



**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:	Clearbrook Nursing Home
Name of provider:	Greenmast Limited
Address of centre:	Heathfield View, Cappagh Road, Finglas West, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	03 June 2026
Centre ID:	OSV-0005590
Fieldwork ID:	MON-0049844

About the designated centre

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

Clearbrook Nursing Home is a designated centre delivering care to male and female residents, located in a north Dublin city suburb. The premises comprises of a two-storey, purpose-built building with 90 single en-suite bedrooms. The centre consists of four separate units with central communal spaces including dining areas, sitting rooms and activity rooms. Full-time long and short-term care is provided for older people, people living with dementia, and people with physical and sensory disabilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	89
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How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 3 June 2026	08:00hrs to 17:30hrs	Niamh Moore	Lead
Wednesday 3 June 2026	08:00hrs to 17:30hrs	Aoife Byrne	Support

What residents told us and what inspectors observed

This unannounced inspection was conducted with a focus on adult safeguarding and to review the measures the registered provider had in place to safeguard residents from all forms of abuse. During this inspection, the inspectors spent time in the centre observing the environment, the care provided, and talking to residents, visitors and staff to see what life was like for residents living at Clearbrook Nursing Home. From what residents told inspectors and what the inspectors observed, residents were generally content in the centre. However, this inspection identified that poor governance and management arrangements did not support residents' rights at all times.

Inspectors arrived unannounced at the centre, and waited for entry via the bell system at the front door. However, the person in charge arrived to work and permitted the inspectors entry.

Inspectors walked through the centre, and observed there was a calm and relaxed atmosphere. Many residents remained in bed and staff were observed delivering breakfast on trays to residents' bedrooms. Following the morning walk around, an introductory meeting was held with the person in charge, where the purpose of the inspection was set out.

The designated centre was registered for 90 residents, with 89 residents on the day of this inspection. Residents' bedroom accommodation was set out across two floors with access by stairs and a lift. On the ground floor, there were communal spaces, such as two-day rooms and a dining room. The first floor had two day rooms, a dining room, and smaller rooms such as a quiet room and a family meeting room. Inspectors observed that since the last inspection in February 2026, improvements had been made to these communal spaces to make them homely, warm and inviting spaces for residents to enjoy. This included shelving units, mirrors, flowers and pictures on the walls.

Later in the morning many residents were up and seen to be sitting in some of the day rooms, receiving visitors, having their needs attended to by care staff, the visiting hairdresser and chiropodist. Throughout the day, many occasions were seen where staff were observed knocking on bedroom doors and seeking permission prior to entering residents' bedrooms. However, residents' rights to privacy was not consistently upheld, as inspectors observed occasions where staff entered residents' bedrooms without knocking.

Due to staff shortages, there was one activity co-ordinator working on the day of the inspection, and this was seen to impact residents on the first-floor access to activities. As a result, residents on this floor were observed to be sitting in front of the television in the day room for most of the morning. Residents attended a chair

exercise class in the morning on the ground floor, however residents did not appear to be actively engaging in the session.

Residents' bedroom accommodation comprised of single rooms with en-suite facilities. Inspectors saw a sample of rooms and found them to be of suitable size, clean and personalised with the residents' belongings such as family photos, ornaments and furniture. Residents expressed to inspectors that they were happy with their bedrooms. However, inspectors were told and observed that a hoist was stored in one resident's bathroom. The designated storage area for this hoist was at the nurse's station. However, during the day the medicine trolleys were also stored there leaving minimal space. This was raised with the person in charge on the day.

Noticeboards signposted residents and visitors to useful information such as "meet the team" which contained pictures, names and job titles for key members of management. There was also information available on previous inspection reports, safeguarding policies, the complaints procedure and advocacy services. However, inspectors found examples where complaints were not managed in line with these procedures, including where residents feedback was not actioned or responded to, limiting the residents' right to be consulted and engaged relating to their life within the centre.

