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:	Beech Lodge Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Kilmallock Road, Bruree, Limerick
Type of inspection:	Unannounced
Date of inspection:	16 April 2026
Centre ID:	OSV-0000408
Fieldwork ID:	MON-0049768

About the designated centre

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

Situated in the village of Bruree, County Limerick, Beech Lodge Care Facility offers long term care, rehabilitative care, respite care and convalescent care for older adults. The age range catered from is 18 to 65+. Our care facility is a 66-bed facility which is made up of 48 single en-suite bedrooms and nine double en-suite bedrooms. There is 24-hour nursing care available from a team of highly trained staff. Our mission is to promote the dignity and independence of residents. The designated centre provides short & long-term care, respite/convalescence and palliative care and care for residents' with dementia. Here at Beech Lodge an individual programme of activities is tailored to each individual resident. Referrals for admission may come from acute or long-term facilities, community services or privately. Private admissions are arranged following a pre-admission assessment of needs including medical background, dietary requirements etc. We aim to provide the best care possible and use a variety of care assessment tools to help us to do this. We also involve both the resident and their representative in this process. We provide a GP and physiotherapy service to all residents. We aim to make dining a social experience. Individual dietary requirements are incorporated into the menu planning process. Catering personnel are trained in the appropriate skills and are supported by the dietitian and the speech and language therapist (SALT). The facility has its own mini bus for the use of residents. There is a monthly residents' meeting to discuss issues ranging from activities, improvements in daily life, the environment and other issues. Activities include: newspapers, exercises, brain games, music, mass, art, baking, hairdresser, bingo, sensory therapy, and much more. We are interested in feedback to ensure that our service is continually reviewed in line with best practice. Visitors are welcome and local community events are accessible.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	63

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 16 April 2026	10:00hrs to 18:30hrs	Una Fitzgerald	Lead
Thursday 16 April 2026	10:00hrs to 18:30hrs	Sean Ryan	Support

What residents told us and what inspectors observed

Residents who spoke with inspectors expressed high levels of satisfaction with life in the centre and attributed this to the supportive and familiar staff team. Residents described feeling comfortable and reported that they were happy with the direct provision of care. They spoke positively about nursing staff, describing them as kind and attentive, and said they responded promptly when they used their call bed seeking assistance. Residents were also generally satisfied with their accommodation, they reported that their bedrooms were comfortable, had adequate storage, and that their personal laundry was returned to them promptly.

On arrival to the centre, the inspectors were met by a member of the nursing management team. The entrance area was a welcoming space. This area was a hub of activity throughout the day. Many residents were observed to sit in this area, reading their newspaper, and in many cases just watching the comings and goings of other residents and staff. The nurses office was also located in this area. Inspectors observed multiple occasions where the residents called to the office to seek clarify on queries and have a chat with staff in the vicinity. Inspectors observed that staff greeted residents by name as they passed, which added to the friendly atmosphere. In the main, the inspectors observed that the centre was clean. The premises met the needs of the current residents. The centre is divided out into two main sections. The upper part of the premises is called the main unit, and the lower part of the premises is called the Daffodil unit.

Residents reported that staff were generally present and attentive to their needs in communal areas, and inspectors observed that residents in communal day rooms were appropriately supervised, with staff responding to them in a timely manner. However, inspectors observed that supervision arrangements were not consistently in line with residents' assessed needs. In particular, residents who required enhanced or continuous supervision did not always have staff available to them, and staff assigned to provide this level of support were at times observed undertaking other duties. On multiple occasions throughout the day, inspectors observed residents who had been assessed as in need of one-to-one care with no carer in attendance.

A staff member was designated to coordinate and deliver activities within the centre, and inspectors observed group activities taking place at intervals throughout the day in both the main centre and the Daffodil unit, including activities such as chair exercises and music. Inspectors observed that residents in the Daffodil unit did not have consistent access to appropriate and meaningful activities. There were extended periods where no activities were taking place, which was observed at various times throughout the day. During these times, while staff were present, there was limited engagement with residents, and inspectors observed residents sitting in communal areas for prolonged periods without interaction or stimulation.

