and the communication between staff and families.

On the morning of the inspection, inspectors noted a relaxed and unhurried atmosphere in the centre upon arrival. The majority of residents were in bed or their bedrooms at 08:40am, while breakfast was being served to their rooms. Later in the morning, residents were seen dressed in their preferred attire and appeared content. There was Mass broadcast on the television in the late morning, followed by refreshments at 11:15am. These refreshments were followed by activities in the ground-floor sitting room adjacent to the treatment room. Activities observed throughout the day included one-to-one nail manicures, ball games, exercises, and newspaper reading. The hairdresser was present in the morning, and residents proudly displayed their new hairstyles. Two external staff members, were also on-site in the late morning, providing holistic and relaxation therapies to residents, including sensory oils and poetry. The activities schedule referred to activities taking place on the ground floor and the first-floor sitting rooms; however, no activities were observed to take place in the first-floor sitting room. Instead, there was music broadcast on the television for a small number of residents who chose to sit in this area.

Lunchtime was a sociable and relaxed experience, with residents choosing to dine in the lower-ground-floor dining room or their bedrooms, according to their preferences. A three-course meal of soup, a main course and a dessert was freshly prepared on-site in the centre's kitchen and served to residents. A menu was displayed outside the dining room, and residents confirmed that they were offered a choice of main meals. The food served appeared nutritious and appetising. There were ample drinks available for residents at mealtimes and throughout the day. Staff were observed providing discreet and respectful assistance to several residents who required this support during breakfast and dinner times. The majority of residents spoke positively to the inspectors about the food quality, quantity, and

variety, with a minority expressing a neutral response, such as "it's up and down," when asked about the food.

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

Capacity and capability

While this inspection found some improvements in the management systems since the previous inspection on 03 June 2025, further significant focus was required to improve the management and oversight of service delivery to residents in the centre, as the provider worked towards improved regulatory compliance.

This unannounced inspection was carried out by inspectors of social services to:

- Monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulation 2013 (as amended).
- Review monitoring notifications submitted by the provider to the Office of the Chief Inspector regarding the safeguarding and protection of residents.
- Review unsolicited information received by the Office of the Chief Inspector since June 2025.
- Follow up on the actions taken by the registered provider to address the non-compliance findings identified during the previous inspection in June 2025.
- Follow up on the written representation submitted by the provider regarding the proposed decision to attach a condition to the registration of the designated centre.
- This information was used to support the development of lines of enquiry for this inspection.

Following the June 2025 inspection, a warning meeting was held with the provider to discuss the inspection's findings, the governance structure within the centre, and a proposal to attach a condition to the registration of Beechfield Manor Nursing Home.

The findings of this inspection were that the provider had made some improvements and was progressing their compliance plan submitted following the previous inspection of the centre. However, there were repeated findings of non-compliance found on this inspection in a number of regulations, including governance and management, protection, residents' rights and the management of behaviour that is challenging, as set out in this report.

Inspectors reviewed unsolicited information received by the Chief Inspector. The information received pertained to concerns regarding the governance and

management of the centre, the organisation and management of the staffing resources, safeguarding, residents' rights, and delays in care provided to residents. This information was substantiated on this inspection.

The registered provider for Beechfield Manor Nursing Home is Beechfield Manor Nursing Home Limited. This company has two directors. One of the directors is the group director of operations and represents the provider in regulatory matters. The centre is part of the Beechfield Care Group, which operates eight centres.

The person in charge (PIC) worked full-time, was responsible for the centre's day-to-day operations, and reported to the group quality and clinical practice lead. At the time of inspection, the person in charge was on planned leave and the assistant director of nursing (ADON) was deputising in their absence. The person in charge was supported in their management of the centre by the recently recruited ADON, who had commenced in the role some weeks before this inspection. The person in charge was also supported by two clinical nurse managers, a team of staff nurses, senior healthcare assistants, healthcare assistants, activities, administration, catering, household, and maintenance staff.

An unstable organisational structure and ineffective management systems for monitoring and oversight continued to impact the quality and safety of care provided to residents. Since an inspection in February 2025, several changes have been made to the centre's governance and management. The centre has undergone a change in PIC, ADON and two persons participating in management. During this inspection, the inspectors were informed of current and forthcoming changes to personnel within the two clinical nurse manager (CNM) grades.

The inspectors reviewed the provider's staffing levels. While staffing levels were appropriate on the day of inspection, and records reviewed found that call bell response times had improved, a review of the number and skill mix of staff was required. From a review of previously worked rosters and based on the information provided by residents and staff to the inspectors, it was evident that nursing and healthcare assistant staffing levels were not consistently maintained. The management of staff absenteeism and vacant staff posts, as well as the management of break times to cover staff providing one-to-one care, was impacting the timely delivery of care, including social care, to residents. These matters are further discussed under Regulation 15: Staffing, Regulation 16: Training and staff development and Regulation 23: Governance and management.