The inspectors observed the lunch-time service on the day of the inspection. Residents were asked their preference to dine in the dining rooms or their bedrooms for this meal. Inspectors saw that most residents did prefer to have their meals in their bedrooms. For example, on the first floor only 15 residents had their lunch in the dining room, on the day of the inspection. There was a pictorial menu in the dining room which outlined a choice of cottage pie or bangers and mash. However, inspectors saw that where residents preferred an alternative such as sandwiches or a chicken salad, their preference was seen to be respected. Meals were observed to be well presented. Inspectors saw that condiments were available on tables to support resident's independence. Where support was required, there were enough staff available to assist residents with their meals, and inspectors observed this support was provided in a dignified manner. Residents reported to enjoy the meals.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre, and how these arrangements impacted on the quality and safety of the service being delivered.

Capacity and capability

Following the provider's previous inspection in February 2026, regulatory non-compliances were found and subsequent engagement with the Chief Inspector resulted in a warning letter being issued to the provider. Furthermore, this safeguarding inspection found that some of the management systems in place were

not effective, particularly in relation to Regulations 4: Written Policies and Procedures, 21: Records, Regulation 23: Governance and Management and Regulation 34: Complaints Procedures, which posed a risk to residents.

While inspectors did see some action was taken following the February 2026 inspection, it was evident that continued non-adherence with the regulations, combined with actions set out by the provider, in response to the previous poor inspection findings had not been completed or sustained. Due to the findings of this inspection, an in-person warning meeting was held where the registered provider was informed that the Chief Inspector intended to issue a Notice of Proposed Decision to attach a restrictive condition to the registration of the designated centre.

The registered provider of Clearbrook Nursing Home is Greenmast Limited. This company had two company directors and had appointed a general manager, who is a person participating in management, and supports the person in charge in the operations of the nursing home.

The person in charge worked full-time in the centre, and was supported in their role by a support service manager, an assistant director of nursing, a clinical nurse manager, staff nurses, a care supervisor, healthcare assistants, activity coordinators, housekeeping, laundry, catering, administration and maintenance staff. Inspectors were told that there were a number of staff vacancies which were in the final recruitment stages, such as two clinical nurse managers and additional health care assistants. The inspectors observed that during the day, there were sufficient staff on duty to cater for the needs of residents, as evidenced by residents being provided with timely assistance to their needs in a respectful and unhurried manner. Inspectors were informed by residents that staff response times were slower in the evening, and the provider had planned to increase staffing levels in the evening, for which they were in the process of recruiting.

The registered provider maintained policies and procedures in line with the regulations and Schedule 5, such as those relating to staff training and development, safeguarding residents from abuse and a complaints policy. However, inspectors saw that some of these policies were not adopted and implemented into practice.

Inspectors found that there were arrangements in place with clear lines of responsibility for safeguarding. However, inspectors found that there lacked a human-rights based culture where residents' rights were embedded in everyday practice. For example, while some safeguarding concerns were recorded, investigated and appropriately reviewed, inspectors found that there were inconsistent approaches to the management of all incidents, which impacted on residents' rights and posed a risk to safeguarding measures. This is further discussed under Regulation 23: Governance and Management.

The registered provider had a complaints procedure in place which was displayed within the designated centre. Inspectors reviewed the complaints log and saw that the person in charge had completed investigations in relation to complaints received, included safeguarding allegations of concerns. However, not all complaints had been

investigated, and some had not been managed in line with the provider's policy. This is further discussed under Regulation 34: Complaints Procedures.

Regulation 15: Staffing

Overall inspectors found that on the day of the inspection, the number and skill-mix of staff was appropriate with regard to the needs of the residents, and the size and layout of the designated centre.

Judgment: Compliant

Regulation 21: Records

Schedule 2 staff records were reviewed. There was a record of current registration details for all staff nurses with the with the Nursing and Midwifery Board of Ireland. Inspectors reviewed vetting disclosures for staff in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, and found that one staff file did not have a vetting disclosure in place prior to the commencement of their employment.