The dining experience was observed to be a social and positive occasion for residents, with the majority of residents choosing to attend the dining room at mealtimes. Staff were present to provide assistance as required, and residents were offered choice in their meals. Residents spoke positively about the quality and quantity of food provided. Inspectors spoke with catering staff, who demonstrated good awareness of residents' preferences and confirmed that, in addition to daily menu options, alternative meals were prepared when requested. Meals were observed to be attractively presented and served in a manner that supported residents' dignity and choice.

Capacity and capability

This unannounced inspection was carried out by inspectors of social services to monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended). The findings of the inspection reflected a commitment from the provider to ongoing quality improvement that would enhance the daily lives of residents. Following the last inspection in May 2025, a number of changes had occurred in the centre which lead to the strengthening of the governance and management structure. In the main, the provider was delivering appropriate direct care to residents. However, the management and oversight of record-keeping, the supervision of staff, the management of nutritional care and the system in place monitoring and ensuring oversight of the service as a whole was not in full compliance with the regulations.

Beech Lodge Care Facility Limited is the registered provider of the centre. The centre was registered to accommodate 66 residents. On the day of inspection, there was 63 residents living in the centre, with three vacancies. Operational and managerial support for the person in charge was in place through weekly onsite visits from the chief executive officer and a facilities manager. Within the centre, the person in charge was supported by a team of nurses, healthcare assistants and support staff.

On the day of inspection, inspectors observed that the supervision of the staffing and the allocation of duties was insufficient. A small number of residents with complex care needs had been assessed as requiring one-to-one care. While inspectors found that each resident had an assigned member of staff to provide this care, in practice, the carers were frequently completing other care tasks outside of providing the one-to-one care to residents to whom they were assigned.

Records reviewed by inspectors confirmed that staff training was provided through a combination of in-person and online formats. All staff had completed role-specific training in safeguarding residents from abuse, manual handling, infection prevention and control, the management of responsive behaviours (how people with dementia

or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) and fire safety.

A sample of staff personnel files were reviewed and contained all the information required by Schedule 2 of the regulations. This included a vetting disclosure for each member of staff in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2021.

The management systems in place to monitor the quality of the service did not always ensure the service provided to residents was in full compliance with the regulations. For example,

- record management systems did not meet regulation requirements. This was a repeated non compliance from the May 2025 inspection. This is discussed in detail under Regulation 21: Records.
- The management system on the oversight of individual resident financial records. This was evidenced by the unavailability of records requested on the day of inspection.

The person in charge held responsibility for the review and management of complaints. At the time of inspection all logged complaints had been resolved and closed.

Regulation 15: Staffing

On the day of inspection, inspectors found that the staffing resources were adequate for the current residents.

Judgment: Compliant

Regulation 16: Training and staff development

Inspectors found that the system in place supervising the staff was inadequate. This was evidenced by,

- Residents who required enhanced or continuous supervision in line with their assessed need did not have this supervision in place, as staff were allocated to other duties. For example, on the morning of inspection, one carer who was on the staff roster assigned to one-to-one care was in the kitchenette in the Daffodil unit having completed the clearing of the breakfast dishes and the loading of the dishwasher. At dinner-time, a carer assigned to one-to-one care was out in the communal dining area providing assistance to other residents with their meal. While completing this task the resident under their care was left unsupervised.

- there was no system of oversight in place to ensure that residents, who were assessed as requiring 30 minute safety checks, had their checks consistently completed.

Judgment: Not compliant

Regulation 21: Records

Records were not consistently maintained as required by the regulations. For example:

- Records of on-going medical assessment, treatment and care were not consistently maintained, as required by Schedule 3(4)(e) of the regulations. For example, a record of a resident's reviews by health and social care professionals was not always maintained in the centre, or available to staff for review.
- Records of specialist treatment, nutritional care and nursing care provided to residents were not appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records pertaining to the nutritional care, wound care and supervision of residents with complex care needs was not appropriately maintained or not available for review.
- Nursing records were not completed in line with the requirements of Schedule 3(4)(c). For example, a review of residents' nursing records found that nursing notes were duplicate from the previous entries. This meant that the record was not person-centered, and did not provide assurances that the daily care needs of the residents had been met.
- Training records on the day of inspection were not an accurate reflection on the training provided.
- On the day of inspection, records underpinning the management of resident finances and financial transactions were not available in the centre, as is required by the regulations.
- Treatment provided to residents was not consistently recorded. For example; safety checks.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had not ensured that there was effective governance and management systems in place to ensure the service provided to residents was fully safe, appropriate, consistent and effectively monitored.

