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:	28 May 2026
Centre ID:	OSV-0000013
Fieldwork ID:	MON-0050644

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:	66

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 28 May 2026	07:15hrs to 16:00hrs	Mary Veale	Lead
Thursday 28 May 2026	07:15hrs to 16:00hrs	Bernadette McDonald	Support

What residents told us and what inspectors observed

The overall feedback from residents who spoke with the inspectors was that they were very happy and content living in Beechfield Manor Nursing Home. Residents were complementary of the centre, the staff, and the quality of the care provided. During the day, the inspectors met with many of the 66 residents living in the centre and spoke to 11 residents and four visitors in more detail. The inspectors spent time observing daily life in the centre to gain an insight into the lived experience of residents in Beechfield Manor Nursing Home. Residents praised the staff working in the centre. One resident stated that "they were very happy with the staff", with another resident saying that “the staff are attentive to my needs”.

This was a one day inspection conducted by two inspectors to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres) Regulations 2013 (as amended) and to follow up the compliance plan following the February 2026 inspection.

The inspectors arrived at the centre and were greeted by the assistant director of nursing. The inspectors conducted a walk around of the premises, listened to the morning handover, followed by an introductory meeting with the assistant director of nursing. To gain insight into the residents' experiences in the centre inspectors spoke to residents, visitors, staff and spent time observing the environment and reviewing documentation.

Beechfield Manor Nursing Home comprises of 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. On the day of inspection one of the two passenger lifts was not in use, as it was being serviced.

Bedroom accommodation comprises 67 single-occupancy bedrooms and one twin-occupancy bedroom. Twenty 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 most were personalised with items from home, such as family photographs, artwork, bedding and ornaments. The bedrooms had a television, locked storage, and call-bell facilities.

On the walk around the centre, inspectors observed two frame-less glass panels in the ground floor outdoor terrace area that were loose and could tilt when pushed. This posed a safety risk to residents. Inspectors requested that immediate action be taken to address this risk. This was completed by the provider on the day of the inspection.

A small number of residents were observed resting in their bedrooms, while others were relaxing in the communal spaces. Parts of the premises were showing significant wear and tear, and this is discussed further in this report under Regulation 17: Premises. There was a choice of communal areas for residents on each floor, for example, there was a large dining room and two sitting rooms 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 observed sitting in armchairs near the nurse's station on certain floors, watching the comings and goings.

Residents had restricted access to outdoor spaces on the day of inspection. There were two enclosed terrace areas; one located at ground-floor level was observed to be nicely decorated for a garden party on the evening of inspection and the other outdoor space could be accessed from the lower ground-floor dining area and lobby. These outdoor spaces are discussed further under Regulation 7: Managing behaviour that is challenging. There was a separate outdoor space which contained the designated smoking area on the lower ground-floor level.

The inspectors observed a relaxed atmosphere in the centre and residents were not rushed to get up following breakfast in their bedrooms. Most residents who spoke with the inspectors, were complimentary of the home-cooked food and the dining experience in the centre. A daily menu was displayed in the dining room. The inspectors observed the main lunch time meal on the ground floor. The lunchtime was a relaxed and sociable experience, with residents appearing to enjoy each other’s company as they ate while engaging in conversation. Meals were prepared in the centre's on-site kitchen and the main lunch was served in the dining room by the staff. Residents confirmed that they were offered a choice of main meal. The food served appeared nutritious and appetising. The inspectors observed drinks and snacks being offered to residents in the morning and afternoon. Notwithstanding this good practice, a number of residents and visitors told inspectors that they were not offered a choice in the portion size of some meals or a choice of desert. This is discussed further under Regulation 9: Residents rights.

Residents were observed interacting with staff, attending activities, and spending their day moving freely through the centre from their bedrooms to the communal spaces. Residents were observed engaging in a positive manner with staff and fellow residents throughout the day and it was evident that residents had good relationships with staff. Many residents had built up friendships with each other and were observed sitting together and engaging in conversations with each other. The inspectors observed staff treating residents with dignity during interactions throughout the day.