Judgment: Substantially compliant

Regulation 23: Governance and management

Systems that were in place to monitor and oversee the quality and safety of the service required strengthening. For example:

- Commitments given in the compliance plan response from the previous inspection were not fully completed in respect of reviewing incidents, ensuring staff adopt and implement policies and the management and documentation for responsive behaviours. As a result, there were repeat findings in these areas.
- There was insufficient oversight arrangements in place to ensure that residents' rights were upheld at all times, specifically decisions made in relation to discharging residents.
- Risk management systems were not effective. For example, inspectors reviewed a documented risk assessment that did not appropriately identify the risk, outline the control measures in place to mitigate the risk, or specify any actions required to be taken by the registered provider. As a result, this

impacted the implementation of appropriate safeguarding measures for a resident. Complaints were not used to support organisational learning or to ensure that safeguarding measures were appropriate and effective, as complaints were not investigated or responded to in line with the provider's policy.
Judgment: Not compliant
Regulation 34: Complaints procedure
The management of complaints was not effective. For example: - Inspectors found that when residents voiced dissatisfaction with parts of the service, there was a lack of evidence that appropriate action was taken. For example, during the inspection, the inspectors were aware of one documented complaint, recorded in the residents' care records, that was not managed in line with the provider's complaints policy. - There were four documented complaints recorded in the complaints log which had not been investigated.
Judgment: Not compliant
Regulation 4: Written policies and procedures
The following policies were not implemented in practice. - The complaints procedure - The admissions and transfer policy These are repeat findings.
Judgment: Substantially compliant
Quality and safety
This inspection, which focused on adult safeguarding, was carried out to review the quality of the service being provided to residents, and ensure they were receiving a high-quality, safe service that protected them from all forms of abuse. Overall, the inspectors found that the provider had made improvements in their approach to

safeguarding residents since the last inspection in February 2026. However, further improvement was required in the areas of individual assessment and care planning, managing behaviours that challenge and residents' rights. These are detailed further under the respective regulations. As outlined in the capacity and capability section, significant failures in management oversight was seen to negatively impact the quality of care and support provided to residents.

Arrangements were in place to assess residents' health and social care needs upon admission to the centre, using validated assessment tools. These were used to inform the development of residents' care plans, which were reviewed every four months, or more frequently if required. From a review of resident's records it was evident that residents who had specialist communication requirements had these recorded in their care plan. Meaningful activity care plans were in place, and clearly documented the resident's likes and dislikes in respect of activities. The inspectors reviewed a sample of safeguarding care plans and found that they were generally person-centred and reflected the care needs of the residents, however, two care plans reviewed did not outline the actions required to safeguard the resident. This is discussed further under Regulation 5: Individual assessment and care plans.

Staff training in 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) was completed and up-to-date. However, residents with identified behaviours that challenge did not have detailed care plans in place to guide staff. This is outlined further under Regulation 7: Managing Behaviour that is challenging.

Staff had received training in safeguarding vulnerable adults and inspectors found that overall staff understood the principles of safeguarding and their responsibilities in relation to protecting the residents from abuse. There were clear and transparent systems in place to ensure residents' finances were protected at all times. Improvements were seen in relation to the investigation and follow-up of safeguarding concerns.

Residents had access to newspapers, televisions, and radio's. There was a system in place for consulting with residents in relation to the operation of the centre, through residents' meetings. Contact details for advocacy services were displayed around the centre, and it was observed by inspectors that residents had been referred and were utilising this service. Overall, residents were provided with a variety of recreational opportunities. However, not all residents were afforded the choice to access activities. This is discussed further under regulation 9: Residents' rights.

Since the last inspection in February 2026, it was observed that efforts were made to ensure the centre was decorated and homely. Action was taken to ensure that the premises were in line with the statement of purpose and floor plans for which it was registered.

Regulation 10: Communication difficulties

Residents with communication difficulties had access to specialist services such as GP, speech and language therapy, ophthalmology and audiology, as required. Staff spoken with demonstrated their awareness of any specialist needs required to enable residents to communicate freely, including non-verbal cues and appropriate interventions such as communication books to support residents.