- On the day of inspection, financial records on the breakdown of individual resident monies was not available in the centre.
- The system in place to ensure that policies and procedures were kept updated in line with changes that occur in the centre was not effective. For example; the complaints policy directed the complainant to a person who was no longer working in the centre. In addition, the identified complaint officer was also the review officer, contrary to the requirements of the regulations.
- There was poor oversight of nursing documentation. A review of the quality of a sample of residents' care plans found that care plans were not based on the assessment of residents' needs or risks.
- The system in place ensuring appropriate supervision of staff was ineffective, as outlined under Regulation 16: Staff training and development.

Judgment: Not compliant

Regulation 34: Complaints procedure

Following the last inspection the provider had taken appropriate action to ensure that there was an effective complaints procedure in place. A review of the complaints records found that the complaints logged had been appropriately managed and responded to in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Residents living in the centre expressed overall satisfaction with the quality and safety of care provided. Residents had timely access to appropriate medical and health care services. Inspectors found that the provider had taken action to ensure that residents' transfers and discharges from the designated centre were planned and carried out in an organised manner. The provider had also taken some action to improve the quality of residents' individual assessments and care planning, and to ensure there were effective safeguarding measures in place to protect residents. However, these actions were not sufficient to bring the centre into full regulatory compliance. In addition, arrangements in relation to the management of nutritional care did not always ensure that residents received nutritional support, in line with their assessed nutritional requirements. A further finding of this inspection was that residents were not consistently facilitated to engage in social and recreational activities in line with their interests and capacities.

All residents had a pre-admission assessment completed prior to admission to the service, to ensure the centre could meet their needs. Inspectors found that while these assessments comprehensively assessed residents' nursing and medical care needs, they did not adequately assess residents' social or psychological care needs. All residents had a care plan in place, and there was evidence that their needs were assessed using validated assessment tools. However, care plans were not always updated to reflect changes in residents' assessed needs, particularly in relation to nutritional care, weight management, and wound management. In addition, some care plans did not always accurately reflect residents current care needs and did not consistently provide person-centred guidance to inform care delivery.

All residents had access to general practitioner (GP) services, as required or requested. Where residents were identified as requiring further specialist assessment, appropriate referral arrangements were in place to ensure timely access to relevant health care professionals.

Procedures had been established to ensure that the transfer of residents from the designated centre occurred in line with the requirements of the regulations. This included arrangements to ensure information, pertinent to the care of residents, was communicated to the receiving health care facility, and to ensure residents were consulted about their discharge and transfer from the service.

A review of food and nutrition found that arrangements were in place for residents to access the expertise of health care professionals such as dietetic services, and speech and language therapists for further expert assessment. Residents were provided with access to adequate quantities of food and drinks, and meals were prepared, cooked and served on-site. However, this inspection found that, although the food provided was wholesome and nutritious, therapeutic diets prescribed to support the management of residents' medical conditions were not consistently provided.

There were arrangements in place to safeguard and protect residents from the risk of abuse. A safeguarding policy detailed the roles and responsibilities of staff, and the appropriate steps to take, should a concern arise. All staff spoken with were clear about their role in protecting residents from abuse.

Staff demonstrated an understanding of their role in supporting residents to exercise their rights, including respecting residents' choice in their daily routines, seeking consent when providing care, and supporting residents to provide ongoing feedback about the service. Residents social and recreational needs were also considered. However, while activities were observed to take place at intervals throughout the day, not all residents had equal access to activities in line with their interests, capacities and assessed needs.

Regulation 18: Food and nutrition

Food and nutrition was not always delivered in line with regulatory requirements. For example;

- Residents' dietary needs were not consistently met, as prescribed by allied health care professionals. Residents who were prescribed a therapeutic diet, including low sodium, high protein and fortified meals to manage their weight were not provided with their prescribed diets.
- Residents nutritional care was not consistently managed in accordance with their assessed needs and care plans. Recommendations made by dietetic staff in relation to the monitoring and assessment of residents' nutritional needs were not always implemented in practice.

Judgment: Substantially compliant

Regulation 25: Temporary absence or discharge of residents

Arrangements were in place to support the transition of residents from the designated centre to hospital or home in consultation with each resident, including the resident's general practitioner (GP).

