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:	03 June 2025
Centre ID:	OSV-0000013
Fieldwork ID:	MON-0047262

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:	53

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
Tuesday 3 June 2025	18:10hrs to 21:35hrs	Aisling Coffey	Lead
Wednesday 4 June 2025	08:00hrs to 16:25hrs	Aisling Coffey	Lead
Tuesday 3 June 2025	18:10hrs to 21:35hrs	Laura Meehan	Support
Wednesday 4 June 2025	08:00hrs to 16:25hrs	Laura Meehan	Support

What residents told us and what inspectors observed

From what inspectors observed and what the residents told them, residents were generally content living in Beechfield Manor Nursing Home; however, a number of factors were negatively impacting their day-to-day lives in the centre, as set out in this report. The residents spoken with were complimentary of the staff and the care they received. One resident described the staff as "grand people", while others described the staff as "nice" and "kind". While acknowledging the positive attributes of individual staff members, some residents spoken with referred to staffing levels being "a little short", with two residents referring to long waiting periods for assistance after ringing the call-bell. Similar resident feedback regarding inadequate staffing levels to support them, including with timely access to the toilet, was noted in the records of the residents' meetings.

This unannounced inspection was conducted with a focus on adult safeguarding and reviewing the measures the registered provider had in place to safeguard residents from all forms of abuse. The inspection was conducted by two inspectors over two days, commencing with an evening inspection on the first day and followed by a second day of inspection on the following morning. During the inspection, the inspector spoke with 16 residents and two visitors to gain insight into the residents' lived experience in the centre. The inspectors also spent time observing interactions between staff and residents, as well as reviewing a range of documentation.

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 most 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, which was vacant at the time of the inspection, did not have a hand-wash basin present.

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 days of inspection, the lower ground-floor activity room was inaccessible to residents because equipment was being stored in the room and it was locked. One activity room and a small dining room on the

ground floor were also not available to residents as they were used as staff break rooms.

There was an on-site laundry service located on the lower ground floor where residents' personal clothing, towels and bed linen were laundered.

In terms of outdoor space, there were two enclosed terrace areas: one at ground-floor level and one 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 days. The inspectors spoke with two visitors. Overall, they expressed their satisfaction with the quality of care provided to their relatives living in the centre and the communication between staff and families. However, some visitors reported that at times there were insufficient staff on duty. They described experiencing difficulties in finding a staff member to speak with or not seeing staff providing supervision to residents within the centre.

On the first evening of the inspection, the inspectors found that the temperature within the centre did not ensure the comfort of the residents. Multiple residents, visitors and staff reported that the temperature in the centre, including some of the bedrooms and communal areas, was excessively warm. This continued to be a significant issue on the second day. The inspectors were informed that the central heating could not be switched off, nor could the settings be adjusted to account for the outdoor temperature.

As the inspectors walked the centre, they noted that many aspects of the premises required maintenance. The inspectors observed that fire doors to bedrooms were equipped with a device that allowed the resident to keep their door open, but would automatically close the door upon activation of the fire alarm to prevent the spread of fire and smoke. These devices were acoustically operated and powered by batteries. The inspectors observed two instances where these devices were emitting a noise indicating that the batteries needed to be changed. This continuous noise negatively impacted the residents' peaceful enjoyment of their environment and also highlighted the risk that the device would soon not be functioning once the batteries expired. Staff had not responded to this noise and arranged for the batteries to be replaced. The inspectors found that the door to the ground-floor laundry was not closing correctly, which meant the laundry room was accessible to residents. This room housed cleaning and laundry chemicals and had an exit door leading to the outside of the centre. Given the risks to resident safety, these matters were brought to the attention of the person in charge on the first evening of the inspection and to other members of the provider's management team on the second inspection day as the door continued not to close correctly.

The inspectors noted fire safety concerns as they walked the premises, including fire doors observed to be held open with chairs in resident bedrooms, locked fire doors, including an emergency escape route door, and hoist batteries charging on bedroom corridors. These matters were brought to the attention of the person in charge to ensure safety of the residents was maintained. Actions taken by the provider

included removal of chairs from doorways and clearing of all emergency escape routes.

On the first evening, residents were observed sitting at the nurse's stations, in some of the communal rooms, and relaxing in their bedrooms, where they read, watched television, or hosted a visitor. There was a relaxed and unhurried atmosphere in the centre on arrival. Residents were dressed in their preferred attire and appeared content. Staff were serving refreshments between 8:00pm and 9:00pm, which included sandwiches, yoghurts, fruits, biscuits, tea, and coffee. However, inspectors also observed a number of instances where residents were not adequately supervised. For example, on the lower ground floor, the inspectors observed a resident standing on a chair with no staff present. This resident had been assessed as being at high risk of falls. Three residents in the first-floor sitting room were seen sitting for 20 minutes without staff supervision and without access to a call-bell to summon assistance if required.