The centre provided a laundry service for residents. All residents’ whom the inspectors spoke with on the day of inspection were happy with the laundry service.

Friends and families were facilitated to visit residents, and the inspectors observed many visitors in the centre throughout the day. Visitors who spoke with the inspectors were mostly happy with the care and support their loved ones received.

Two visitors whom the inspectors spoke with, expressed their overall dissatisfaction with the quality of food & portion size provided to their relative living in the centre.

Residents' spoken with said that they were very happy with the activities programme in the centre and some preferred their own company, but stated that they were not bored as they had access to newspapers, books, radios, the internet and televisions. An activities programme was displayed on notice boards near one of the lift areas and in resident's bedrooms. The inspectors observed residents attending an exercise session in the afternoon of the first day of this inspection and a memory game on the second day. Residents' views and opinions were sought through resident meetings and satisfaction surveys, and they informed inspectors that they felt they could approach any member of staff if they had any issue or problem to be solved. Residents had access to advocacy services.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

Inspectors found that the provider was in the process of embedding governance and management systems in the centre. However, there were repeated findings of non-compliance in the management of behaviours that are challenging, and governance and management, as set out in this report. Inspectors reviewed unsolicited information received by the Office of the Chief Inspector. The information received pertained to concerns regarding care planning, healthcare, the governance and management of the centre, safeguarding, residents' rights, and contracts of provision. Some of this information was substantiated on this inspection.

Following an inspection of the centre in October 2025, which identified that the registered provider had failed to inform the Chief Inspector of significant changes to the governance structure of Beechfield Manor Nursing Home, as required by the regulations, a warning meeting was held with the provider.

Prior to this inspection poor compliance with the regulations was identified over the course of three previous inspections of the centre on 19 February 2025, 3 June 2025, 6 August 2025 and 22 October 2025. Following multiple engagements with the office of the Chief Inspector, a notice of decision was issued to attach a restrictive condition to the centre's registration, requiring admissions to the centre to cease until improvements in compliance with specific regulations were demonstrated and a revised governance and management structure was implemented. The provider made an application to appeal this decision in the District Court.

Following a further inspection of the centre in February 2026, a decision was made in the District Court to attach a condition to the registration of Beechfield Manor

Nursing home. This condition required the provider to ensure that effective supervision and adequate resources are allocated to deliver compliance with Regulations 7: Management of Challenging behaviours and Regulation 23: Governance and management, of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013.

The registered provider for Beechfield Manor Nursing Home is Beechfield Manor Nursing Home Limited. This company has two directors. One director was present during the afternoon of inspection and for the feedback meeting following the inspection. The centre is part of the Beechfield Care Group, which operates eight designated centres for older people.

The person in charge was on planned leave at the time of inspection. The person in charge worked full-time, was responsible for the centre's day-to-day operations, and reported to the group director of operations. The person in charge was supported in their management of the centre by an assistant director of nursing, two clinical nurse managers, a team of staff nurses, senior healthcare assistants, healthcare assistants, activities, administration, catering, household, and maintenance staff. The person in charge also had support from the group quality and care manager who attended the centre on the day of inspection.

The staffing and skill mix on the day of inspection appeared to be appropriate to meet the care needs of residents. Residents were seen to be receiving support in a timely manner, such as providing assistance at meal times and responding to requests for support.

There was an ongoing schedule of training in the centre and the person in charge had good oversight of the training records. An extensive suite of mandatory training was available to all staff in the centre and training was 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. Regular tool-box talks (short presentations) had taken place on topics such as; residents' rights and dignity, responsive behaviours, communication, restrictive practices, call-bell response times, residents' mealtime choice, enhancing the dining experience, and care planning. Staff with whom the inspectors spoke, were knowledgeable regarding safe guarding procedures. However, inspectors found that restrictive practice tool box talks and training provided were not fully understood by staff. This is discussed further under Regulation 7: Managing behaviour that is challenging.

Improvements were found in the records for restraint use. These records included documentation outlining other less restrictive interventions, used to manage the behaviour and the duration for which the restraint was to be used.

