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:	Beechwood Nursing Home
Name of provider:	Maisonbeech Limited
Address of centre:	Rathvindon, Leighlinbridge, Carlow
Type of inspection:	Unannounced
Date of inspection:	20 March 2026
Centre ID:	OSV-0000199
Fieldwork ID:	MON-0049875

About the designated centre

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

Beechwood Nursing Home is a purpose-built, single-storey residential service for male and female persons over 18 years of age and is located within close proximity to the town of Leighlinbridge and across the road from a busy arboretum. The designated centre provides accommodation for 57 residents in 57 single bedrooms. Full ensuite facilities were provided in 30 single bedrooms. Sufficient toilet and shower facilities were conveniently located throughout the centre to meet residents' needs. Accommodation for residents is provided at ground floor level throughout. The centre has a number of communal facilities, including two dining rooms and three sitting rooms, one of which could be subdivided to meet residents' activity needs. The centre provides long-term, respite, and convalescence care for residents with chronic illness, dementia and palliative care needs. The provider employs a staff team in the centre to meet residents' needs consisting of registered nurses, care assistants, maintenance, housekeeping and catering staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	56

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
Friday 20 March 2026	08:25hrs to 16:35hrs	Niamh Moore	Lead
Friday 20 March 2026	08:25hrs to 16:35hrs	Sinead Lynch	Support

What residents told us and what inspectors observed

Inspectors observed numerous kind and courteous interactions between staff and residents throughout the day. Staff were observed supporting residents when required or requested. However, on the morning of the inspection some residents were observed to have no access to call bells. Notwithstanding that these call bells were in each residents bedroom, in some bedrooms they were found to be clipped to the wall and not within easy reach for some residents.

Inspectors arrived unannounced to the centre, and were met by the assistant director of nursing. Following a brief discussion, inspectors walked through the centre, reviewed the premises and met with residents and staff. Following this, the inspectors then completed an opening meeting with the person in charge.

The designated centre is registered for 57 residents with 56 residents living in the centre on the day of the inspection. The premises is located on a ground floor level, and was observed to have appropriate lighting, heating and ventilation. There was ample communal space for residents to spend time together, and also some smaller areas to receive visitors. The communal spaces included, two sitting rooms, two dining room's, a library, and an activity room. There were outdoor secure areas made available to residents, and on the day of inspection as the weather was fine, residents and staff were observed utilising these areas.

Inspectors observed that the physical environment of the centre was clean. However, there were areas which required further maintenance, such as paint work on corridors and particularly to the outdoor areas where weeds were seen. Some visitors also raised the premises as an area for improvement, stating that the areas of wear and tear particularly of the outdoor areas, limited a pleasant and inviting space for residents to enjoy.

Residents' accommodation was in single bedrooms, with access to en-suites or shared bathrooms. Inspectors viewed a sample of bedrooms and saw that they were personalised with residents' belongings and had sufficient storage facilities for residents' clothes. Residents said that they were happy with their bedrooms.

Inspectors spoke with five visitors who gave mixed feedback regarding their experience of the service. While many visitors complimented the care their loved ones received, several expressed dissatisfaction with some areas, which included the provision of care their loved ones had received recently. In addition, one visitor expressed concern regarding managements responsiveness to address issues raised, noting that despite raising a concern, the same incident reoccurred.

Relatives and residents raised concerns about the laundry service and the safe-keeping of personal possessions. One resident had complained on numerous occasions to staff, while other residents reported different items going missing at

different stages throughout their stay in the centre. The inspectors visited the laundry room where they observed clothing that had no labels so these could not be returned. However, no action had been taken by management to actively seek out their rightful owners and return these personal possessions.

A varied activities schedule was on display on the notice board in the centre and residents were informed of the daily events, while also staff reminded residents of the daily events each morning. Mass was provided to the residents in the centre each Thursday, and they also had the opportunity to watch Mass daily on the television. Other activities included; group exercise and live music.

Inspectors observed the lunchtime meal in the dining room, and saw that staff were attentive to resident's needs. On the day of the inspection, residents were given a choice of two options, such as salmon and lamb stew. Those who required assistance with their meals received support from staff in a respectful and dignified manner. Residents spoken with confirmed they enjoyed their meals.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect 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

Overall there were systems in place to ensure the service was monitored. However, inspectors found that these systems had not ensured residents were always provided quality care and support. The areas that did not fully meet the regulations, included the implementation of policies, staff supervision, governance and management oversight, timebound action plans and the notification of incidents.