The provider's staff training records were reviewed. Following the June 2025 inspection, staff had completed training in care planning and communication, as well as in-house presentations on topics such as enhancing the residents' dining experience, falls prevention, and infection prevention and control. A suite of mandatory training was available to all staff in the centre, and training was mostly up to date. There was a high level of staff attendance at training in areas such as safeguarding, fire safety, manual handling, and infection prevention and control. The staff members with whom the inspectors spoke were knowledgeable about safeguarding procedures. Although staff were not observed taking their breaks in the residents' communal rooms on this inspection day, other arrangements in place

to supervise and support staff were ineffective. For example, the supervision of incident documentation records was inadequate, failing to ensure accurate reporting of adverse events. This is discussed further in this report under Regulation 16: Training and staff development.

The management structure within the centre was new and emerging. Additional education, guidance and support had been provided by the group quality and care manager and an ADON from another of the group's centres since the June 2025 inspection. Notwithstanding this support, the inspectors found evidence of a lack of clarity regarding roles and responsibilities among staff, and inconsistencies in the information provided to staff in the centre.

There were communication systems in place between the registered provider and management within the centre, as well as between the person in charge and staff working in the centre. Records of clinical governance meetings that had taken place since the previous inspection were reviewed during this inspection. Records of staff meetings were not available on the day of inspection, but were submitted following the inspection. Governance and staff meetings took place monthly. The person in charge also completed a weekly key performance indicator (KPI) report, which was discussed with the group quality and clinical practice lead. Notwithstanding these good practices, further robust oversight was needed to safeguard residents and improve regulatory compliance, as the provider's oversight arrangements had not always been effective at identifying or addressing risks, including a high rate of staff unplanned absence and staff turnover within the centre. These matters are discussed under Regulation 23: Governance and management.

There was a record of accidents and incidents that took place in the centre. Most notifications were submitted to the Chief Inspector as required. However, two notifications had not been submitted. These notifications were submitted retrospectively. This is discussed further in this report under Regulation 31.

Regulation 15: Staffing

While inspectors observed sufficient numbers of staff on duty on the day of the inspection, a review of staff rosters and feedback from residents and staff found that there were times when the centre did not have adequate staff on duty, considering its size and layout, as well as the assessed needs of residents. For example:

- Some residents reported delays in call bell response times during day and night duty shift handover.
- Three residents in the centre required one-to-one supervision on a daily basis. Two residents required 24-hour supervision, and one resident required 12-hour supervision. When these staff members took meal breaks, the staff providing coverage were sourced from the remaining complement of staff,

which reduced the staffing levels for the remaining residents during staff meal breaks.

Reduced staffing levels during break times can negatively impact the residents' care needs, potentially leading to delays in medication administration, increased wait times for assistance, and a higher risk of errors. This can decrease resident safety and satisfaction.

Judgment: Substantially compliant

Regulation 16: Training and staff development

While acknowledging that staff had access to a suite of training programmes to enable them to perform their respective roles, further action was required to ensure staff were appropriately supported and supervised at all times, for example;

- Absenteeism was impacting the ability of the CNMs to supervise staff in a supernumerary capacity. Based on a review of the rosters and the information provided to the inspectors on the inspection day, CNMs were covering for nurse absences and filling vacancies. When CNMs are not working in a supernumerary capacity, it can negatively impact residents' care by reducing their availability to direct resident assessment and treatment, oversee staff interactions with residents, mentor staff, and oversee the quality of care provided to residents.
- The registered provider had failed to ensure that effective supervision was in place to ensure the accurate reporting of incidents. Inaccuracies in the incident recording were confirmed by the provider on the day of the inspection.
- Action was required in the supervision of the centre's audit process to ensure key areas of risk were being audited and that staff could access the provider's auditing system. This matter is discussed further under Regulation 23: Governance and Management.

Judgment: Substantially compliant

Regulation 23: Governance and management

At the time of the centre's registration renewal in June 2024, the registered provider, Beechfield Manor Nursing Home Limited, had committed to providing specific staffing whole-time equivalent (WTE) resources, as outlined in the statement of purpose against which the provider was registered to operate, to ensure safe care for residents. While staffing levels were appropriate to meet residents' needs on the inspection day, the staff resources available within nursing,

healthcare assistant, and housekeeping roles were not in line with the statement of purpose, as evidenced by the reviewed rosters. For example:

- The provider was registered to have 12 WTE nursing staff, but there were 2 WTE nursing posts vacant at the time of inspection.
- The provider was registered to have 33.5 WTE healthcare assistant staff, but there were 6 WTE posts vacant at the time of inspection.
- The provider was registered to have 3.5 WTE catering assistant posts, but there were 0.5 WTE posts vacant at the time of inspection.

Additionally, staff absenteeism was having an impact on meaningful activities provided to residents. Inspectors were informed that activities staff replaced or covered some absences of healthcare assistants, which resulted in some residents not receiving activities on these days.