Records maintained in the centre were in electronic and paper format. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. Garda vetting disclosures, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, were available for each member of staff.

Some improvements were found in the governance and management of the centre since the previous inspection. Since the February 2026 inspection, the management

structure within the centre continued to be operationally stable. However; a number of management systems such as the centres audit system and the use of restrictive practice were inconsistently being monitored.

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 and staff meetings that had taken place since the previous inspection were reviewed during this inspection. Governance and staff meetings took place monthly and staff meetings took place quarterly. In addition to these meetings, there were daily management walk-arounds and huddle meetings. The person in charge completed a weekly key performance indicator (KPI) report, which was discussed with the quality and care manager.

While there was a schedule of clinical and environmental audits completed, many audits had high levels of compliance and some audits had non-specific action plans which did not address the audit findings. This was a repeated finding from previous inspections. Furthermore, the oversight of restrictive devices was inadequate, resulting in residents being restricted to access outdoor space and being restricted to mobilise independently to the toilet. This is discussed further in this report under Regulation 23: Governance and Management.

The management team had a good understanding of their responsibility in respect of managing complaints. The inspectors reviewed the records of complaints raised by residents and relatives and found they were appropriately managed. Residents spoken with were aware of how to make a complaint and whom to make a complaint to.

Regulation 15: Staffing

On the inspection day, staffing levels were found to be sufficient to meet the needs of the residents. There was a minimum of two registered nurse and four health care assistants on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

The provider did not ensure that restrictive practice training and restrictive practice tool box talks provided by the provider were fully understood by staff. This is discussed further under Regulation 7: Managing behaviour that is challenging.

Judgment: Substantially compliant

Regulation 21: Records

All records, as set out in Schedules 2, 3 and, 4 were available to the inspectors. Retention periods were in line with the centres' policy and records were stored in a safe and accessible manner.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had not implemented all the actions committed to in their compliance plan from the previous two inspections. As a result, repeated non-compliance was identified during this inspection. This was evidenced by the following;

- Ineffective systems of monitoring. For example;
    - While the provider had an auditing system in place, to monitor the quality of the service provided, completed audits did not capture areas of non-compliance in restrictive practices, and the premises, as detailed in this report. Clinical and environmental audits reviewed were not aligned to up-to-date regulation and standards, or best practice guidelines. As a result, completed audits did not drive improvements.
    - The effectiveness of staff training was not fully evaluated. The provider did not ensure that restrictive practice training and restrictive practice tool box talks provided by the provider were fully understood by staff. This is discussed further under Regulation 7: Managing behaviour that is challenging.

- Inadequate management of environmental risks. For example;
    - Two frame-less glass panels in the ground floor outdoor terrace area, accessible to residents, were observed to be loose and could tilt when pushed. This presented a potential safety risk to residents. Assurances were received on the afternoon of inspection that all the panels on the ground floor terrace area had been reviewed and were secure.
    - Further oversight was required of issues pertinent to premises as outlined further under Regulation 17: Premises.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

Residents had a written contract and statement of terms and conditions agreed with the registered provider of the centre. These clearly outlined the room the resident occupied and additional charges, if any.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider provided an accessible and effective procedure for dealing with complaints, which included a review process. The required time lines for the investigation into, and review of complaints was specified in the procedure. The procedure was prominently displayed in the centre. The complaints procedure also provided details of the nominated complaints and review officer. These nominated persons had received suitable training to deal with complaints. The complaints procedure outlined how a person making a complaint could be assisted to access an independent advocacy service.

Judgment: Compliant

Quality and safety

Inspectors observed that staff were kind and treated residents with dignity and respect. While acknowledging the improvements in care planning, not all areas of non-compliance, identified on previous inspections had been addressed, specifically in the areas of; managing behaviour that is challenging, residents rights, and the premises.

