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

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| Name of designated centre: | Beechfield Manor Nursing Home |
| Name of provider: | Beechfield Manor Nursing Home |
| Address of centre: | Shanganagh Road, Shankill, Co. Dublin |
| Type of inspection: | Unannounced |
| Date of inspection: | 09 February 2026 |
| Centre ID: | OSV-0000013 |
| Fieldwork ID: | MON-0049498 |

## About the designated centre

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

Beechfield Manor Nursing Home is a purpose built nursing home located in Shanganagh Road, Shankill Co. Dublin. It is registered to provide accommodation for 69 residents in 67 single and one double bedrooms. Each room is fully decorated and furnished. Residents are encouraged to bring personal belongings and small items of furniture where appropriate. The majority of the rooms have en suite facilities. Professional nursing care is provided to residents 24 hours a day by our dedicated team of qualified registered nurses, headed by our Director of Nursing and supported by Assistant Director of Nursing, two Clinical Nurse Managers, qualified staff nurses and experienced carers, with additional input from catering, housekeeping and laundry staff.

**The following information outlines some additional data on this centre.**

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| Number of residents on the date of inspection: | 61 |

## 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 |
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| Monday 9 February 2026 | 13:55hrs to 20:00hrs | Mary Veale | Lead |
| Tuesday 10 February 2026 | 07:30hrs to 13:45hrs | Mary Veale | Lead |
| Monday 9 February 2026 | 13:55hrs to 20:00hrs | Sharon Boyle | Support |
| Tuesday 10 February 2026 | 07:30hrs to 13:45hrs | Sharon Boyle | Support |

## What residents told us and what inspectors observed

The overall feedback from residents who spoke with the inspectors was that they were very happy and liked living in Beechfield Manor Nursing Home. Residents were complementary of the centre, the staff, the quality of the care, and activities provided. During the two days, the inspectors met with many of the 61 residents living in the centre and spoke to 11 residents and two visitors in more detail. The inspectors spent time observing daily life in the centre to gain an insight into the lived experience of residents in Beechfield Manor Nursing Home. Residents praised the staff working in the centre. One resident stated that "the staff were lovely", with another resident saying that “they were well looked after, the staff were good to them and that the food was too good”. Another resident told inspectors that they “were happy living in the centre and that the staff were exceptional”.

This was a two day inspection to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres) Regulations 2013 (as amended), and to follow up the compliance plan, submitted by the provider, following an inspection of the centre in October 2025.

Inspectors arrived at the centre in the afternoon on day one of the inspection and were greeted by a person in charge and an assistant director of nursing. Inspectors conducted a walk around of the premises, followed by an introductory meeting with the person in charge. To gain insight into the residents' experiences in the centre, inspectors spoke with residents, visitors, and staff, and spent time observing the environment and reviewing documentation. Inspectors returned early the following morning to listen to the nursing handover following the night shift and to observe the morning routines.

Beechfield Manor Nursing Home comprises a period house with a purpose-built extension, located in Shankill, Co. Dublin. Resident accommodation within the centre is set out over three floors. The centre is accessed through a ground-floor entrance lobby of the period house and includes a lower ground floor and a first floor. Two passenger lifts facilitate travel between the three floors.

Bedroom accommodation comprises 67 single-occupancy bedrooms and one twin-occupancy bedroom. Twenty bedrooms had an en-suite shower, toilet, and wash-hand basin, while 41 bedrooms had an en-suite toilet and wash-hand basin. The remaining seven bedrooms shared communal bathroom facilities. Bedrooms had comfortable seating, and most were personalised with items from home, such as family photographs, artwork, bedding and ornaments. The bedrooms had a television, locked storage, and call-bell facilities.

During the days of inspection, some residents were resting in their bedrooms, while others were relaxing in the communal spaces. The premises appeared comfortable and nicely decorated. There was a choice of communal areas for residents on each

floor, for example, there was a large dining room and two sitting rooms on the lower ground floor, two sitting rooms and a visitor's area on the ground floor, and a sitting room on the first floor. Some residents were also observed sitting in smaller seating areas near the nurse's station on certain floors, watching the comings and goings.

Residents had access to outdoor spaces. There were two enclosed terrace areas; one located at ground-floor level, and the other accessible from the lower ground-floor dining area and lobby. There was a separate outdoor space which contained the designated smoking area on the lower ground-floor level.