While the provider had provided support to enhance the management systems in the centre since the previous inspection, further robust actions were required to ensure the service provided was safe, appropriate, consistent, and effectively monitored, for example:

- The monitoring arrangements for managing behaviour that is challenging, protecting residents from harm, safeguarding residents' finances, and upholding residents' rights continued to require robust attention, as evidenced by the findings under Regulation 7: Managing behaviours that are challenging, Regulation 8: Protection and Regulation 9: Residents' rights.

- The oversight of incident reporting required improvement as statutory notifications to the Chief Inspector in relation to alleged peer-to-peer abuse were not submitted within the required time frames. This was a repeat finding from the June 2025 inspection.

The provider's auditing processes and systems required review to be more robust in identifying risk and driving quality improvement, and to be readily accessible to staff requiring this data:

- While auditing was taking place, its effectiveness and impact were limited as the provider was not auditing key areas of risk found on the inspection day and areas known to be not compliant with the regulations from the previous inspection report, for example: individual assessment and care planning, the management of responsive behaviours, safeguarding of residents from abuse, residents' right and communication needs.
- Improvements were required in relation to accessing audit data and quality improvement plans from the provider's electronic auditing system. The inspectors sought to review the provider's electronic audits, which covered areas such as medication management, laundry, falls risk assessments and mealtimes. Notwithstanding staff efforts to identify and retrieve this data for the inspectors, it could not be accessed in a timely manner to fully assess the effectiveness of the provider's auditing systems.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors found that all notifiable incidents concerning alleged peer-to-peer abuse had not been notified to the Chief Inspector. These notifications were submitted following the inspection.

Judgment: Not compliant

Quality and safety

The inspectors found some improvements to the standard of care provided to residents since the previous inspection. Inspectors observed kind staff treating residents with dignity and respect. While acknowledging the improvements that had occurred, further actions were required concerning individual assessment and care planning, managing challenging behaviour, protection, residents' rights and communication difficulties, as the provider continued to work towards improved regulatory compliance.

The person in charge had arrangements for assessing residents before admission into the centre. The inspectors saw that validated risk assessment tools were used to assess residents' needs. Some improvements in individual assessment and care planning were noted since the last inspection, with enhanced person-centred detail documented within the care plans to guide staff. The provider had also delivered care planning workshops for registered nurses working in the centre since the last inspection, to improve compliance with regulations and enhance care planning practices. Notwithstanding the progress underway, action continued to be required to ensure each resident was comprehensively assessed on an ongoing basis and had a sufficiently detailed person-centred care plan to guide staff in meeting their needs. These matters will be outlined under Regulation 5: Individual assessment and care plan.

Robust action continued to be required concerning the management of behaviour that is challenging. While the provider had ensured all staff had training in managing challenging behaviours and residents had responsive behaviour care plans, the training provided to date and care planning in place was not sufficient to ensure that responsive behaviours were always managed in a way that kept residents, visitors and staff safe, while also having a minimal impact on the person exhibiting these behaviours. This is discussed in the report under Regulation 7: Managing behaviour that is challenging.

The registered provider had systems in place to safeguard residents from abuse, but these systems had not ensured that all residents were protected from abuse. Records reviewed found the registered provider had ensured all staff had An Garda Síochána (police) vetting disclosures on file and staff had completed safeguarding training. The provider had a safeguarding policy to guide staff in recognising and responding to allegations of abuse. Staff spoken with were knowledgeable about what constituted abuse and their role in protecting residents from harm. The provider held quantities of money in safekeeping for one resident at their request. The provider had a robust and transparent system where all lodgements and withdrawals of residents' personal funds were accounted for by two persons and recorded on a paper-based system. Notwithstanding these good practices, action was required to ensure that all reasonable measures were taken to protect residents from abuse and safeguard their finances. This will be discussed further under Regulation 8: Protection.

The inspectors found that many aspects of residents' rights were upheld in the centre. The centre had weekly religious services available. Some residents were supported to communicate freely and had access to radio, television, newspapers, telephones and internet services throughout the centre. The provider had an activity schedule, and both individual and group-based activities were observed taking place on the inspection day. Residents had access to independent advocacy services. Records reviewed found staff had participated in communications skills training to support effective communication between staff, residents and visitors. There were improvements to resident privacy in the centre with the removal of signage on bedroom doors outlining aspects of the residents' healthcare needs, and previous visibility into bedrooms from the smoking area had been addressed. Residents had the opportunity to be consulted about and participate in the organisation of the designated centre by participating in residents' meetings. Notwithstanding these good practices, further action was required by the provider as discussed under Regulation 9: Residents' rights.

Some residents in the centre had additional communication needs, such as sensory needs, or they did not speak English. These residents had their communication needs documented in their care plan, and the inspectors found that staff were aware of these residents' communication needs. Where a resident required access to a communication device, such as hearing aids, the staff ensured these aids were available to enable the resident's effective communication and inclusion. In circumstances where a resident did not speak English, staff were observed to use a combination of tools to facilitate communication. Communication books and pictorial systems with translated descriptions were used to enquire about specific needs, such as pain, the requirement for food and drinks, or the need to use the toilet, for example. The provider had placed pictures with translated descriptions in key areas, such as the resident's en-suite bathroom. The provider had arranged for professional translation services on three occasions. The provider had also purchased an electronic device with translation facilities to support communication, and staff were seen to use this device. While acknowledging that the provider had made efforts to support communication for residents who did not speak English

since the last inspection, further action was required as outlined under Regulation 10: Communication difficulties.