Residents spoken with expressed mixed opinions on the food offered in the centre. Food was prepared and cooked on-site by the centre's chef. Choice was offered to residents at mealtimes, and adequate quantities of food were served on the day of inspection. Residents also had access to fresh drinking water and other refreshments at mealtimes and throughout the day. There was adequate supervision at mealtimes.

While the premises were designed and laid out to meet the number and needs of residents in the centre, some areas were observed to be in a poor state of repair,

and were not in full compliance with Schedule 6 requirements. This is detailed under Regulation 17: Premises.

The inspectors viewed a sample of residents' nursing notes and care plans. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet their needs. Care plans viewed by the inspectors were generally person-centred, routinely reviewed and updated in line with the regulations and in consultation with the resident.

Residents were supported to access appropriate health care services, in accordance with their assessed need and preference. General Practitioners (GP's) attended the centre and residents had regular medical reviews. Residents also had access to a consultant geriatrician, emergency department in the home team, a psychiatric team, nurse specialists and palliative home care services. A range of allied health professionals were accessible to residents as required, for example; physiotherapist, speech and language therapist, dietician and chiropodist. Residents also had access to dental and optician services.

All staff had An Garda Síochána (police) vetting disclosures on file. Staff had completed safeguarding training. Staff spoken with were clear about their role in protecting residents from abuse, demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. All interactions between staff and residents were observed to be respectful throughout the inspection. Residents reported that they felt safe living in the centre.

There was a policy in place to guide staff on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. There was evidence that staff had received training in managing behaviour that is challenging and residents' had access to psychiatry of later life. Inspectors found there was a reduction in the level of restrictive practices in use since October 2025, but the use of restrictive devices remained high in the centre. There was documentation to support that the use of restrictive practice was reviewed regularly, including the trialling, application and oversight of restrictive practices. However, inspectors found that a number of staff whom they spoke with on the day of the inspection did not demonstrate appropriate knowledge of restrictive practices, and the restrictive practices in use did not fully align to the national policy or the provider’s policy. Inspectors observed that a restraint-free environment was not always promoted as all doors to enclosed out door spaces were key-pad locked and not accessible to residents. This meant that the residents who were independently mobile or residents who smoked could not freely access these spaces without the assistance of staff. This is discussed further under Regulation 7: Managing behaviours that are challenging.

Residents were provided with recreational opportunities, including games, music, pet therapy, exercise, bingo, and art. Arrangements were in place for consulting with residents in relation to the day-to-day operation of the centre. Resident feedback was sought in areas such as activities, meals, and mealtimes. Records

showed that items raised at resident meetings were addressed by the management team. Information regarding advocacy services was displayed in the centre. Residents had access to local and national newspapers, the internet, televisions, and radios.

Regulation 17: Premises

Parts of the premises did not conform to the matters set out in Schedule 6 of the regulations, for example;

- Areas of the premises were not sufficiently maintained internally and some areas of the centre were observed to be in a poor state of repair. For example, the inspectors observed scuffed doors, chipped paint on walls, wooden skirting and handrails.
- There was a malodour in the ground floor clinical treatment room and on the adjacent corridor.
- There was a ceiling water stain above the nurses station on the first floor.
- An automatic door closure was observed not working on the door of bedroom 203.
- A fire exit sign (a running man sign) was not working on a stairwell between the ground floor and the lower ground floor.
- Rust stains were observed on radiators through the centre.
- Inspectors observed the use of plastic cups and glasses that were worn and stained. Teacups were also visibly stained.

These were repeated findings on previous inspections.

Judgment: Not compliant

Regulation 18: Food and nutrition

Residents were offered a choice of courses for the lunch-time meal. Residents who required assistance received it, in an unhurried and respectful manner. It was evident that residents who required review by a dietitian or a speech and language therapist, were referred and assessed, in a timely manner. The inspectors observed that drinks and snacks were provided to residents regularly.

Notwithstanding this good practice, inspectors observed that some residents were not offered choice during the meal time experience and residents gave mixed feedback to the inspectors about the portion size of their meals. This is discussed under Regulation 9: Residents rights.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Based on a sample of care plans viewed appropriate interventions were in place for residents' assessed needs. Care plan reviews were comprehensively completed on a four-monthly basis to ensure care was appropriate to the resident's changing needs.