This was an unannounced inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended). The inspectors reviewed documents and evidence in relation to information received since the last inspection in January 2026.

Beechwood Nursing Home is owned and operated by Maisonbeech Limited, which is the registered provider and part of the Beechfield Care Group. The company is comprised of two directors. There had been substantial changes to the senior management structure since the previous inspection. The person in charge had left and had been appointed as a person participating in management with oversight for quality and care for the provider group. A new person in charge had been appointed and notified to the Chief inspector of Social Services, however not all required information was submitted to ensure timely processing of the information. They worked full-time in a supernumerary capacity in the centre. The person in charge

was supported in their role by an assistant director of nursing, a team of nurses and health care support staff.

Other staff included nurses, healthcare assistants, activity coordinators, catering, housekeeping, laundry and administrative support. The person in charge informed the inspectors that staffing allocation was determined by the residents' assessed needs, and these may change from day- to-day.

Staff were provided with mandatory and relevant training to meet the needs of their role. Staff training was closely monitored to ensure a high attendance at training. However, inspectors found that enhanced supervision of staff practices was required to ensure that staff member's knowledge was effectively implemented into practice, leading to positive outcomes for residents. In addition, there were gaps in supervision not provided in line with the registered provider's Staff Education and Development policy. This is further discussed under Regulation 16: Training and staff development.

Some management oversight systems were in place which included meetings, committees and auditing. Key clinical data was trended on a monthly basis and there was evidence of a reduction in falls occurring. Inspectors saw there was regular management meetings held in the centre which were attended by key members of management, and these meetings discussed key aspects of the service. However, inspectors found that areas of oversight did not always identify gaps in compliance with the regulations, and in some cases despite identifying required improvements, they were not fully actioned. This is further discussed under Regulation 23: Governance and Management.

Notifiable incidents were not always submitted to the Chief Inspector in line with regulatory requirements, as detailed further under Regulation 31: Notification of incidents.

The management of complaints required further strengthening. Verbal concerns and complaints raised to staff by residents or relatives were not escalated to the management or complaints officer in line with policy. Therefore management had not always received the complaints in a timely manner, impacting their ability to respond and to put actions in place. There were two complaints recently reported and these were not dealt with in line with the centres policy.

Registration Regulation 6: Changes to information supplied for registration purposes

While the registered provider had given notice in writing to the Chief Inspector of the intended change in the identity of the person in charge, they had not supplied full and satisfactory information, within 10 days of being appointed to the role, in relation to the matters specified in Schedule 2.

Judgment: Substantially compliant

Regulation 14: Persons in charge

The person in charge has the relevant experience and qualifications as required by the regulations. For example, they are a registered nurse with experience in the care of older persons and hold a post registration management qualification. They were also in the process of completing a nursing post-graduate qualification at a minimum of Level 9 on the National Framework of Qualifications which includes a management or leadership module with expected completion of this in the coming months.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured that staff were appropriately supervised and in line with their own policy. For example:

- There was a lack of oversight to ensure all residents were given the correct consistency of food as prescribed. Following a recent complaint, staff received re-training in International Dysphagia Diet Standardisation Initiative levels, however supervision measures had not ensured this training was put into practice, this resulted in a repeated incident of the incorrect consistency of food provided to a resident.
- Staff were not supervised to ensure that all residents care was provided in line with their assessed needs, as discussed under Regulation 5: Individual assessment and care plan.
- A staff member who commenced their post in December 2025 did not have any evidence of an induction form completed or evidence of any probation review completed for new employees.
- There was no evidence that annual appraisals for two staff who had been employed within the centre for a number of years, had been completed.
- A number of staff were overdue their annual appraisal since December 2025.

Judgment: Not compliant

Regulation 23: Governance and management

The management systems in place were not sufficiently robust to ensure that the service provided is safe, appropriate, consistent and effectively monitored. For example:

- The risk register was not reviewed regularly to reflect all known identified risks. For example, while the provider was aware of gaps in the adherence to follow local policies on falls management which impacted on the quality and safety of the care provided to residents, this was not recorded on the risk register to ensure that appropriate controls were identified and in place to mitigate recurrence.
- Review and analysis of information or incidents within the designated centre did not consistently inform quality improvement measures and positive outcomes for residents. For example:
    - inspectors reviewed a recent investigation report, and noted that the report had not identified that the staff member did not receive on-site safeguarding training in line with policy, and that there was no supervision records available for this staff member.
    - prior to this inspection, inspectors had sought additional assurances from the registered provider relating to serious incident reviews which the provider had completed. Supplementary learning had been identified and submitted to the Chief Inspector, and while management outlined reviewing physiotherapy resources, additional training for staff and developing policies, on the day of the inspection there were no timebound action plans developed to ensure these actions were completed timely. It is acknowledged this was submitted following this inspection.
- The management systems in place to ensure that the service provided was consistent, had not identified that staff were unfamiliar with local policies and therefore policies were not always implemented in practice. For example, failure to effectively escalate concerns raised by residents or relatives meant that not all complaints were managed appropriately and through the correct processes.
- There was insufficient oversight to ensure the information submitted as part of the registration renewal was accurate and correct.