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

Most residents who spoke with the inspectors were complimentary of the home cooked food and the dining experience in the centre. The daily menu was displayed in the dining rooms. Inspectors observed the main lunchtime meal on the ground floor. The lunch time was observed to be a relaxed and sociable experience, with residents enjoying each other’s company as they ate, while engaging in conversation. Meals were freshly prepared in the centre's on-site kitchen and the main lunchtime and teatime were served in the dining rooms by the staff. Residents confirmed they were offered a choice of main meal and dessert. The food served appeared nutritious and appetising. Staff were observed to be respectful and discreetly assisted the residents during the mealtimes. Inspectors observed that drinks and snacks such as fruit, yogurt and biscuits were offered to residents.

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

Friends and families were facilitated to visit residents, and the inspectors observed many visitors in the centre throughout the two days. Visitors who spoke with the inspectors were mostly happy with the care and support their loved ones received. One visitor said that they had previously raised concerns with the person in charge and that these concerns were followed up and addressed appropriately.

Residents’ spoken with said that they were very happy with the activities programme in the centre, others stated that they preferred their own company and had appropriate access to newspapers, books, radios, the internet and televisions, that helped to pass the time. The activities programme was displayed on notice boards near one of the lift areas and in resident’s bedrooms. Inspectors observed residents attending an exercise session in the afternoon of the first day of the inspection and a memory game on the second day. Residents who did not enjoy social activities and preferred their own company told inspectors that the activities staff came to visit them daily and provided them with plenty of opportunities and

activities to keep them busy. Residents' views and opinions were sought through resident meetings and satisfaction surveys, and residents felt that they could approach any member of staff if they had any issue or problem to be solved. Residents had access to advocacy services.

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

## Capacity and capability

Overall, inspectors found that the provider had enhanced management systems within the centre since the last inspection, however, there were repeated findings of non-compliance in a number of regulations, including care planning, the management of behaviours that are challenging and governance and management, as set out in this report. Inspectors reviewed unsolicited information received by the Office of the Chief Inspector. The information received pertained to concerns regarding care planning, the governance and management of the centre, the change in the management structure, safeguarding, residents' rights, and notifications. Some of this information was substantiated on this inspection.

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

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

The registered provider for Beechfield Manor Nursing Home is Beechfield Manor Nursing Home Limited. This company has two directors. Inspectors met both directors on this inspections, and one director and a person participating in management was present for the feedback meeting on the second day of the inspection. The centre is part of the Beechfield Care Group, which operates eight centres.

The person in charge worked full-time, was responsible for the centre's day-to-day operations, and reported to the group director of operations. The person in charge was supported in their management of the centre by an assistant director of

nursing, two clinical nurse managers, a team of staff nurses, senior healthcare assistants, healthcare assistants, activities, administration, catering, household, and maintenance staff. Since the previous inspection there had been a change in the personel working in the role as Clinical Nurse Managers. At the time of inspection the role of the group quality and care manager had been vacant since July 2025. The inspection in October 2025 found that this position remained vacant and that the registered provider had failed to notify the Chief Inspector of these changes to the governance structure in the centre. Subsequently, a warning meeting was held with the provider in January 2026. It is acknowledged that at the time of this inspection, the recruitment process was in its final stages, and it was expected that the successful candidate would commence in the role in the weeks following the inspection.

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

Since the previous inspection there had been improvements in staff training and development. There was an ongoing schedule of training in the centre and the person in charge had good oversight of training. An extensive suite of mandatory training was available to all staff in the centre and training was up-to-date. There was a high level of staff attendance at training in areas such as safeguarding, fire safety, manual handling, and infection prevention and control. Since the previous inspection the person in charge had implemented regular tool-box talks (short presentations). Records viewed outlined that staff had attended tool-box talks on topics such as; residents' rights and dignity, responsive behaviours, communication, call-bell response times, residents' mealtime choice, enhancing the dining experience, and care planning. Staff with whom the inspectors spoke, were knowledgeable regarding safe guarding procedures.

Records maintained in the centre were in electronic and paper format. Staff files reviewed contained all the requirements under Schedule 2 of the regulations. Garda vetting disclosures, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, were available for each member of staff. While most, records and documents were well-presented and organised, gaps were seen in the documentation of care plans and assessments, which will be discussed under Regulation 5: Individual assessment and care plan and Regulation 23: Governance and management.

The notification of incidents had improved since the previous inspection. Incidents and reports, as set out in Schedule 4 of the regulations were notified to the Chief Inspector of Social Services, within the required timeframes. Inspectors followed up on incidents that were notified since the previous inspection and found these were managed in accordance with the centre’s policies.