Judgment: Compliant

Regulation 6: Health care

GP's routinely attended the centre and were available to residents'. Allied health professionals also supported the residents on site where possible and remotely when appropriate, for example, a dietitian, and physiotherapist. There was evidence of ongoing referral and review by allied health professional, as appropriate.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

On the day of inspection, inspectors spoke with a number of staff who demonstrated inadequate knowledge of environmental restraints and the rationale for the use of restrictive practice devices were in use such as sensor devices. A number of residents who had undergone trials of removal of sensor devices at night time and who were able to independently mobilise, continued to have these devices in place following the trial. Inspectors were told that these sensor devices alerted staff to assist the residents with going to the toilet even thought the residents had been trailed as been independent with mobilising to the toilet.

Inspectors observed that a restraint-free environment was not always promoted as doors to the outdoor spaces on the lower ground floor were key-pad locked and were not open. This meant that the residents who were independently mobile could not freely access the courtyards without the assistance of staff.

These practices are not in line with the national policy or the providers policy and training.

Judgment: Substantially compliant

Regulation 8: Protection

Measures were in place to protect residents from abuse including staff training and an up-to-date policy. Staff were aware of the signs of abuse and of the procedures for reporting concerns.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' right to exercise choice was not always upheld by the registered provider. For example;

- Staff were observed placing clothes protectors on residents during the lunch-time meal experience. Staff did not engage in conversation with the residents as to whether it was their preference to wear a clothes protector.
- Residents gave mixed feedback to inspectors about the portion size of their meals, some residents said the portion size was too small, while others said it was too big.
- Some residents and visitors told inspectors that the dessert was the same every day and were not offered a choice of dessert.

Judgment: Substantially 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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 18: Food and nutrition	Compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Beechfield Manor Nursing Home OSV-0000013

Inspection ID: MON-0050644

Date of inspection: 28/05/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Substantially Compliant

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

• All staff have completed mandatory HSELand training, and additional Human Rights Based Approach training.

• The DON/ADON has implemented structured competency assessments, including quizzes and reflective discussions after each restrictive practice toolbox talk, to ensure staff fully understand the training and can apply FREDA principles when supporting residents.

The Clinical Nurse Manager carries out regular spot checks and direct supervision to confirm that learning is applied in practice, with daily walk around documentation demonstrating that restrictive practices are used only in a manner that upholds residents' fairness, respect, equality, dignity, and autonomy.

• Monthly restrictive practice meetings continue to review all restrictive practices and share learning across the team to ensure the least restrictive, rights based approach; FREDA principles are discussed as part of each review. The most recent meeting was held on 26 June 2026

Regulation 23: Governance and management	Not Compliant

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

• Restrictive practice, clinical and environmental audits were reviewed, and audit tools were redeveloped where gaps in identifying non compliance were found. All tools now align with current regulations and standards, ensuring non-compliance is consistently captured and escalated.

• The daily walk around template and staff practice in completing environmental audits were reviewed and corrected to ensure accurate, comprehensive monitoring of environmental and safety compliance.

• All staff involved in audit activity have completed formal audit training. In addition, the DON has provided refresher training to all staff who conduct audits. Audit findings will be reviewed and discussed in the DON's monthly reports to strengthen oversight, support trend analysis, and ensure timely follow up actions.

• The DON ensures that effectiveness of staff training is evaluated through post training assessment and quizzes after the tool box talk is delivered. The clinical management team to conduct regular observations of staff practice, including spot checks to ensure learning is translated into day to day safe practice. Feedback will be provided to staff with additional coaching or refresher training when required. The DON encourage staff to reflect on their learning and share best practice with colleagues during handover/staff meetings. The DON review incidents and complaints daily to assess the effectiveness of the training, monitor KPI monthly and identify any trends.