Judgment: Not compliant

Regulation 31: Notification of incidents

Following an unexpected death, the required notification was not submitted within two working days of the occurrence as set out under Schedule 4 of the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The complaints procedure that the provider had in place, was not consistently effective as it was not being followed by all staff. For example:

- The inspectors observed that verbal complaints that had been raised with staff at unit level were not escalated to the complaints officer. Therefore there was no action plan, no follow up or any learning identified and the complainant was not responded to as per the centre's policy.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

As mentioned throughout this report, the registered provider had not ensured that all Schedule 5 policies were adopted and implemented in the designated centre. For example:

- Supervision of staff had not occurred in line with the provider's policy on Staff Education and Development November 2024.
- Inspectors were not assured that when residents or visitors voiced dissatisfaction with parts of the service that could not be managed at local level, that this information was escalated to the complaints officer and managed in line with the centre's complaints policy.

Judgment: Substantially compliant

Quality and safety

Overall, inspectors found that the provider was, in general, delivering a good standard of care and support to residents. Residents were provided with opportunities for social activation and were encouraged to spend their days in the manner that they chose. Some aspects of individual assessment and care planning did not fully comply with the regulations, and as such could present a risk to the care and welfare of residents.

Both residents and relatives raised concerns in respect of the management of their personal possessions. Residents' personal laundry often went missing and was not always returned to the correct resident. Inspectors reviewed the laundry processes and found there were many items left in the laundry that could not be returned as

there was no labelling system in place. One resident had been reporting that their shoes had been missing for some time. Only when inspectors escalated these concerns, the shoes were found and returned to the resident.

Inspectors observed examples of very good person centred-care plans that clearly outlined residents' preferences including the time they like to go to bed, what their preferred routine was and their likes and dislikes. While some care plans were personalised to the resident's assessed needs, there were residents who had care plans developed without an appropriate assessment being completed. One resident had a personal hygiene care plan and a skincare care plan completed but with the absence of a skincare-assessment, there was no evidence that the care plan would address the assessed needs of the resident.

The provider had ensured that facilities were available for residents' occupation and recreation, and residents were provided with opportunities to participate in activities in accordance with their interests and capabilities. Residents expressed their satisfaction with the variety of activities on offer and said they could choose whether or not to attend.

The risk management policy dated November 2024 was not in line with the requirements of the regulations which had been amended in March 2025, this is further discussed under Regulation 26: Risk Management.

Regulation 11: Visits

On the day of the inspection, there were no visiting restrictions in place and visitors were observed coming and going to the centre. Residents were able to meet with visitors in private or in the communal spaces through out the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents' clothing and personal possessions were not managed effectively. Relatives and residents that spoke with the inspectors reported that residents' clothing had gone missing. There were a number of clothing items cleaned in the laundry but these items could not be returned as they had no labels to indicate which resident they belonged to.

Judgment: Substantially compliant

Regulation 26: Risk management

While there was a risk management policy in place, it did not fully meet the criteria of the regulations. For example, it did not contain the following:

- Arrangements for the identification, recording, investigation and learning from serious incidents or adverse events involving residents.
- A process for the implementation of actions and recommendations arising from serious incidents.
- A process for the audit, review and learning from events.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

While all residents had care plans in place that were initiated within 48 hours from admission and reviewed at regular intervals, from a review of a sample of residents' records, inspectors found that further action was required in relation to individual assessment and care planning. This was evidenced by the following;

- One resident did not have their skincare care plan updated following an assessment by an appropriate health care professional. Therefore the resident was not using the recommended product on their skin.
- One resident had two care plans completed, however, these were developed without a prior appropriate assessment being carried out. This may negatively impact on the resident receiving the care they need or require.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to a general practitioner (GP) of choice, who visited the centre regularly. Residents had a medical review completed within a four month time period, or sooner, if required. There was evidence that residents had access to all required allied health professionals services and that a variety of these practitioners were involved in caring for the residents, including chiropody, optician, dietitian, speech and language therapist, physiotherapist, occupational therapist (OT) and tissue viability.