Judgment: Compliant

Regulation 5: Individual assessment and care plan

A review of a sample of residents' assessment and care plans found that they were not fully in line with the requirements of the regulations. For example;

- One pre-admission assessment reviewed was incomplete and did not identify the residents complex psychological and social care needs. This resulted in the necessary supportive interventions not being identified or implemented.
- Care plans were not reviewed or updated when a resident's condition changed. For example, the care plan of some residents who had experienced weight-loss had not been reviewed or updated following a change in their nutritional care needs. Consequently, their care plan did not reflect the nursing and medical interventions required to support their needs.
- Care plans were not always guided by a comprehensive assessment of the resident's care needs. Some residents care plans did not accurately reflect the needs of the residents and did not identify interventions in place to support residents who had significant complex behavioural care, support and supervision needs. Consequently, the care needs of some residents were not always being met.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had access to appropriate health and social care professional support to meet their needs. Residents had a choice of general practitioner (GP) who attended the centre, as required or requested.

Services, including physiotherapy, tissue viability nursing expertise, speech and language, and dietetics were available through a system of referral.

Judgment: Compliant

Regulation 8: Protection

There were systems in place to safeguard residents and protect them from the risk of abuse.

Safeguarding training was up-to-date for all staff and a safeguarding policy provided staff with support and guidance in recognising and responding to allegations of abuse. Residents reported that they felt safe living in the centre.

Judgment: Compliant

Regulation 9: Residents' rights

Inspectors found that activity provision was not consistently delivered in accordance with the centre's schedule or tailored to meet the individual needs of residents, including those who required more specialised sensory-based engagement.

While there was an emphasis on group-based activities, residents who required more individualised support, including those assessed as benefiting from one-to-one engagement or enhanced supervision, were not provided with activities in line with their assessed needs or care plans. Consequently, some residents were not afforded appropriate opportunities to participate in meaningful activities suited to their preferences and capacities.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 18: Food and nutrition	Substantially compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Beech Lodge Care Facility OSV-0000408

Inspection ID: MON-0049768

Date of inspection: 16/04/2026

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Post inspection the following actions have taken place:

- Implementation of a Policy on 1:1 which isolates assigned carers from any ancillary, household, or general floor duties.
- Conducted a mandatory emergency briefing for all healthcare assistants (HCAs) and nursing staff regarding individual legal accountability, resident safety risks, and the regulatory consequences of leaving vulnerable residents unsupervised.
- The daily staff roster and allocation sheet will continue to explicitly highlight 1:1 staff members in a specific 1:1 role. These staff are aware that they are responsible for 'Direct Enhanced Supervision Only'.
- During shift handovers, general care duties (e.g., clearing breakfast dishes, assisting other residents at dinner, loading dishwashers) will be explicitly assigned to designated floor staff or household staff member. 1:1 care providers are now aware that they have no responsibility for these task.
- If a 1:1 carer needs to leave the resident for a break or a bathroom visit, they must formally hand over to a designated relief staff member accepts responsibility for the resident in question. The resident must never be left unattended.
- A review of all residents requiring 30 minutes checks has taken place by the Director of Nursing to ensure these checks are required and are risk assessed appropriately. Audits will continue daily to ensure appropriate documentation is in place.
- A Daily Walkaround Sheet has been implemented for the DoN and ADoN specifically targeted at high-risk times to ensure appropriate supervision and allocations are as rostered daily.
- Targeted huddles have taken place to explicitly define what constitutes "continuous supervision" versus "close observation," and reiterate that failing to maintain a 1:1 line of sight is a reportable clinical incident.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

Medical Assessment: Post inspection we implemented an 'MDT Specialist Tracker' on our computerised clinical platform. Every time an MDT member such as Dietitian, Speech & Language Therapist (SALT), Tissue Viability Nurse (TVN), or GP reviews a resident, the attending nurse must log the visit on the tracker and upload the written recommendation within 2 hours of the professional leaving the building. A mandatory 'MDT Action Flag' is now added to the handover sheet to alert the oncoming shift of any immediate changes to treatment or care.

Wound Care: Post inspection an immediate risk review was completed by the ADoN of all residents on therapeutic diets, fortified diets, texture-modified diets, and weight-management plans.