Judgment: Compliant

Regulation 17: Premises

The premises were appropriate to the needs of the residents and conformed to the matters set out in Schedule 6 of the regulations. There was a programme of progressive, ongoing maintenance in place.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Care planning documentation was available for each resident in the centre. A sample of resident care plans were reviewed. Notwithstanding some good person-centred care plans, there were examples where regulatory requirements were not met as follows:

- A safeguarding care plan was in place for a resident, however, it did not clearly outline the safeguarding concern and appropriate control measures to safeguard the resident.
- While there was a safeguarding care plan in place for a resident who was at risk of another resident entering their room, there was no care plan in place to guide staff on how to manage the behaviours of the resident who was entering the room.
- A safeguarding care plan was in place for a resident however it was a chronology of incidents rather than identifying the safeguarding risks and identifying control measures to safeguard the resident.

This is a repeat finding.

Judgment: Not compliant

Regulation 7: Managing behaviour that is challenging

Despite overall good systems in place to respond to and manage behaviours that challenge, there was lack of evidence that during some episodes of responsive behaviour that staff had the skills to respond to and manage this behaviour.

- The centre's policy is to complete an Antecedent Behaviour Consequence (ABC) chart following each episode of responsive behaviour. This was not completed for a resident who was identified by management to have several incidents of responsive behaviour.
- A review of documentation, including care plans and behaviour charts, for residents identified as displaying behaviours that challenge, found that alternative interventions and de-escalation techniques were not fully outlined to direct the care of the resident.

This is a repeat finding.

Judgment: Not compliant

Regulation 8: Protection

Staff who were met in the course of the inspection confirmed that they had attended safeguarding training and were confident that they would be able to use this training to ensure that residents were protected from abuse. Inspectors reviewed a sample of safeguarding investigations and found that they were investigated appropriately and in line with the centres policy.

Judgment: Compliant

Regulation 9: Residents' rights

Residents' rights were not always promoted or supported in relation to the following:

- Not all residents had the same opportunities to participate in activities in accordance with their interests and capacities. While most residents expressed their satisfaction with the activities, residents on the first floor did not have equal opportunities to participate in activities. Due to an activity staff vacancy on the day of inspection, residents on the first floor were observed to have no activities provided on the day of the inspection.
- A resident with communication difficulties who required staff assistance to be informed about the activity schedule and to be encouraged to participate in activities did not receive this support. Although the need for encouragement had been identified on several occasions, it was not consistently provided,

thereby, limiting the resident's opportunity to exercise choice in how to spend their day.

- It was observed on four separate occasions where staff entered a resident's bedroom without knocking. This does not support residents' privacy and dignity.
- Inspectors found that one resident's rights were not fully upheld, as they were not adequately informed or consulted regarding aspects of their ongoing residency in the designated centre. This limited the residents ability to fully exercise choice and participate in decisions relating to their care. Inspectors brought this to the attention of management on the day of the inspection.

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	Compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 17: Premises	Compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 7: Managing behaviour that is challenging	Not compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Clearbrook Nursing Home OSV-0005590

Inspection ID: MON-0049844

Date of inspection: 03/06/2026

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 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: We have introduced a centralised compliance tracking system to monitor Garda Vetting, professional registration, mandatory training, employment documentation and other key regulatory requirements. New staff will not be permitted to commence in post until all of these checks are in place and there is a satisfactory Garda Vetting Disclosure on file. Compliance reports will be reviewed monthly by senior management and reported to the Board to provide assurance regarding ongoing compliance – effective from 07/07/2026	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Nursing staff will receive refresher training on the providers policy in relation to managing behaviours that challenge – scheduled for completion by 2nd September 2026. • Monthly audits of incidents/ known behaviours are in place. These specifically review that the providers policy is being implemented in practice and that each incident can evidence that a behavioural log has been completed and that care plans are updated to clearly outline potential triggers and deescalation/ diversionary techniques to manage the behaviour. The outcome of this monthly audit is now discussed at our monthly governance meetings for additional oversight effective 18th August. Quality improvement plans will be developed and implemented for any areas of non-conformance with the providers policy concerned with assessment and care planning and the providers policy in	

relation to managing behaviours that challenge.

- Management staff have completed training on Discharge Planning and Resident Advocacy to reinforce resident rights and safe discharge practice - completed on 23rd July 2026

- To strengthen the governance and management oversight of risk, residents' rights and complaints we have added each of these as individual standing agenda items to our weekly governance meeting and monthly clinical governance and operations meeting to track, analyse and review performance in this area – effective from 1st July 2026.