Some improvements were found in the governance and management of the centre since the previous inspection. The management structure within the centre was becoming operationally stable, with management systems being embedded. There

were communication systems in place between the registered provider and management within the centre, as well as between the person in charge and staff working in the centre. Records of clinical governance and staff meetings that had taken place since the previous inspection were reviewed during this inspection. Governance and staff meetings took place monthly and staff meetings took place quarterly. In addition to these meetings there were daily management walk-arounds and huddle meetings. The person in charge completed a weekly key performance indicator (KPI) report, which was discussed with the quality and clinical practice lead.

Notwithstanding these good practices, the absence of a quality and care manager was evident during the inspection and was found to have an impact on the effectiveness of the centre's governance and management systems. This was evident by deficits in the oversight of the management of behaviors that are challenging, the annual review for 2025 and the audit processes. While there was a schedule of clinical and environmental audits completed, some audits did not contain an associated action plan to address the audit findings. This is a repeated finding from previous inspections. In addition, the systems in place to manage risk were not robust, and did not ensure the appropriate and effective management of adverse incidents, such as falls. Furthermore, the oversight of the documentation of assessment and care plans was inadequate, resulting in a poor standard of care documentation.

## Regulation 15: Staffing

On the inspection days, staffing was found to be sufficient to meet the needs of the residents' living in the centre. There was a minimum of two registered nurses and four health care assistants on duty at all times.

Judgment: Compliant

## Regulation 16: Training and staff development

Staff had access to training appropriate to their role. Staff had completed training in fire safety, safe guarding, managing behaviours that are challenging and, infection prevention and control. There was an ongoing schedule of training in place to ensure all staff had relevant and up-to-date training to enable them to perform their respective roles.

Judgment: Compliant

## Regulation 21: Records

All records, as set out in Schedules 2 & 4 were available to the inspectors. However; not all records were available relating to all occasions on which restraint is used. For example; records of restraint use did not include documentation outlining other less interventions attempted to manage the behaviour or the duration for which the restraint was to be used.

Judgment: Substantially compliant

## Regulation 23: Governance and management

The management systems to monitor, evaluate and improve the quality of the service were ineffective. The registered provider had not implemented all the actions committed to in their compliance plan from the previous inspection. As a result, some of the non-compliances were identified again during this inspection. This was evidenced by the following;

- Inspectors found that audits completed did not have associated action plans to address the identified risks or areas for improvement. The audit processes were not sufficiently effective in identifying areas of concern or clearly outline the actions required. Additionally, audits reviewed by inspectors in areas of falls, care plans, restrictive practices primarily focused on confirming the completion of documentation rather than evaluating whether the care was being delivered in line with assessed needs, care plans and regulatory requirements. For example; documentation relating to a falls incident showed that a deterioration in a residents condition had not been recognised, resulting in a delay in escalating the concern and the resident receiving timely assessment and treatment by an appropriate medical practitioner. This was not identified through the audit process, and is a repeated finding from the previous four inspections.
- There were inadequate systems of supervision in place to monitor and respond to issues such as incomplete documentation of assessment and care planning, and ineffective management of behaviours that are challenging. For example; One residents care plan indicated that supervision and assistance was required at mealtimes, while the resident was on a trial of a level four diet due to an acute swallowing difficulties and awaiting review by a speech and language therapist. However, there was no choking risk assessment, or dysphagia mealtime plan or oral and dental care plans in place to support the identified risk, and while staff were aware of the change in diet they were not aware of the reason for this change.

There was inconsistent recordings of blood sugar levels for one resident which did not align with their care plan.

This is a repeat finding.

- While there was a 2025 annual review there was no evidence that this had been completed in conjunction with the residents. Additionally, oversight systems had not identified that the quality improvement plan that was developed had addressed the issues highlighted in the review, this was evident by similar findings by inspectors during this inspection.

Judgment: Not compliant

## Regulation 31: Notification of incidents

Incidents and reports as set out in Schedule 4 of the regulations, were notified to the office of the Chief Inspector within the required time frames.

Judgment: Compliant

## Quality and safety

Inspectors noted improvements to the standard of care provided to residents since the previous inspection. Inspectors observed that staff were kind and treated residents with dignity and respect. While acknowledging the improvements that had occurred, not all areas of concern the provider had committed to in their compliance plan following the previous inspection had been addressed, specifically in the areas of; individual assessment and care planning, and managing behaviour that is challenging.

Inspectors reviewed a sample of care plans, and found that, while the care plans had been reviewed at regular intervals, they had not all been revised and therefore, the quality and accuracy of the information recorded did not consistently reflect the residents' assessed needs. This will be further discussed un Regulation 5: Individual assessment and care plan.