Following this review the following action plan was implemented:

• Diet order reconciliation: cross-checked GP, dietitian, SALT, and nursing records against kitchen communication sheets and meal delivery systems to identify any gaps, mismatches, or outdated orders. This reconciliation now occurs weekly or immediately post an admission/discharge.
• Care plan update: each relevant nutritional care plan has been identified to clearly state the prescribed diet, monitoring frequency, triggers for escalation, and the staff member responsible for implementation and review.
• Kitchen controls: introduced a diet communication system between nursing and catering, so that every diet change is recorded, acknowledged, and actioned before the next meal service.
• Monitoring and audit: weekly audits of the mealtime service on compliance with prescribed diets, weight monitoring, food/fluid charts, and implementation of dietitian recommendations, with results reviewed at weekly clinical governance meetings.
• Staff accountability: provided targeted refresher training for nurses, healthcare assistants, and catering staff on therapeutic diets, nutritional escalation, fortified foods, and documentation standards, with competency checks completed.
• Escalation pathway: defined a clear escalation process for poor intake, weight loss, missed supplements, or diet mismatches, including immediate referral back to GP/dietitian where required. Food and fluid intake is discussed daily at handover and safety pauses for any resident identified as being at risk.

Safety Checks: Between them the Director of Nursing (DoN), Assistant Director of Nursing (ADoN) and the Clinical Nurse Manager (CNM) will conduct daily 'Night Shift Documentation Audits' on a random sample of 3 residents, specifically looking for cloned notes, missing safety checks, or unlogged specialist recommendations.

Nursing Notes: A directive has been issued to all staff nurses regarding the practice of duplicative nursing entries. All progress notes must follow the SOAP format (Subjective, Objective, Assessment, Plan) focusing entirely on what changed, how the resident responded to care, and specific goals met during that specific shift. Between them the

Director of Nursing (DoN), Assistant Director of Nursing (ADoN) and the Clinical Nurse Manager (CNM) will conduct daily 'Night Shift Documentation Audits' on a random sample of 3 residents, specifically looking for cloned notes, missing safety checks, or unlogged specialist recommendations.

Training Records: A comprehensive audit has taken place post inspection and training has taken place. Training is now discussed weekly at the Governance and Management meetings and local policy updated to ensure the Training Matrix is updated within 48 hrs of training taking place. The training matrix is now reviewed formally monthly by the PiC and RPR.

Resident Finances: currently the centre is pension agent for 4 residents. A statement of account will be provided to each of these residents at least monthly to ensure there is complete transparency regarding monies into and out of the account. Each resident will receive an individualised statement which will be retained on their master file for future inspection. All residents' monies maintained and managed by the provider continue to be lodged to a separate bank account.

Records: Senior Management have implemented a dual-layered audit framework to verify ongoing document compliance and promote better record upkeep. These audits are discussed weekly at Governance and Management Meetings.

The Clinical Nurse Manager (CNM) will conduct daily 'Night Shift Documentation Audits' on a random sample of 3 residents, specifically looking for cloned notes, missing safety checks, or unlogged specialist recommendations.
The Person in Charge (PIC) will continue to conduct a comprehensive monthly Schedule 3 Records Audit to evaluate data and this will be discussed weekly at the Clinical Governance & Management Meeting.

Regulation 23: Governance and management	Not Compliant

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

Resident Finances: Currently the centre is pension agents for 4 residents. A statement of account will be provided to each of these residents at least monthly to ensure there is complete transparency regarding monies into and out of their account. Each resident will receive an individualised statement which will be retained on their master file for future inspection. Monthly the residents accounts are reviewed by the CEO/RPR and an independent external accountant/auditor to ensure all financial and regulatory compliance. All residents' monies maintained and managed by the provider continue to

be lodged to a separate bank account.

Complaints Policies: The complaints policy had been updated prior to the inspection and released to all staff. Unfortunately, on the day of inspection the old policy was given to the inspectors in error. The updated policy has been reissued to all staff and all older versions removed. The complaints policy on display was updated to reflect accurate information in relation to the complaints officer and complaints reviewer for the designated centre.