On the second inspection day, the inspectors noted that the activities listed in the daily activity schedule such as arts and crafts, board games and knitting, were not occurring. Instead, residents were observed sitting for lengthy periods in the ground-floor and first-floor sitting rooms, with the television on but without any other meaningful activity. Mass was broadcast in the sitting rooms in the morning, followed by music on television. Refreshments were served at 11:15am. After lunch in the ground-floor sitting room, staff read the newspaper aloud to residents and engaged them in a discussion on current affairs. At this time, a sewing activity was scheduled in the dining room; however, on observation, this room was not yet cleaned after the lunchtime meal, and no activity was in progress. Residents spoken with described their enjoyment of group-based activities such as exercises, bingo, balloon games and music when they occurred. Two residents informed the inspectors that there were insufficient activities taking place to cater for their interests, with one resident stating "there's a lot of sitting around, too much of it"; while the other resident told the inspectors "there aren't activities every day".

Lunchtime was a sociable and relaxed experience, with 25 residents choosing to dine in the lower ground-floor dining room. Meals were freshly prepared onsite in the centre's kitchen and served to residents as gentle music played in the background. A menu was displayed outside the dining room, and residents confirmed that they were offered a choice of main meal, which included ham or shepherd's pie, and a selection of dessert, which was pudding or custard. The food served appeared nutritious and appetising. There were ample drinks available for residents at mealtimes and throughout the day. Staff provided discreet and respectful assistance to several residents who required this support. Residents spoke positively to the inspectors about food quality, quantity and variety.

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

Capacity and capability

This inspection found evidence that significant focus was required to improve the management and oversight of the care of residents in the centre. Through a review of documentation and observations during the inspection, it was evident that there had been a substantial decline in regulatory compliance since August 2024, which was negatively impacting the quality and safety of care for residents and the provider's ability to safeguard them from harm and abuse.

This was an unannounced inspection with a focus on adult safeguarding and reviewing the measures the provider had in place to safeguard residents from all forms of abuse. This inspection found significant action was required concerning several regulations, including governance and management, as outlined in the report. An immediate action was issued on the first evening of the inspection concerning the storage of medicinal products.

The registered provider of the centre was Beechfield Manor Nursing Home Limited, which is part of the Beechfield Care Group, which operates eight designated centres for older people in Ireland. Within Beechfield Manor Nursing Home Limited, there are two company directors, one of whom serves as the group director of operations and represents the provider in regulatory matters. The group director of operations attended on-site to support the inspection process on the second day of the inspection.

Since the last inspection on 19 February 2025, several changes have occurred in the governance and management of the centre, including the appointment of a new person in charge and the replacement of two persons participating in management. These are senior personnel, who support the person in charge in their operational management and clinical oversight of the centre. At the time of the inspection, the director of nursing was the person in charge and had been in this role for less than two weeks before this inspection. In relation to the persons participating in management, the Office of the Chief Inspector had yet to receive full and satisfactory information regarding one of the newly proposed persons participating in management. This was outstanding since March 2025.

The person in charge is a registered nurse and works full-time in the centre. The person in charge is responsible for overall governance and reports to the director of operations. The person in charge is supported by two clinical nurse managers, a team of nurses, healthcare assistants, catering, housekeeping, laundry, maintenance, activities, administration, and physiotherapy staff. The assistant director of nursing role was vacant on the inspection day.

Communication systems were in place to promote safeguarding and uphold residents' rights. Within the centre, staff meetings were held to discuss operational matters related to the daily care of residents, as well as health and safety issues, including clinical governance meetings, staff meetings, and infection control

meetings. A risk register was used to monitor and manage known risks in the centre. The registered provider had audit systems in place to monitor and oversee safeguarding processes within the centre, however these were not always effective at identifying or addressing risks. The provider had a system for recording, monitoring, and managing incidents and related risks. Notwithstanding this good practice, this inspection found that further robust oversight was needed to safeguard residents and improve regulatory compliance. These matters will be discussed under Regulation 23: Governance and management and Regulation 31: Notification of incidents.

The registered provider had supported staff in reducing the risk of harm and promoting the rights of residents by providing training and development opportunities. The records reviewed found evidence of ongoing staff appraisals that covered multiple competencies, including a resident-centred focus and improving the quality of service for residents. Where there were gaps in the staff members' knowledge or practice, an action plan was attached to the appraisal to address the identified learning need. Staff had access to a range of training programmes to support them in their respective roles. All staff had completed training on identifying, preventing, and reporting abuse, as well as managing challenging behaviour. The provider was in the process of rolling out a programme to educate staff on residents' rights and restrictive practices.

Records reviewed found that over 50% of staff had received this training at the time of the inspection. The provider had also conducted multiple in-house workshops on topics including assessment, intervention and person-centred care planning, legislative changes, advocacy for residents, restrictive devices, safety checks and providing one-to-one care. Notwithstanding this good practice in relation to staff appraisal and training, robust action was required to improve the supervision of staff and to ensure the assessed needs of residents were supported and that they were safeguarded from harm. This is discussed under Regulation 16: Training and staff development.