- We have appointed an experienced independent expert to our Board of Directors to further strengthen our governance and management oversight – effective from 3rd July 2026.

Regulation 34: Complaints procedure

Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:

- Management staff will receive refresher training on the providers' complaints procedures and responsibilities – completed on 23rd July 2026
- Complaints logged are now identified, tracked and reviewed through our governance structures in the form of our daily management huddle, weekly governance meetings to ensure that each complaint has been responded to in line with the Provider's policy and that formal Stage 2 complaints have been acknowledged, fully investigated and responded to within the relevant timeframes – effective from 1st July 2026
- Complaint oversight is subject to further review at our monthly clinical governance meeting to ensure all complaints have been fully closed out and that there is real time analysis of any trends emerging – effective from 1st July 2026.
- Compliance reports will be reviewed monthly by senior management and reported to the Board to provide assurance regarding ongoing compliance.

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • Management staff have received refresher training on transfer and discharge procedures– completed on 23rd July 2026 • Management staff will receive refresher training on the providers' complaints procedures and responsibilities – completed on 23rd July 2026 • Complaints and Residents' Rights are now a standing item agenda on our weekly governance meetings, monthly clinical governance and operational meetings and are subject to Board review – effective from 1st July 2026	
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: • Resident care plans identified on inspection have been reviewed. Old information has been archived, the care plans have been updated to reflect current assessed needs, and person-centred information has been included – complete. • Staff have received additional training on assessment and care planning procedures and responsibilities – completed on 25th May 2026 • A full review of all remaining resident care plans with a specific focus on the areas identified on inspection was completed on 31st July 2026. • Care plans audits have been reviewed and revised and will continue to be actioned monthly - complete and ongoing.	
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: • Staff have received additional training on assessment and care planning procedures and responsibilities – completed on 25th May 2026 • Resident care plans identified on inspection have been reviewed. Old information has	

been archived, the care plans have been updated to reflect current assessed needs, and person-centred information has been included – complete. • Nursing staff will receive refresher training on the providers policy in relation to managing behaviours that challenge – scheduled for completion by 17th August 2026. • Monthly audits of incidents/ known behaviours have been in place from 8th April 2026. These specifically review that the providers policy is being implemented in practice and that each incident can evidence that a behavioural log has been completed and that care plans are updated to clearly outline potential triggers and deescalation/ diversionary techniques to manage the behaviour.	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Contingency plans have been developed and implemented subsequent to the date of inspection to ensure that alternative staffing is arranged in the instance of the temporary absence of a member of the activities team – complete and ongoing. • All staff will receive refresher training around respecting resident rights and dignity by knocking before entering resident bedrooms and random spot-checks by senior nurse managers will oversee staff performance in this area – completed on 7th August 2026 and weekly spot checks to commence immediately after. • Residents with communication difficulties will now receive information on the activity schedule through a variety of mediums suitable to their communication needs, such as pictorial schedules, translated schedules or in person daily by activities or care staff – effective from 9th June 2026. • Management staff have completed training on Discharge Planning and Resident Advocacy to reinforce resident rights and safe discharge practice - completed on 23rd July 2026 • All residents are supported to receive support from independent advocacy services. Information regarding accessing advocacy services is displayed prominently throughout the nursing home. Residents receive detailed verbal communications and are supported to access advocacy services on an ongoing basis.	

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 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	07/07/2026
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	02/09/2026
Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on	Not Compliant	Orange	23/07/2026

	foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan.			
Regulation 04(1)	The registered provider shall prepare in writing, adopt and implement policies and procedures on the matters set out in Schedule 5.	Substantially Compliant	Yellow	23/07/2026
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	31/07/2026
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Not Compliant	Orange	17/08/2026
Regulation 9(2)(b)	The registered provider shall provide for residents opportunities to participate in activities in	Substantially Compliant	Yellow	09/06/2026

	accordance with their interests and capacities.			
Regulation 9(3)(d)	A registered provider shall, in so far as is reasonably practical, ensure that a resident may be consulted about and participate in the organisation of the designated centre concerned.	Not Compliant	Orange	23/07/2026