Nursing Notes: A directive has been issued to all staff nurses regarding the practice of duplicative nursing entries. All progress notes must follow the SOAP format (Subjective, Objective, Assessment, Plan) or focusing entirely on what changed, how the resident responded to care, and specific goals met during that specific shift. Between them the Director of Nursing (DoN), Assistant Director of Nursing (ADoN) and the Clinical Nurse Manager (CNM) will conduct daily 'Night Shift Documentation Audits' on a random sample of 3 residents, specifically looking for cloned notes, missing safety checks, or unlogged specialist recommendations.

Records: Senior Management have implemented a dual-layered audit framework to verify ongoing document compliance and promote better record upkeep. These audits are discussed weekly at Governance and Management Meetings.

The Clinical Nurse Manager (CNM) will conduct daily 'Night Shift Documentation Audits' on a random sample of 3 residents, specifically looking for cloned notes, missing safety checks, or unlogged specialist recommendations.

The Person in Charge (PIC) will continue to conduct a comprehensive monthly Schedule 3 Records Audit to evaluate data and this will be discussed weekly at the Clinical Governance & Management Meeting.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
The Senior Management team have reviewed and audited a local 'Dietary Whiteboard' in the kitchen and appointed ADoN to ensure that is updated in real-time within 2 hours of any Allied Health visiting and making changes to any resident's nutrition status.
The Person in Charge (PIC) has overseen a full review of all residents currently under Dietitian care. Food and Fluid Record charts have been updated to include target milestones set by the dietitian. Nurses must review these charts during evening handover to verify that monitoring recommendations are being actively practiced and intake is discussed at handover and the safety pause daily to ensure any resident identified at risk is monitored closely.

A Daily Management Walk Around has been implemented and all residents at risk are highlighted and followed up on throughout the shift.

The Head Chef and an External Nutrition Expert will run a practical workshop on preparing and properly identifying high-protein, fortified, and low-sodium meals.
Care staff will receive refresher training on the importance of adhering to modified diets, identifying clinical signs of nutritional decline, and accurate food/fluid chart documentation.

Mealtime audits by clinical management continue to take place to verify that what is written in the care plan matches what is presented to the resident. These audits have been increased to weekly for a period of 3 months to ensure compliance and understanding.

The auditor will pick three random residents on therapeutic or modified diets, check their care plans, walk to the dining room, and physically verify that the meal served perfectly matches the residents assessed need.

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:
The pre-admission assessment protocol has been updated to ensure no resident is admitted with an incomplete assessment, specifically focusing on complex psychological, behavioural, and social needs. Pre-admission assessment are discussed with the CEO and/or RPR prior to admission to ensure all the residents needs have been clearly identified and can be met within the centre.

An immediate clinical review of care plans for all residents currently identified as high-risk, specifically targeting those with recent weight loss or complex behavioural/supervision needs has taken place.

Care Plan training has been planned with an external provider to ensure all nursing staff are trained on the Care Planning Cycle.

A "Care Plan Update" reminder has been incorporated into the shift handover template and daily clinical safety pause meeting.
Monthly Care Plan Audits are reviewed by the CEO/RPR at weekly Governance and Management Meetings to ensure appropriate documentation is available and evidence to support interventions.

Regulation 9: Residents' rights	Substantially Compliant

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

Post the inspection the PiC has conducted a comprehensive review of all residents' social care plans, specifically targeting those identified as requiring one-to-one or specialised sensory-based engagement (e.g., residents with advanced dementia or high-dependency needs).

The Activity Plan in house has been restructured to include activities scheduled within the Daffodil Area.

An Activity Survey has been distributed to Residents and Families, and the findings will be disseminated and used to form the basis of the activity schedule moving forward.

The Person in Charge (PIC) and/or Clinical Nurse Manager (CNM) will conduct a weekly audit of a random sample of 10% of resident care plans alongside their daily activity logs to ensure delivery matches assessed need.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	22/06/2026
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	31/07/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a	Not Compliant	Orange	22/06/2026

	designated centre and are available for inspection by the Chief Inspector.			
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	22/06/2026
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Substantially Compliant	Yellow	31/07/2026
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 designated centre concerned.	Substantially Compliant	Yellow	31/07/2026

Regulation 5(4)	The person in charge shall formally review, at intervals not exceeding 4 months, the care plan prepared under paragraph (3) and, where necessary, revise it, after consultation with the resident concerned and where appropriate that resident's family.	Substantially Compliant	Yellow	31/07/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in accordance with their interests and capacities.	Substantially Compliant	Yellow	31/07/2026