The inspectors reviewed four personnel files to review the provider's recruitment practices to safeguard residents from abuse. The registered provider had ensured that the necessary information, as required by Schedule 2 of the regulations, including Garda Síochána (police) vetting disclosures, documentary evidence of relevant qualifications, required references and current registration details, was available for these staff members.

The provider had a suite of written policies and procedures to guide staff practice, including a policy of safeguarding residents from abuse, a complaints policy, a policy on the use of restraint, a policy on managing challenging behaviour and a policy on safeguarding residents' property and finances.

Regulation 15: Staffing

While the number and skill mix of staff present throughout the two day inspection was seen to be appropriate to meet the needs of residents, the provider had not ensured that the number and skill mix of staff were suitable to meet all the identified needs of residents while maintaining their safety and promoting their rights, at all times. This was evidenced by the following findings:

- Two residents informed the inspectors of long waiting periods for assistance after ringing the call bell.
- The inspectors reviewed similar resident feedback regarding inadequate staffing levels to support their care needs, including waiting prolonged periods for support to use the toilet, as recorded in residents' committee meetings.
- Some visitors informed the inspectors that at times there were insufficient staff on duty, and these visitors described experiencing difficulties in finding a staff member to speak with or not seeing staff providing supervision to residents within the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider was required to take action to support staff in reducing the risk of harm and promoting the rights of residents by providing enhanced supervision to ensure the assessed needs of residents were supported, for example:

- A number of residents were observed to be unsupervised for 20 minutes in a communal area on the first evening of inspection.
- Staff were observed to utilise resident communal spaces for meal breaks, despite a staff break facility being available. This meant that facilities registered for residents' use were not available to them at all times.
- The registered provider had failed to ensure that effective measures were in place for the supervision of staff to ensure they implemented the local policies in practice. For example, inspectors found poor adherence to care plans, inadequate fire safety measures, and repeated failures of management to recognise and correct deficits in care, including the accurate reporting of incidents.
- Notwithstanding that staff had received mandatory training, further action was required to ensure they were effectively supervised and that they implemented the principles of training into practice.

Judgment: Not compliant

Regulation 23: Governance and management

While the provider had multiple management systems in place in respect of the service's approach to safeguarding these systems were not sufficiently robust to be effective, consistent and appropriate to ensure residents' safety. For example:

- The monitoring, audit and oversight systems were not fully effective in identifying the significant risks found on this inspection and driving quality improvement in areas such as individual assessment and care planning, managing challenging behaviour, protection, residents' rights, communication, and premises.The failure of clinical oversight and effective supervision adversely impacted the safety of the residents and visitors as further outlined under the respective regulations.
- The registered provider had failed to ensure the designated centre was secure and take appropriate action to ensure residents' safety. Despite a risk of a malfunctioning door being highlighted to the provider during the inspection, it was not repaired in a timely manner during the inspection, resulting in a resident leaving the centre unsupervised the following day. This was the second such occurrence in the centre.
- The management systems in place to provide assurance regarding the secure storage of medicinal products were ineffective; for example, inspectors found nutritional supplements accessible and not secured at the first-floor nurses' station. Consequently, an immediate action was issued on the first inspection day concerning the storage of medicinal products. Inspectors confirmed that this was addressed on the second day of the inspection with all medicinal products securely stored.
- 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.
- The provider failed to ensure sufficient arrangements were in place to protect residents' finances within the centre, including clear guidance within the policy. This included the measures to support residents who wished to retain control of their money and measures to return residents' finances and possessions to their estate following the death of a resident. This is further discussed under Regulation 8: Protection.
- While the provider was progressing with a compliance plan to improve fire precautions following the 19 February 2025 inspection, further poor practices and ineffective day-to-day oversight of fire safety risks to residents were observed throughout the two-day inspection, for example:
    - Hoist batteries were observed charging in bedroom corridors on the lower ground and first floors. Charging hoist batteries in a bedroom corridor introduces a fire risk to this protected escape route.
    - Fire doors, including the door to a bedroom that contained oxygen, and a sitting room door, were observed to be propped open by means other than appropriate devices connected to the fire detection and alarm system. This could prevent the door from closing in the event of the fire alarm activating.
    - The door to the lower ground floor activities room from the sitting room was observed to be locked from inside the activities room with a thumb lock. This route through the activities room was identified as an

emergency exit route and was required to be available at all times in the event of an emergency.
    - The door to the laundry, a room of increased fire risk, was not closing correctly, impacting the containment measures in the centre.
- The registered provider had failed to implement actions set out in the previous compliance plans submitted to the Chief Inspector. For example, effective monitoring of the call-bell system, ensuring adherence to the activity schedule following consultation with residents and the installation of a sink in a bedroom.
- While the provider had prepared an annual review of the quality and safety of care delivered to residents, this review did not contain a quality improvement plan as required by the regulations.