Regulation 10: Communication difficulties

In circumstances where a resident did not speak English, these communication needs were documented in the resident's care plan, and efforts had been made to support communication through the use of communication books, electronic devices, and professional translation services. Despite these efforts, further action was required to facilitate communication between residents who did not speak English and staff members, in accordance with the residents' needs and abilities.

The inspectors observed staff making significant efforts to enhance communication by using the recently acquired electronic translation device to support communication. While staff used this device, it was observed to be slow and not sufficiently responsive to support two-way communication. For example, staff members were observed typing into an electronic device that translated English into the resident's native language; however, the device was sufficiently responsive to translate the resident's replies to the staff member. The inspectors observed multiple occasions where a resident who did not speak English was communicating in their native language, but this was not understood by any staff members, and this was seen to cause the resident frustration.

While acknowledging that the provider had made efforts to support communication in these circumstances, these efforts were not fully effective in enabling a resident who did not speak English to communicate their needs freely, and further actions were required.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

The inspectors reviewed a sample of six residents' records. While some improvements in individual assessment and care planning were noted since the last inspection, action continued to be required concerning the review of individual assessments and care plans to ensure that each resident's needs were comprehensively assessed and an up-to-date care plan was prepared to meet these needs, for example:

- Comprehensive assessments were not always completed within 48 hours of the resident being admitted to the designated centre, for example, the provider had an assessment tool for supporting staff to understand a resident's individual needs, routines, preferences, and life histories. From the records reviewed, inspectors noted that one of these assessment tools was

not completed fully, while another was completed with information concerning another resident.
- Some residents' care plans were not updated at four-monthly intervals or sooner as required by the regulations.
- Of the residents' records seen by the inspectors, there was no evidence of consultation with the resident and, where appropriate, their family when care plans were reviewed.

Judgment: Substantially compliant

Regulation 7: Managing behaviour that is challenging

The provider admitted residents with complex care needs, including those deemed to require focused care due to the high risk presented by the behavioural and psychological symptoms associated with their diagnosis. However, the provider had not ensured that staff had up-to-date knowledge and skills appropriate to their role in responding to, and managing such complex challenging behaviours, which at times included incidents of physical violence towards visitors, staff and property. The provider informed inspectors of further specialised training that was due to be delivered to staff by the end of August 2025, but at the time of the inspection, no staff member had completed this training.

Behavioural support care plans were developed for these residents, detailing potential triggers of behaviours and containing recommended de-escalation strategies. While the details within these plans had improved since the last inspection, they were not always effective. For example, the inspectors reviewed documentation related to 17 incidents of responsive behaviour since the previous inspection. From the records reviewed, staff were noted to have implemented the recommended behavioural support plans, including de-escalation techniques; however, these interventions were not always adequate to de-escalate high-risk responsive behaviours, including physical violence.

Robust action was required to:

- Review the provider's capacity to meet the support needs of residents with responsive behaviours, some of whom were recorded as experiencing significant agitation and unease, leading to behaviours that presented a high risk of harm to themselves, other residents, visitors, and staff.
- Ensure that all behavioural support care plans provide effective direction for staff on how to respond to responsive behaviour and manage the needs of residents experiencing significant agitation and unease.
- Alleviate the impact of these responsive behaviours on other residents' quality of life, including their right to a safe and peaceful enjoyment of their living environment, host visitors, and maintain control over their possessions.

- Ensure all staff have up-to-date knowledge and skills to respond to and manage responsive behaviours presenting within the centre.

Judgment: Not compliant

Regulation 8: Protection

The provider did not take all reasonable measures to protect residents, as evidenced by the following findings:

- Some residents with a history of responsive behaviours, which were a known safeguarding risk to other residents, had measures documented to mitigate this risk. However, these measures had not always been effective and had failed to protect residents from abuse.
- Although staff had completed safeguarding training, it was evident that not all staff had the required knowledge, experience and skills to prevent instances of abuse and protect vulnerable residents from harm in the centre. This was evidenced by the number of responsive behaviour incidents which had resulted in staff and visitors being assaulted and injured, residents recorded as being upset and frightened, and property being damaged.
- Since the last inspection, two incidents where residents were negatively impacted by the responsive behaviours of another resident had not been recognised as safeguarding issues and therefore had not been investigated and managed in line with the provider's safeguarding policy.
- The systems in place for managing residents' finances were not sufficiently robust. The provider was acting as a pension agent for two residents living in the centre. However, the pensions were paid into two current accounts under the name Beechfield Manor Nursing Home, and not into a separate resident's client account to ensure residents' finances were safeguarded.