Judgment: Compliant

Regulation 9: Residents' rights

Residents’ rights to exercise choice was impacted by the location and availability of call-bells. On the morning of the inspection, inspectors observed a particular corridor where seven residents who were in bed did not have a call-bell placed nearby to them to ensure they were able to call for assistance if and when required.

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	
Registration Regulation 6: Changes to information supplied for registration purposes	Substantially compliant
Regulation 14: Persons in charge	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Substantially compliant
Regulation 26: Risk management	Substantially compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Beechwood Nursing Home OSV-0000199

Inspection ID: MON-0049875

Date of inspection: 20/03/2026

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**
Registration Regulation 6: Changes to information supplied for registration purposes	Substantially Compliant
Outline how you are going to come into compliance with Registration Regulation 6: Changes to information supplied for registration purposes: All information has now been submitted in relation to the PIC. Going forward all information will be reviewed by the SMT in line with the regulations	
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 formal mealtime verification process has been implemented where nursing staff support and assist the Chef. Prior to serving, meals are checked against each resident's prescribed dietary requirements and IDDSI level as outlined in their care plan. Clear up to date IDDSI level list for all residents is displayed in the kitchen. The external nutritional support provider is being changed to ensure timely staff training and regular on-site visits, strengthening staff competency and providing enhanced practical support in dietary management and IDDSI compliance. The complaints process has been strengthened to ensure the learning is implemented in practice and is effective. A mealtime audit tool has been implemented, which incorporates the verification system. A full monthly audit of all staff files has been completed to identify gaps in induction, probation, and appraisal documentation.	

• The ADON is now supervising staff to ensure that all residents care is provided in line with their assessed needs.
• All staff currently employed in the home have a full induction completed.
• Going forward probation compliance will be reviewed as part of the governance meetings. All outstanding annual appraisals have now been completed and are fully documented. A structured annual appraisal schedule and tracking system has been implemented to ensure all future appraisals are completed within required timeframes with due dates clearly identified. Missing induction records have been completed, ensuring all staff have received appropriate orientation and training.
• All staff that were overdue their annual appraisals have now had same completed.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The risk register has been reviewed and updated to include all identified risks, including falls management and adherence to local policies, with specific risks clearly defined and control measures implemented. Measures include strengthened risk assessment, staff training on falls prevention and management, supervision, and incident review processes. Falls incidents are monitored, trended, and analysed, with learning shared with staff.
• All incident investigation templates have been reviewed and updated to ensure comprehensive analysis, including identification of training gaps, supervision deficits and policy adherence issues. The safeguarding training has been scheduled in accordance with the Policy.
• Incident reviews and investigations have been strengthened to ensure comprehensive analysis, including identification of training, supervision, and policy adherence gaps.
• All investigations now include root cause analysis and time-bound action plans with assigned responsibilities.
• All staff have read and signed relevant policies, with adherence monitored through supervision, audits, and competency assessments to ensure effective implementation in practice. Complaints training is provided to all staff to effectively escalate concerns raised by residents or relatives. Additional complaints training has been arranged for all staff in the home. PIC reviews all investigations and monitors implementation of actions, with learning from incidents used to inform ongoing quality improvement and improved outcomes for residents.
• Going forward all registration renewals will be reviewed by the SMT.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
• The incident has been reviewed, and the required notification has been submitted following the inspection. Compliance with notification requirements is reviewed as part of governance meetings and audits.
• Any delays or omissions will be identified, addressed, and used to inform learning and improvement.
• The PIC and relevant staff have been reminded of their responsibilities regarding statutory notifications and associated timeframes.
• Notifications are reviewed and discussed within the weekly senior management report by the PIC to identify any incidents requiring immediate notification and to ensure compliance with statutory reporting timeframes.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All staff have been reminded that any complaints including the verbal complaints must be treated as formal complaints and escalated without delay.
• Complaints are acknowledged, investigated, and responded to within required timeframes, with clear communication to the complainant.
• Action plans are developed for all complaints, with learning identified and documented.
• Training on the complaint's procedure has been arranged for all staff, with emphasis on the identification, recording, and escalation of all complaints.
• All complaints are reviewed by the PIC to ensure appropriate management and resolution; action plans are developed, follow-up is completed, and learning is identified and shared, with complainants responded to in line with the centre's policy.
• A tracking system is in place to monitor progress, responses, and closure of complaints.
• Complaints and outcomes are reviewed at governance and management meetings

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:

• A full review of Schedule 5 policies has been completed to ensure they are current, accessible, and implemented in practice. A number of these policies have now been updated.