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. A review of the documentation and nursing records found multiple incidents whereby residents had been impacted by the responsive behaviours of a peer. These incidents had not been notified as required. The provider was required to conduct a full review of all incidents and retrospectively submit these to the Chief Inspector.

Judgment: Not compliant

Quality and safety

The purpose of this inspection, focused on adult safeguarding, was to review the quality of service being provided to residents and ensure they were receiving a high-quality, safe service that protected them from all forms of abuse. This inspection found that robust action was required from the provider to proactively recognise and respond to safeguarding concerns in the centre, and ensure all measures were taken to protect residents from harm. Significant action was required concerning individual assessment and care planning, managing behaviour that is challenging, protection and communication needs. Other areas also requiring improvement included residents' rights and premises.

While the person in charge had made arrangements to meet the safeguarding needs of each resident as identified through their assessments before and upon admission

to the centre, significant gaps in care planning were observed, which will be outlined under Regulation 5: Individual assessment and care plan.

Robust action was 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 and care planning was not sufficient to ensure that responsive behaviours were 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 to safeguard residents from abuse, but these systems had not ensured 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. Records reviewed found some allegations of abuse had been investigated in line with this policy. The provider was in the process of making arrangements to act as pension-agent for two residents, but had not assumed this responsibility at the time of the inspection. Notwithstanding these good practices, considerable action was found to be required to ensure all reasonable measures were taken to protect residents from abuse. This will be discussed further under Regulation 8: Protection.

The inspectors found that 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. Residents had access to independent advocacy services, and records reviewed found that several residents had been referred for advocacy support. The person in charge had recently arranged an in-house awareness campaign by an advocacy service. The provider had displayed information posters on recognising abuse and accessing support services. Notwithstanding these good practices, further action was required by the provider to foster a culture where a human rights-based approach to care was central to how residents were supported, and the FREDA principles of fairness, respect, equality, dignity, and autonomy were implemented in daily practice. This is discussed under Regulation 9: Residents' rights.

The inspectors observed that several residents had communication difficulties. Some residents had challenges communicating verbally, while other residents could communicate verbally but did not speak English. These residents had their communication difficulties documented in their care plans, and the inspectors found that staff were aware of these residents' communication needs. For non-verbal residents, the inspectors observed that care plans included communication techniques to enhance the resident's understanding of what was being communicated and referenced activities to ensure the resident's participation and inclusion. Where residents did not speak English, however, further improvements were required to ensure such residents could communicate freely and had their

specialist communication requirements met. This is discussed under Regulation 10: Communication difficulties.

While the provider had decorated the premises to an acceptable standard and provided communal spaces for residents to use, the provider was required to consider safeguarding in ensuring that the premises were appropriate to meet the needs of all residents and in accordance with all the requirements of Schedule 6 of the regulations. This is discussed under Regulation 17: Premises.

Regulation 10: Communication difficulties

The inspectors observed a resident who did not speak English attempting to communicate in their native language, experiencing agitation and upset due to not being understood, and similarly struggling to understand what was being communicated to them. The inspectors were informed by some staff that they had previously used their personal mobile phones to facilitate translation and to provide the resident with music and television programming from their native country. Notwithstanding these kind and considerate actions by individual staff members, the registered provider did not ensure that residents were facilitated to communicate freely in accordance with the residents' individual needs and abilities, for example:

- A resident's communication care plan recorded the fact that the resident could not speak English and referred to the resident having the support of an interpretation service four times per week. Staff spoken with confirmed the resident had accessed the interpretation services just once previously. There were no records of the service being used to facilitate the assessment and care planning process or to support the development of further communication tools that would enhance the resident's communication and inclusion.
- A resident's communication care plan referred to the use of pictorial signage and a picture book to orient the resident and support their communication; however, these tools were not seen to be available to the resident. Staff showed the inspectors a booklet that had been provided to support the residents' communication, but this booklet was unsuitable for the resident's needs and the designated centre setting.

Judgment: Not compliant

Regulation 17: Premises

The registered provider had failed to ensure that the premises of the designated centre were used in line with its conditions of registration and in accordance with the statement of purpose prepared under Regulation 3. Inspectors found that the

lower ground floor activity room was locked and not available to residents, and was used for storing equipment. In addition staff also utilised residents' communal spaces for their breaks. This meant that recreational spaces and facilities registered for residents' use were not available to the residents.