Judgment: Not compliant

Regulation 9: Residents' rights

While many aspects of residents' rights were upheld in the centre and improvements were observed since the last inspection, further actions were required as outlined below.

- While the provider had an activity schedule and both individual and group-based activities were observed taking place on the inspection day, some residents, particularly those with a dementia diagnosis, were seen sitting for lengthy periods in their bedrooms with minimal opportunities for engagement. When their care records were reviewed to establish what their

interests and capacities were, these records were seen to document that the resident enjoyed their own company and self-directed activities of interest. Action was required by the provider to review both the needs and records of residents with dementia to ensure all residents had opportunities to engage in activities of interest to them in line with their individual capacities.

- The impact of staff absenteeism on meaningful activities provided to residents has been referenced under Regulation 23: Governance and management.
- Inspectors identified that residents' rights regarding their finances required improvement. The provider held money belonging to two residents in a current account; however, these residents were not receiving statements as to how much money belonging to them was in the current account. The provider also held quantities of cash in safekeeping for one resident at their request. Similarly this resident was not receiving statements or documentation as to how much money belonging to them was held in safekeeping.
- While there had been improvements to residents' privacy since the last inspection, inspectors observed one example on the first floor, where a resident's dietary requirements were displayed on the wall inside just inside the bedroom door, which was fully visible from the corridor.
- The inspectors observed inappropriate storage, impacting residents' rights to comfortably use their communal space. For example, the inspectors observed that the lower ground-floor activities room was also being used to store catering fridges, hot trolleys and meal tray trolleys. This was a repeat finding from the June 2025 inspection.
- A review of the functionality of the communal spaces in the centre was required to ensure all residents had facilities for occupation and recreation. The inspector observed that the ground-floor sitting room adjacent to the treatment room, where activities took place and where the majority of residents spent their day, was noisy and crowded at times. In contrast, the provider also had a quiet, larger sitting room at the front of the centre, adjacent to the reception area, which was not seen to be used by residents over the course of the inspection. A sitting room and activities room on the lower ground floor were difficult to find and were sparsely decorated. The absence of inviting and comfortable communal spaces can lead to social isolation and a decline in residents' well-being. Poorly decorated communal spaces can hinder the development of social connections, increase the likelihood of loneliness, and may contribute to feelings of insecurity and vulnerability amongst 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	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Beechfield Manor Nursing Home OSV-0000013

Inspection ID: MON-0047782

Date of inspection: 06/08/2025

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:

- As stated by HIQA, *'inspectors observed sufficient numbers of staff on duty on the day of the inspection'.* The Nursing Homes statement of purpose reflects the total number of Whole Time Equivalents in each discipline within Beechfield Manor. On the day of the inspection the RPR acknowledged to HIQA that there were several vacant positions (nursing / non nursing) that were being processed for replacement by the Group HR Team. The RPR also affirmed to HIQA that on any day should the Director of Nursing require replacement of staff (sick leave / unplanned leave) that relief / extra hours / agency was available to them to ensure appropriate staffing levels on any given day. Beechfield Care Group through national and international recruitment has successful replacement strategies in place and interim replacement availability for short term needs. As per action dates staff vacancies will be filled by 31/10/2025.

- The roster is reviewed on a weekly basis by the PIC to ensure that there is an appropriate level and skill mix of staff in line with the Statement of Purpose. Staff allocations sheet has been devised the same of which clearly outlines individual roles and responsibilities, oversight expectations and incorporates assigned individual responsibility for the answering of call bells especially change of shift. A daily call bell audit is completed by the Assistant Director of Nursing / Clinical Nurse Manager. Any findings are documented in an action plan and these are addressed immediately by the Assistant Director of Nursing / Clinical Nurse Manager.

- There are now only two residents in the home that require one to one support.

This support is provided by Healthcare assistants. The Director of Nursing has put a system in place to ensure all staff receive their allocated breaks and provide cover on the floor throughout the home. A staff allocations sheet has been devised the same of which clearly outlines individual roles and responsibilities, oversight expectations and break times. It has been agreed that when both residents attend the dining room for their lunch the two ono to one healthcare assistants go on their break. While in the dining room the residents along with the other residents in the home are supervised by:

- CNM
- Staff Nurse
- Three Healthcare Assistants.

Regulation 16: Training and staff development	Substantially Compliant

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

- As stated in the report inspectors observed *'sufficient numbers of staff on duty on the day of the inspection'.* The statement of purpose reflects the total number of WTE's in each discipline within this nursing home. On the day of the inspection the RPR acknowledged to HIQA that there were a number of vacant positions (nursing / non nursing) that were being processed for replacement by HR which would be normal within all industries. The RPR also affirmed to HIQA that on any day should the director of nursing require replacement of staff (sick leave / unplanned leave) that relief / extra hours / agency was available to them in order to ensure appropriate staffing levels on any given day. Beechfield Care Group through national and international recruitment has successful replacement strategies in place and interim replacement availability for short term needs. The Director of Nursing conducts return to work interviews with staff who have been absent from the home.
- When a staff nurse is sick in the home the Director of Nursing can replace staff (sick leave / unplanned leave) by offering extra hours, using relief staff or agency when available to them in order to ensure appropriate staffing levels on any given day. If this is not achieved the CNM on duty steps into the nursing role to ensure compliance with medication management and care of the residents. When this happens the ADON can supervise staff in a supernumerary capacity ensuring direct resident assessment and treatment, oversee staff interactions with residents, mentor staff, and oversee the quality of care provided to residents.