• The glass panels were repaired immediately on the day of the inspection. To ensure this issue does not recur, the inspection of glass panels has been incorporated into the daily maintenance walk around and is checked routinely by the maintenance staff and the clinical management team.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:

• The Nursing home are engaging with external painting company's and along with our onsite maintenance a full painting schedule has been put in place and is being monitored by the SMT.

• The DON ensures that daily cleaning schedule is in place with documented cleaning records. Clean and disinfect all work surfaces and equipment after use. Ensure proper appropriate ventilation. The Clinical nurse manager is to continue Infection control audits to ensure cleanliness standards are maintained and address any issues promptly.

• The ceiling in the nursing station on the first floor has been repainted.

• The Automatic Door Closer which was not working on the day of inspection has now been repaired.

• The Running Man that was identified as not working has now be repaired.

• A Full Audit of all Radiators throughout the premises was carried out and repairs on radiators are on a schedule to be either repaired and/or radiator covers replaced/ repaired.
• The teacups have been descaled, and replacement cutlery is now onsite to maintain dining standards. Additionally the Schedule of descal of kitchen / cutlery / Teacups and Glass has been increased.
• Environmental audit practices and the daily walk around template were reviewed and refined to support precise, comprehensive oversight of environmental and safety compliance.

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:
• Staff understanding of environmental restraints and restrictive practice rationale is reinforced through regular knowledge quizzes following toolbox talks. The clinical management team conducts routine observations and spot checks to ensure learning is applied in daily practice. The DON/ADON re audit restrictive practice implementation to confirm knowledge gaps have been addressed. All staff have completed mandatory HSELand training, and additional Human Rights Based Approach training. Staff are encouraged to seek guidance when unsure, and knowledge is evaluated through appraisals and performance reviews.
• Residents who completed trials of restraint removal were reassessed, and any resident who no longer required a restraint had the device removed. All restrictive practices now reflect the least restrictive option based on individual risk assessment and assessed independence. Staff have been reminded of the requirement to complete risk assessments before implementing any restraint. Independently mobile residents have been provided with keypad access codes to support freedom of movement, with a butterfly symbol displayed on keypads to identify authorised users. These arrangements are documented in each resident's care plan.
• The DON reviews incidents and complaints daily, monitors KPIs monthly and identifies trends to assess the effectiveness of training and restrictive practice governance. Clinical management continues to observe practice, provide feedback and deliver refresher coaching where required, ensuring restrictive practices are used only when clinically justified and fully aligned with national and provider policy.

Regulation 9: Residents' rights	Substantially Compliant

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

• Staff now seek each resident’s consent and preference before applying clothing protectors at mealtimes. The CNM supervises the dining room daily, completing spot checks and providing feedback to ensure dignity, autonomy and choice are consistently upheld. An audit has identified residents who prefer clothing protectors, and this is documented in their care plans. All staff have completed Human Rights Based Approach training to ensure mealtime practices fully respect residents’ rights.
• Residents were consulted on preferred portion sizes, with feedback documented in care plans and discussed at the residents’ meeting on 29/06/2026. The DON met with the catering team on 03/06/2026 to reinforce the importance of providing meals that reflect individual preferences and nutritional needs. Both chefs completed full day Dining with Dignity training on 29 June, with learning embedded into daily practice and monitored through regular mealtime observations by the DON.
• Residents are offered a choice of two desserts daily, ensuring individual preferences are respected. Daily menus are displayed in the dining room, nurse’s station and reception area, and residents are asked the day before to choose their preferred meals. Dining room experience audits are carried out twice monthly to monitor quality, choice and resident satisfaction.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(2)(b)	The person in charge shall ensure that copies of any relevant standards set and published by the Authority under section 8 of the Act and approved by the Minister under section 10 of the Act are available to staff.	Substantially Compliant	Yellow	13/07/2026
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Not Compliant	Orange	30/11/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe,	Not Compliant	Orange	30/11/2026

	appropriate, consistent and effectively monitored.			
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.	Substantially Compliant	Yellow	13/07/2026
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	13/07/2026
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.	Substantially Compliant	Yellow	13/07/2026