The provider was required to consider safeguarding in ensuring that the premises were appropriate to meet the needs of all residents and in accordance with all the requirements of Schedule 6 of the regulations. For example:

- The temperature within the centre did not ensure the comfort of residents. Multiple residents, visitors and staff reported that the temperature in the centre, including some of the bedrooms and communal areas, was too hot. The inspectors similarly observed this finding over the two inspection days, but were informed that the central heating could not be switched off or adjusted as required.
- The decor and upkeep of resident bedrooms and communal areas required review, as these areas showed signs of wear and tear, with walls and doors damaged and plaster missing from some walls. There were also areas within the centre with damaged flooring, including residents' bedrooms and communal areas.
- Some bedrooms were observed to be bare with no decorative features in place. There was no evidence of consultation with residents or their families should they wish to decorate or personalise this space.
- Premises were not kept in a good state of repair internally to ensure it was safe and appropriate for the residents. For example, the door to the laundry room was not closing correctly, meaning it was accessible to residents. This room contained chemicals and had an exit door leading outside the centre.
- The door to the lower ground-floor staff canteen was unlocked, making it accessible to residents. This room contained food that may present a risk to a resident with specialist dietary requirements.
- A bedroom on the ground floor did not have a resident sink available within the bedroom, as required by the regulations. This was a repeat finding from the previous inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

Significant action was required concerning individual assessments and care plans to ensure that each resident's needs were comprehensively assessed and an appropriate care plan was prepared to meet these needs, for example:

- The registered provider had failed to meet the needs of each resident, despite these needs having been assessed before admission. For example, in two care plans reviewed, known safeguarding risks identified before admission had not been incorporated into the residents' care plan to guide

staff in meeting the complex and specific care needs of those residents who may display behaviours that would pose a safeguarding risk to others.

- Care plans were not always reviewed and updated at required intervals. For example, for residents who commenced displaying responsive behaviours, their care plans had not been reviewed and updated at regular intervals, to reflect the changing needs of the resident and to ensure staff had clear guidance on how to meet these changing and complex needs.
- Recommendations from health care professionals were not always incorporated into care plans to reflect each resident's current needs. For example, the general practitioner (GP) had recorded written recommendations regarding the care needs of a resident 11 weeks before the inspection; however, these recommendations had not been implemented and were not documented in the care plan, which meant that resident was not provided with appropriate care to meet their needs
- Some of the individual care plans outlined interventions that the resident was not receiving, such as access to interpreter services four times per week.
- While the provider had tools to capture person-centred information, such as "a key to me", "my concerns" and "my day", in a sample of resident documentation reviewed, there was limited or no information about the residents' life history and social care needs, such as their hobbies, preferred routines, and other personal preferences which would support and inform person-centred care.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

The provider had admitted residents with complex care needs, including those deemed to require focused one-to-one care for the behavioural and psychological symptoms associated with their diagnosis. The person in charge had failed to ensure that staff had the required knowledge and skills to respond to and manage responsive behaviours. Behavioural support care plans were developed for these residents, detailing potential triggers of behaviours and containing generic de-escalation strategies. The behavioural support care plans were not effective as they did not provide clear and step-by-step guidance to staff on how to manage or respond to known responsive behaviours displayed by some residents.

Robust action was required to:

- Review 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 risk of harm to themselves, other residents, visitors, and staff.
- Ensure the behavioural support care plans provide accurate and clear direction for staff to respond to responsive behaviour appropriately and in a

stepped fashion, managing the behaviour and ensuring that appropriate supports are in place for residents with responsive behaviour.
- 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 personal possessions.
- Ensure all staff had up-to-date and knowledge and skills to respond to and manage responsive behaviours.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had failed to take all reasonable measures to protect residents from all forms of abuse. 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.

The registered provider had failed to recognise a known safeguarding concern and to implement measures to mitigate this risk. Safeguarding concerns had been documented by the resident's previous care setting and were recorded in the resident's electronic notes within the centre. However, the provider had failed to risk-assess these concerns and implement measures to safeguard all residents from potential harm. While these known risks were identified within the individual's care plan, staff spoken with were unaware of the risk and what measures were required to safeguard all 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, including residents' possessions, being damaged.

A number of 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 provider's policy outlined the requirement for a safeguarding plan if a resident entered a peer's bedroom. Despite these incidents occurring, no such safeguarding plans were in place for the relevant parties.

The provider had not put sufficient arrangements in place to protect residents' finances within the centre, for example:

- A clear system was not in place to safeguard residents' finances should they wish to maintain funds within the centre. During the inspection, it was noted that a resident's wallet had been misplaced. Due to a lack of recording, the staff were unsure of the amount of money in the wallet. Staff spoken with discussed the measures in place to safeguard finances, including a logbook and recordings. These were not present on the day of the inspection.
- The provider's policy stated that any money received within the centre was to be logged by delegated persons, including the person in charge. This did not account for instances when the person in charge was absent and did not ensure that the money was effectively logged and stored in a secure manner. Staff were not aware of this procedure.
- The registered provider has not ensured that effective measures were in place to return residents' finances and possessions to their estates following the death of a resident. Guidance for staff on the procedure to follow was not present within the provider policy to ensure all residents' possessions were returned following their passing and safely stored while awaiting this transition.

Judgment: Not compliant

Regulation 9: Residents' rights

Action was required by the provider to foster a culture where a human rights-based approach to care was central to how residents were supported, and the FREDA principles of fairness, respect, equality, dignity, and autonomy were implemented in daily practice, as outlined below.