- To improve incident reporting accuracy and improve consistency the Director of Nursing and Assistant Director of Nursing review incidents daily to ensure the accurate reporting of incidents are maintained. This is achieved through reviewing the details on the Care Monitor System and detailed review of incident reports and care notes. The RPR has had a session with nursing Management reviewing consistency and accuracy of documentation in relation to incident reporting. The DON and ADON are currently providing regular toolbox talks to the staff regarding incident management and record keeping in relation to incident management including witness of incident, management of incident and reporting on incident.
- Beechfield Manor Nursing Home uses the Viclarity electronic Auditing System. As with all homes within the group, Viclarity is used by the Nursing Management team within each home. The members of the Management Team carry out Audits as per the nursing homes schedule, i.e. weekly, monthly, quarterly etc in the areas of:
    - Medication Management
    - Falls
    - Skin Tear
    - Notifications etc

  The reports identifies the level of compliance within the home. Any areas of non-compliance require a full action plan including a timeline for completion. Findings of the results are discussed with the nursing staff with the DON / ADON at their monthly nursing meetings.

Regulation 23: Governance and management	Not Compliant

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

- As stated by HIQA, *'inspectors observed sufficient numbers of staff on duty on the day of the inspection'.* The Nursing Homes statement of purpose reflects the total number of Whole Time Equivalents in each discipline within Beechfield Manor. On the day of the inspection the RPR acknowledged to HIQA that there were several vacant positions (nursing / non nursing) that were being processed for replacement by the Group HR Team. The RPR also affirmed to HIQA that on any day should the Director of Nursing require replacement of staff (sick leave / unplanned leave) that relief / extra hours / agency was available to them to ensure appropriate staffing levels on any

given day. Beechfield Care Group through national and international recruitment has successful replacement strategies in place and interim replacement availability for short term needs. As per action dates staff vacancies will be filled by 31/10/2025.

- The Director of Nursing now ensures that the activity co-ordinator does not replace or cover absences of healthcare assistants.

- Since the previous inspection in June 2025 Beechfield Care Group has provided support to enhance the management systems in the nursing home. The below Management structure is in place following the inspection on the 6th August.

  Director of Nursing
  Assistant Director of Nursing (new external appointment)
  CNM x 1 (new external appointment post inspection 6th August)
  CNM x 1 (internal promotion)

- In addition to the above management structure within the nursing home the Senior Management Team provide oversight and support to the team. This is achieved by:
  - Strengthening of governance structures through increased management presence on-site and clear delegation of responsibilities.
  - Implementation of a more comprehensive auditing schedule, with results reviewed at monthly governance meetings.
  - Introduction of an improved incident and feedback tracking system to ensure timely identification, escalation, and resolution of issues.
  - Ongoing staff supervision and performance monitoring to promote accountability and consistency in service delivery.
  - Quarterly management reviews to evaluate the effectiveness of governance systems and identify areas for continuous improvement

- To improve incident reporting accuracy and improve consistency the Director of Nursing and Assistant Director of Nursing review incidents daily to ensure the accurate reporting of incidents are maintained. This is achieved through reviewing the details on the Care Monitor System and detailed review of incident reports and care notes. The RPR has had a session with nursing Management reviewing consistency and accuracy of documentation in relation to incident reporting. The DON and ADON are currently providing regular toolbox talks to the staff regarding incident management and record keeping in relation to incident management including witness of incident, management of incident and reporting on

incident. The Director of nursing submitted alleged peer to peer abuse retrospective notifications to HIQA. This have since been closed off on the portal.

- Beechfield Manor Nursing Home uses the Viclarity electronic Auditing System. As with all homes within the group, Viclarity is used by the Nursing Management team within each home. The members of the Management Team carry out Audits as per the nursing homes schedule, i.e. weekly, monthly, quarterly etc in the areas of:
    - Medication Management
    - Falls
    - Skin Tear
    - Notifications etc
- The reports identify the level of compliance within the home. Any areas of non-compliance require a full action plan including a timeline for completion. Findings of the results are discussed with the nursing staff with the DON / ADON at their monthly nursing meetings.