• All staff have been reminded that any complaints including the verbal complaints must be treated as formal complaints and escalated without delay.
• Complaints are acknowledged, investigated, and responded to within required timeframes, with clear communication to the complainant.
• Action plans are developed for all complaints, with learning identified and documented.
• Training on the complaint's procedure has been arranged for all staff, with emphasis on the identification, recording, and escalation of all complaints.
• All complaints are reviewed by the PIC to ensure appropriate management and resolution; action plans are developed, follow-up is completed, and learning is identified and shared, with complainants responded to in line with the centre's policy.
• A tracking system is in place to monitor progress, responses, and closure of complaints.
• Complaints and outcomes are reviewed at governance and management meetings

Regulation 12: Personal possessions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• Families are advised to bring all clothing and personal items to the nurses' station for labelling prior to use, supporting effective identification and reducing the risk of items being misplaced.
• There is a robust clothing labelling system in the home, with all residents' belongings labelled on admission and regularly reviewed to ensure continued identification.
• Laundry processes have been strengthened and staff reminded of their responsibilities to ensure items are returned appropriately.
• Regular laundry audits will be conducted monthly, with findings reviewed and any issues addressed promptly to ensure effective management of residents' personal clothing and prevent loss or misplacement.
• The PIC monitors compliance through follow-up of any missing items, ensuring improved outcomes for residents.

Regulation 26: Risk management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management:
• The risk management policy has been updated to include clear processes for identification, recording, investigation, and learning from serious incidents, as well as implementation and tracking of actions.

• A tracking and audit system has been introduced, with incidents reviewed by the PIC and learning shared with staff. Risk management systems are monitored and reviewed regularly to ensure continuous improvement and safe outcomes for residents

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
• All Care plans have been reviewed and updated to reflect current assessments, including specialist input.
• The resident's skincare care plan has been updated following the assessment by health care professional. They are now using the recommended product on their skin.
• The resident who had two care plans developed has now had the appropriate assessments completed. All care plans are overseen and reviewed by the ADON or PIC to ensure they ae based on up to date assessments and reflect residents current needs including specialist recommendations.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC and Assistant Director of Nursing conduct regular walkarounds and audits, including checks on call bell accessibility, with additional spot checks carried out throughout the day to ensure ongoing compliance.
• Staff have been reminded of their responsibility to ensure call bells are accessible following care delivery, transfers, or repositioning.
• Call bell accessibility is now included as part of routine clinical governance walkarounds and handovers.
• Weekly call bell audits are conducted to ensure call bells are positioned within reach of residents and remain accessible at all times.

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
Registration Regulation 6 (2) (b)	Notwithstanding paragraph (1), the registered provider shall in any event supply full and satisfactory information, within 10 days of the appointment of a new person in charge of the designated centre, in regard to the matters set out in Schedule 2.	Substantially Compliant	Yellow	08/05/2026
Regulation 12(b)	The person in charge shall, in so far as is reasonably practical, ensure that a resident has access to and retains control over his or her personal property, possessions and finances and, in particular, that his or her linen and clothes are laundered regularly and returned to that resident.	Substantially Compliant	Yellow	30/04/2026

Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/05/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure that the service provided is safe, appropriate, consistent and effectively monitored.	Not Compliant	Orange	08/07/2026
Regulation 26(1)(d)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes arrangements for the identification, recording and investigation of serious incidents or adverse events involving residents.	Substantially Compliant	Yellow	31/03/2026
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy set out in Schedule 5 includes a process for the implementation of actions and recommendations arising from subparagraph (d).	Substantially Compliant	Yellow	31/03/2026
Regulation 26(1)(f)	The registered provider shall ensure that the risk management policy set out in	Substantially Compliant	Yellow	31/03/2026

	Schedule 5 includes a process for the audit, review and learning from events.			
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	30/04/2026
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Substantially Compliant	Yellow	31/05/2026
Regulation 34(7)(b)	The registered provider shall ensure that all staff are aware of the designated centre's complaints procedures, including how to identify a complaint.	Substantially Compliant	Yellow	31/05/2026
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on	Substantially Compliant	Yellow	30/04/2026

	the matters set out in Schedule 5.			
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).	Substantially Compliant	Yellow	30/04/2026
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	31/03/2026