Improvements were required to ensure that all residents were provided with opportunities to participate in activities in accordance with their interests and capacities, for example:

- While the majority of staff were respectful and courteous towards residents, some interactions observed were primarily task-based, focused on the personal care task or assistance required by the resident, without meaningful engagement, such as a warm greeting, a smile or chatting with the residents about their interests.
- While the provider had an activity schedule and group-based activities were observed on the second inspection day, residents were also seen sitting for lengthy periods in the sitting rooms with the television on, but without other meaningful activities. Additionally, two residents informed the inspectors that insufficient activities were geared towards their interests and capacities.

Action was required to ensure that the dignity and privacy of residents were maintained at all times, for example:

- Residents and visitors using the ground floor sitting room could be observed by staff located in the treatment room. There was no signage in the sitting room advising residents and visitors that they were visible.
- There was visible signage on some bedroom doors and directly inside the residents' bedrooms, which could be seen from the corridor, outlining aspects of the residents' care needs, dietary requirements, and medical treatments.
- The privacy in some residents' bedrooms required review, as these looked directly onto outdoor communal spaces such as the smoking area and main entrance.

The registered provider failed to facilitate residents to exercise choice in their daily lives, for example:

- One resident informed inspectors that they could not attend activities in the communal areas, if they chose to, as they had no access to correct seating to support them. This resident spent all their time in bed in their room and spoke to inspectors about how they would like to have the choice to do more and leave their room. While a referral for an occupational therapy review had been made no follow up had been completed. Multi-disciplinary reviews completed did not include a review of seating for the individual.
- Another resident stated that they did not leave their room because they felt unsafe mobilising to the communal space alone and therefore could not join their peers in the dining room or participate in group activities as and when they wished to.

Improvements were required to ensure that residents' religious rights were respected. For example, a resident who was not Roman Catholic and had documented in their care plan that they did not wish to attend Roman Catholic services was incorrectly recorded as having regularly attended such services.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Not compliant
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and care plan	Not 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-0047262

Date of inspection: 04/06/2025

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: • Beechfield Nursing Home has implemented a revised governance and management structure within the home, which will ensure effective oversight of the care of residents incorporating effective supervision of staff and all aspects of resident care. • The home has reviewed the number and skill mix of staff present throughout the home and it meets the needs of residents. Retraining for staff regarding the call bell system was arranged via Call Bell Contractor, a company the nursing home uses in specialising in customised communications solutions for healthcare facilities in Ireland. • A new allocations system has been rolled out across the home. This enurses that there is sufficient staff across the home to attend all residents needs and supervision. • A new daily walk around template has been rolled out across the home. This is conducted by a member of the local management team and SMT when in the home. Visual inspections are conducted and any findings documented on the day. This can then be checked / verified by checking the call bell system which is done daily. • Call bells are located in all resident areas, since the inspection, signs have been placed above the call bell to identify the location for residents residing in these areas. • A residents meeting was held on the 29/07/2025 and issues identified in at the inspection were discussed. • Effective communication training was delivered on site by external training company for all staff.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development:	

• A new allocations system has been rolled out across the home. This ensures that there is sufficient staff across the home to attend all residents needs and supervision, both day and night.
• All staff have been communicated and informed about not using resident communal spaces for their breaks. All staff are now using the dedicated staff break area only for meals and break times.
• All staff have been spoken to about placing inappropriate items to hold open doors. This forms part of the daily walk round.
• Care plan workshop training has been attended by all nurses. A full review of all care plans has been carried out across the home.
• A new suite of toolbox talks have been rolled out across the home and circulated to staff to include:
o Effective communication training
o Continence Care
o Enhancing the dining experience
o Restrictive Practice
o Safeguarding
o Call bell training
o IDDSI
o IPC
o End of Life
o Medication Management
o Falls
o Patient Advocacy
o Fire

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• Beechfield Nursing Home has ensured that any post holders in the revised governance and management structure have the knowledge, competence and skills required to supervise the delivery of care to our residents and to comply with regulations.
• Beechfield Nursing Home confirms that there are effective management systems within the home. These are guided by the governance structure as outlined above which is made up of trained, competent and experienced individuals, supported and overseen in a structured way by Beechfield Care Group senior management team. Supervision of staff has increased in the home. This is ongoing and has been achieved by regular monitoring by the new senior governance team who provide on the floor monitoring and observation of all aspects of care across all departments. The auditing schedule has been further developed and accountability enhanced. With enhanced monitoring of practice on the floor, issues, as they arise, are actioned not only in completion but the teaching surrounding the approach to completion is in place. This is providing staff with immediate

feedback, and with supported learning so they can learn in a practical manner and show improvement thereby ensuring improved standards of care.

• All policies and procedures have been reviewed and updated since the inspection. The home has provided, specific retraining on line and in person in:
• Individualised assessment and care planning.
• Managing behaviour that is challenging.
• Protection and safeguarding.
• Residents' rights, choice and personalized and person-cantered care.
• Communication including nonverbal.

• The malfunctioning laundry door has been repaired. Access to the Laundry and the door now forms part of the daily walk around checks. Any issues raised or identified are actioned immediately where applicable or escalated to the Group Maintenance manager for actioning.