- The Director of Nursing along with the new Assistant Director of Nursing have increase the frequency of auditing within the home. This will help identify risks earlier so the can act and implement quality improvements. There is a stronger focus currently on individual assessment and care planning, the management of responsive behaviours, safeguarding of residents from abuse, residents' right and communication needs. The Director of Nursing will ensure that all staff will be aware of any change in residents condition during handover and there should be an open communication to facilitate the sharing of information.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:

- To improve incident reporting accuracy and improve consistency the Director of Nursing and Assistant Director of Nursing review incidents daily to ensure the accurate reporting of incidents are maintained. This is achieved through reviewing the details on the Care Monitor System and detailed review of incident reports and care notes. The RPR has had a session with nursing Management reviewing consistency and accuracy of documentation in relation to incident reporting. The DON and ADON are currently providing regular toolbox talks to the staff regarding incident

management and record keeping in relation to incident management including witness of incident, management of incident and reporting on incident. The Director of nursing submitted tow alleged peer to peer abuse retrospective notifications to HIQA. This have since been closed off on the portal.

Regulation 10: Communication difficulties	Substantially Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:

- As highlighted in this report Beechfield Nursing Home, had made efforts to support communication through the use of communication books, electronic devices, and professional translation services (provided by the HSE) for one specific resident. The Nursing Home had detailed behavioural support plans, including de-escalation techniques in place. A supplemental communication book in the resident's native language had also been recirculated for staff use. Due to the residents escalating clinical deterioration, after many months and in consultation with the homes medical and nursing team in collaboration with the HSE it was deemed that the placement within the home was unstainable. This resident has since been discharged to the acute services. Notwithstanding the Nursing Home will continue to support all residents with their communication needs.

Regulation 5: Individual assessment and care plan	Substantially Compliant

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

- Beechfield Nursing Home uses an electronic software system. It is a care planning, assessment and safety management system for nursing homes. It incorporates best practice and evidence-based assessment tools. The Director of Nursing runs daily and weekly reports to ensure that the home is compliant in identifying risk and driving quality improvements for residents needs. The Director of Nursing and Assistant Director of Nursing run a report from the system to ensure that any new residents Care Plans have been completed within 48 hours of admission.
- The Director of Nursing has met with the nursing staff within the

home and discussed the importance of ensuring the Care Plans are updated at four-monthly intervals or sooner as required by the regulations. This will be overseen by the Assistant Director of Nursing and Director of Nursing ensuring that all residents choice is reflected.

- The Director of Nursing has met with the nursing staff within the home and discussed the importance of ensuring the Care Plans have evidence of consultation with the resident and, where appropriate, their family when care plans were reviewed. This will be overseen by the Assistant Director of Nursing and Director of Nursing ensuring that all residents choice is reflected.

Regulation 7: Managing behaviour that is challenging	Not Compliant

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

- MAPA training (Management of Actual or Potential Aggression) is a specialist training. This enhanced training was booked following the June 2025 Inspection through an external training company. First available dates that could be secured were the 20th of August 2025. MAPA training trains the individual to use a non-restrictive safety intervention which includes disengagement techniques which are designed to enable a person to move away to a place of safety. The first training date (20/08/25) priority was given to train the 10 staff who were providing 1:1 care for the resident and the remaining staff who also worked on the floor with the resident. Remaining training dates secured from the external company are 05/09/25, 17/09/2025 and 20/10/2025. To note, the resident has since been discharged from the home.
- Additional Behaviour that is Challenging training is being provided by an external Company to all staff and Management Team on 03/10/2025 and 10/10/2025.

- The resident in question had 24hour one to one special who was with them at all times. As highlighted in this report Beechfield Nursing Home, had made efforts to meet the needs of the resident through the use of communication books, electronic devices, and professional translation services (provided by the HSE). The Nursing Home had detailed behavioural support plans, including de-escalation techniques in place. A supplemental communication book in the resident's native language had also been recirculated for staff use. The residents clinical deterioration led to increased medical supervision, including weekly clinical review by the GP, adjustments in their medication, adjustments in their day-to-day care. A referral to Psychiatry of Old age had already been sent in

but a consultation not secured until August 2025 Due to the residents escalating clinical deterioration, after many months and in consultation with the homes medical and nursing team in collaboration with the HSE it was deemed that the placement within the home was unstainable. This resident has since been discharged to the acute services. Notwithstanding the Nursing Home will continue to support all residents with Behavioural needs.

- Care Plan training from an external Company is being provided to the Staff Nurses and Management Team on 01/10/2025.

- Care plan templates are being used by all nurses within the home. All care plans within the home are been reviewed and updated where appropiate. The Director of Nursing and Assistant Director of Nursing will oversee that residents are safe at the centre. If there are any changes in a residents behaviour their care plan will be updated to reflect any changing needs and the Director of Nursing will ensure staff have clear guidance on how to meet these changing and complex needs. This will be supported alongside a GP review in collaboration with other Multidisciplinary team such as Psychiatry of old age and the Geriatrician.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

- One specific resident with behaviours that challenge was admitted with 24-hour one-to-one care provided by Health Care Assistants to the home. These staff would provide support to the resident through the use of communication books, electronic devices, and professional translation services. Due to the extreme clinical deterioration, measures in place within the home were not sufficient nor could be made sufficient to manage the resident. A decision was made for his and other residents safety to discharge the resident to the acute services in consulation with the HSE community and nursing home team in August 2025.