• All nutritional supplements were removed and stored appropriately on the day of inspection. Following this all nurses completed Medication Management training. Observations of medication also forms part of the daily walk arounds. A risk memo was sent to the home and all homes within the group re: thickening agents.
• Since the inspection, retrospective submissions were made to the regulator relating to the identified incidents which fell under the required statutory remit for notification.

• Following the inspection the 'Management of Residents' Accounts and Property, including Pension Management policy' was updated. A Finance audit was carried out in the home after the inspection by the Group Financial Controller. The safe has been reviewed by the Group Quality Lead and Assistant Director of Nursing. A new financial log record has commenced.

• All incidents are reviewed daily by the management and governance team within the home. They are supported by the SMT who will provide support and guidance around any incidents. Since the inspection, retrospective submissions were made to the regulator relating to the identified incidents which fell under the required statutory remit for notifications.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• Since the inspection, retrospective submissions were made to the regulator relating to the identified incidents which fell under the required statutory remit for notification.

• The PIC reviews all incidents which occur in the centre on a weekly basis and

documents the same on a newly devised and implemented clinical oversight template. Escalation to regulatory agencies is made where necessary.

Regulation 10: Communication difficulties	Not Compliant

Outline how you are going to come into compliance with Regulation 10: Communication difficulties:
• Since the inspection, the residents' communication has been reviewed in its entirety to ensure that the care planning process is reflective of known or expressed personal preferences. The home recognises that facilitating appropriate communication channels are fundamental to resident rights and integral to person-centered care delivery.

• The PIC has made internal arrangements to circulate an electronic assistive communication tool for staff to use to enhance and supplement communication channels for the resident and a supplemental communication book in the resident's native language has been recirculated for staff use.

• Arrangements remain in place for the resident to avail of interpreter inputs at regular pre-determined intervals or more frequently as dictated by preference or an alteration in the clinical status of the resident.

• A component of these interpreter supports now also includes seeking resident input as a component of the assessment and care planning process.

• The PIC has devised and implemented a record template which outlines and stipulates when the resident avails of the service.

• Following the inspection, the PIC has instigated a review of the pre assessment process for the centre. The pre assessment now incorporates a more robust review of all relevant domains inclusive of communication to ensure that the necessary resources and supports required for each individual resident is agreed upon and where necessary, escalatory support pathways sourced prior to admission to the centre.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• The lower ground floor activity room is unlocked and in use for all residents. The right for residents to avail of ongoing and maintained access to facilities and communal areas

in line with individual preference is acknowledged and respected. Since the last inspection it has been enforced that staff are not permitted to avail of or use residents' communal areas at break times.

• Arising from the inspection findings, subsequent arrangements have been made for an external contractor to attend the centre to review the central heating system. A mechanism and an accompanying SOP have since been implemented and circulated to relevant staff outlining how to adjust and control all aspects of the system.

• Supplemental thermometers have since been purchased and circulated in various areas throughout the centre. The PIC in collaboration with the Clinical Management team assumes ongoing responsibility for ensuring that temperature checks are conducted at daily intervals and any concerns in this regard appropriately escalated.

• The PIC in consultation with the residents residing in the centre has commissioned a review of the décor in bedrooms and communal areas of the home. In incidences whereby notable wear and tear is noted to exist, arrangements have been made to escalate to the Group Maintenance Manager for review and remedy.

• Since the inspection, the PIC has further consulted with residents and/or their nominated representative where appropriate to ascertain individual preference with respect to the decorating of personal spaces.

• The malfunctioning internal laundry door identified on the date of the inspection has since been remedied. Further subsequent arrangements have also been made to source an external contractor who attended the home to review the integrity of the exit-door leading from the laundry to outside the designated centre. This has been completed.
• A key coded access point has since been installed to the staff canteen.

• A sink is scheduled to be installed into the room on the ground floor

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• The pre-admission assessment is completed prior to admission to the centre. The residents care plan has been reveiwed. The PIC oversee that comprehensive care plan review is carried out when a risk identified. Each of the nurses have allocated residents for care plan to complete. The PIC have to check any care plans oustanding daily. This is printed out and given to each nurse after the morning huddle. This then will be checked and ensure that all care plans are completed.

• The PIC including the clinical managers increase the frequency of care plan audits to

monitor and incorporate in care plan any significant changes in residents condition. The PIC ensures 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. A new handover document has been drafted by the group quality lead and implemented.

• A care plan workshop has been facilitated for all nurses by group quality and care lead. Care plan templates have been developed and circulated to all nurses within the home. All care plans within the home have been reviewed and updated where appropiate.

• During the GP visits, the CNM ensures that GP recommendations are documented, implemented and shared in the afternoon huddle. Any recommendations that are made by healthcare proffessionals are incorporated into their Care monitor record and updated.