- There were a number of staff incidents, all of which were reported. The resident was recorded as having an outburst in front of other residents which was managed by clinical staff on the day and notified retrospectively to HIQA. All staff in the home had completed safeguarding training. MAPA training had been booked for the 20/08/2025 for the staff who worked directly with the resident. Remaining training dates secured from the external company are 05/09/25, 17/09/2025 and 20/10/2025. Staff always made every effort to redirect the resident away from other residents, visitors and staff.

- To improve incident reporting accuracy and improve consistency the

Director of Nursing and Assistant Director of Nursing review incidents daily to ensure the accurate reporting of incidents are maintained. This is achieved through reviewing the details on the Care Monitor System and detailed review of incident reports and care notes. The RPR has had a session with nursing Management reviewing consistency and accuracy of documentation in relation to incident reporting. The DON and ADON are currently providing regular toolbox talks to the staff regarding incident management and record keeping in relation to incident management including witness of incident, management of incident and reporting on incident. The Director of nursing submitted tow alleged peer to peer abuse retrospective notifications to HIQA. This have since been closed off on the portal.

- The company is working with its banking provider to change the name on the current account used exclusively to manage residents' finances. The name change will clearly demonstrate that this current account is for residents' finances. The company is dependent on the bank's requirements to effect the change and is not currently in a position to give a definitive operational date. Attached to this Additional Response are all the bank statements from inception to the end of August 2025 clearly showing that all incoming receipts from the Department of Social Protection. The only payments out of the account are bank charges for maintaining the bank account on behalf of the residents.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

- We recognise that several residents' care records reflect their personal preference for privacy, time alone, and self-directed activities. However, we also appreciate that a review of these preferences is necessary to ensure that they continue to reflect current needs and that opportunities for engagement remain meaningful and accessible. A full review of all residents' activity care plans has been conducted with a specific focus on those living with dementia, to ensure their preferences, abilities, and engagement needs are accurately documented and acted upon. The Director of Nursing will ensure that enhanced documentation to evidence residents' choices, levels of engagement, and outcomes of activities is achieved.

- Residents with dementia or a cognitive impairment may choose to also spend time within their rooms surrounded by familiarity, i.e. personalised pictures. The activity staff will attend to the residents throughout the day. On the day of inspection an outsourced company that provides 1:1 hand massage and manicure to residents was in the home. The provider specifically delivers this

care to residents with a cognitive impairment or dementia who may remain in their rooms and who may not choose to engage in group activities. Beechfield Manor also engages with external providers to support all our residents, in addition group activities, painting, baking, pottery, music etc, Irish Therapy Dogs also attend the home. The residents Care Pans will be updated to ensure the above information is clear and appropriate in line with their individual capacities.

- The Director of Nursing now ensures that the activity co-ordinator does not replace or cover absences of healthcare assistants.

- Beechfield Manor Nursing Home Ltd will issue monthly statements to the two residents for whom the company acts as pension agent. Additionally, the company will issue a monthly statement to the resident for whom Social Inclusion funds are safeguarded. Monthly statements for these residents will commence issuance on September 30th 2025. A sample statement for one of the residents is attached to our Additional Response. The company has one current account where it receives pension payments from the Department of Social Protection for two residents, not two separate current accounts as stated.

- Resident's dietary requirements that were displayed on the wall inside just inside the bedroom door, which was fully visible from the corridor has now been removed.
- The home can confirm that the fridge, hot trollies and meal tray trollies have been moved from these areas.
- A full review of the current communal spaces has commenced, with the aim of ensuring each area is appropriately designated, accessible, and inviting for residents' use. The larger front sitting room adjacent to reception is being promoted as a quieter alternative for residents who wish to relax or participate in small family gatherings or private parties. Staff will encourage and support residents to make use of this space. The lower ground-floor sitting room and activities room will be redecorated and signposted more clearly to improve accessibility and visibility. The décor will be enhanced to create a warm and homely environment that encourages use and supports residents' well-being. There is now directional / wayfinding signage for residents to find sitting room 3. Environmental audits will be undertaken quarterly to ensure all communal spaces remain welcoming, comfortable, and fit for purpose. Residents' views will be sought through regular meetings and individual feedback to ensure communal spaces reflect their preferences and support meaningful occupation and social connection.

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 10(1)	The registered provider shall ensure that a resident, who has communication difficulties is facilitated to communicate freely in accordance with the residents' needs and ability.	Substantially Compliant	Yellow	14/08/2025
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	31/10/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	05/09/2025

	are appropriately supervised.			
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/10/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	05/09/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	05/09/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the	Substantially Compliant	Yellow	05/09/2025

	designated centre concerned.			
Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/10/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	31/10/2025
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Not Compliant	Orange	31/10/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to	Not Compliant	Orange	30/09/2025

	protect residents from abuse.			
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Not Compliant	Orange	31/10/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Not Compliant	Orange	05/09/2025
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	30/092025
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	30/09/2025
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	30/09/2025