• Arrangements remain in place for the resident to avail of interpreter inputs at regular pre-determined intervals or more frequently as dictated by preference or an alteration in the clinical status of the resident. The PIC has designed a template so accurate information is being entered every time the interpreter comes.

• PIC and CMT reviewed all care plans ensuring that theses are all up to date and reflects that it is person-centred and meet the individual care needs.

• PIC and CMT maintain oversight of care plan interventions to ensure completion and that services are being access where needed.

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:
• A detailed pre-assessment is carried out on all prospective residents prior to admission to ensure that their needs are being met by the centre. All staff at the centre have all the required trainings in responsive behaviour, dementia, restrictive practices and safeguarding. The centre has clear policies in place to guide same. The home is arranging MAPA training for all staff within the home.

• Care plan workshop was attended by all staff and refresher training has been attended by all staff for responsive behaviour, safeguarding and communication. The quality lead and PIC/ADON are giving daily tool box talk with regards to managing responsive behaviour. ABC charts are in place in the occurrence of any behavioural incidents.

• Care plan templates have been developed and circulated to all nurses within the home. All care plans within the home have been reviewed and updated where appropiate. The

PIC 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 PIC will ensure staff had clear guidance on how to meet these changing and complex needs.

• Any residents with complex needs will continue to have 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:
• Pre-admission assessments are carried out by the PIC prior to admission to ensure that residents needs are being met at the centre.

• All staff have completed their safeguarding training and there are policies in place to guide staff. Safeguarding toolbox talks have been conducted during morning huddle.

• If there are any incidents related to responsive behaviour, staff will document all information in the appropriate reports, incident reports / ABC charts. The PIC will oversee that all residents are safe in the nursing home. If there are any changes in a residents behaviour, their care plan will be updated to reflect any changing needs and the PIC will ensure staff have clear guidance on how to meet these changing and complex needs.

• Care plans are all in place and updated with regards to responsive behaviour and safeguarding care plan

• Following the inspection the 'Management of Residents' Accounts and Property, including Pension Management policy' was updated.

• A Finance audit was carried out in the home after the inspection by the Group Financial Controller. The safe has been reviewed by the Group Quality Lead and Assistant Director of Nursing. A new financial log record has commenced.

• A new SOP has been designed on how the residents can access their money at all times even out of hours. This is being kept in DON's office and all delegated staff have been informed of this procedure.
• A circular has been sent to families / NOK informing them to let management know when they bring money in so it can be logged and stored in the safe preferably. Request made to families if they want to keep money in room to let management know so safe storage can be provided.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The staff have all completed training online. The company engaged with an external company who provided on site training on Communication Skills on July 28th.

• The activity schedule was reviewed by the Director of Nursing and activity staff ensuring that preferences are included in the activity schedule. There is a clear plan on how and where the activities are happening and this is displayed throughout the home. More external activities are being planned and implemented.
• There is now signage on the window in the ground floor sitting room advising visitors and residents that they can be viewed. Signs on bedroom doors whuch outlined care needs removed by ADON.
• Any signage with residents personel information in residents bedrooms that could be seen from the corridor has since been removed.
• Privacy screens have been installed on all bedrooms loking out onto the smoking area and main entrance.
• The Director of Nursing along with the Group Quality and Care lead spoke with the resident who informed inspectors that they could not attend activities. This residents wishes has been updated within their care plan ans narrative notes. They do not wish to attend activities or have an OT referral sent on their behalf.
• All residents religious rights have been reviewed and staff informed of their individual preferences.

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.	Not Compliant	Orange	30/06/2025
Regulation 10(3)	The person in charge shall ensure that staff are informed of any specialist needs referred to in paragraph (2).	Substantially Compliant	Yellow	30/06/2025
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	Substantially Compliant	Yellow	31/07/2025

	of the designated centre concerned.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/07/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/07/2025
Regulation 17(1)	The registered provider shall ensure that the premises of a designated centre are appropriate to the number and needs of the residents of that centre and in accordance with the statement of purpose prepared under Regulation 3.	Not Compliant	Orange	31/08/2025
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	31/08/2025
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and	Not Compliant	Orange	31/07/2025

	effectively monitored.			
Regulation 23(1)(h)	The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e).	Not Compliant	Orange	31/07/2025
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	30/06/2025
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Not Compliant	Orange	31/07/2025
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	31/07/2025

	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.	Not Compliant	Orange	31/07/2025
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.	Substantially Compliant	Yellow	31/08/2025
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	31/07/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to	Not Compliant	Orange	31/07/2025

	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.	Substantially Compliant	Yellow	31/07/2025
Regulation 8(3)	The person in charge shall investigate any incident or allegation of abuse.	Not Compliant	Orange	31/07/2025
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	30/06/2025
Regulation 9(3)(a)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise choice in so far as such exercise does not interfere with the rights of other residents.	Not Compliant	Orange	30/06/2025
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.	Not Compliant	Orange	30/06/2025

Regulation 9(3)(e)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may exercise their civil, political and religious rights.	Substantially Compliant	Yellow	30/06/2025