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

There was a policy in place to guide staff on the management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. There was evidence that staff had received training in managing behaviour that is challenging and residents' had access to psychiatry of later life. However, inspectors found there was a significant level of restrictive practices in use which did not align to the national policy. While, the use of restrictive practice was reviewed regularly, oversight of the management of behaviours that are challenging, including the trialling, application and oversight of restrictive practices was not sufficiently robust. This is discussed further under Regulation 7: Managing behaviours that are challenging.

Since the previous inspection, a system had been put in place to review clinical incidents as part of the weekly clinical operations review. The inspectors reviewed a number of potential safeguarding incidents which had occurred since the previous inspection, and found that these incidents were managed in line with the centre's policies and procedures. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. All interactions between staff and residents were observed to be respectful throughout the inspection. Residents reported that they felt safe living in the centre. The provider was acting as a pension agent for two residents living in the centre and records reviewed showed that these pensions were paid into a separate residents' client account to ensure residents' finances were safeguarded. The provider had a transparent system in place where all lodgements and withdrawals of residents' personal monies were signed by two staff and logged. The provider also audited the balances on a regular basis in line with the centre's policies.

Evidence of improvement was noted in the breakfast dining experience since the previous inspection. Residents were offered a choice of a hot or cold breakfast and a choice of hot and cold beverages. Residents on modified- consistency diets were offered a choice of two main lunch time meals and two options of vegetables. Residents were provided with adequate quantities of food at all meals and were offered additional portions. The lunch-time and tea-time meals were facilitated in the dining and communal rooms. Most residents preferred to eat their breakfast meal in their bedrooms and residents said that their preferences were facilitated. Residents spoken with overall confirmed that they enjoyed the meals provided. Residents on modified diets received their meals and drinks in a consistency that was aligned to their assessed needs and residents were observed to be supervised and assisted, where required, to ensure their safety and nutritional needs were met.

Improvements were found in residents' rights since the previous inspection. Residents were offered choice to attend the dining room for breakfast, and suitable crockery had been acquired and was observed in use by residents. Residents were offered a choice to wear clothes protectors at mealtimes.

Residents were provided with recreational opportunities, including games, music, pet therapy, exercise, bingo, and art. Arrangements were in place for consulting with residents in relation to the day-to-day operation of the centre. Resident

feedback was sought in areas such as activities, meals, and mealtimes. Records showed that items raised at resident meetings were addressed by the management team. Information regarding advocacy services was displayed in the centre. Residents had access to local and national newspapers, the internet, televisions, and radios.

## Regulation 18: Food and nutrition

A validated assessment tool was used to screen residents regularly for risk of malnutrition and dehydration. Residents' weights were closely monitored and there was timely referral to and assessment of residents' by the dietician.
Meals were pleasantly presented and appropriate assistance was provided to residents during meal-times. Residents had choice for their meals and menu choices were displayed for residents.

Judgment: Compliant

## Regulation 5: Individual assessment and care plan

Inspectors found that not all care plans were updated and revised and some care plans contained inconsistent and conflicting information. As a result, care plans did not consistently provide staff with clear and reliable information to support them in meeting residents' assessed needs. This was evidenced by the following examples;

- One resident, who was assessed as requiring intervention in relation to seizures, did not have a care plan developed to guide staff in the management of the seizure.
- One resident's care plans had inconsistent and conflicting supervision requirements recorded, with monitoring intervals documented as 15 minutes, 30 minutes and 1 hour.
- One resident's mobility assessment identified that they required the assistance of one person, however, the corresponding care plan documented that they required the assistance of two people.

This is a repeat finding from previous inspections.

Judgment: Not compliant

## Regulation 6: Health care

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

Judgment: Compliant

## Regulation 7: Managing behaviour that is challenging

The number of residents with responsive behaviours had reduced since previous inspections and the residents that were identified with responsive behaviours had behavioural plans in place. However, the information within the behavioural plans was insufficient to ensure that the staff had up to date information and knowledge on how to respond and manage the behaviours. For example; the behavioural charts did not document potential triggers or person-centered de-escalation techniques, and instead recorded descriptions of the incidents with responses such as supervise, monitor and reassure.

The use of restraints was not aligned with national policy to ensure a restrain free environment. This was evidenced by the following;

- Inspectors observed a substantial amount of restraints used for the number of residents in the centre; there was a total of 12 different types of restraint used in the centre including bed alarms for 20 residents and bed rails for 16 residents.
- Where restraints such as bed alarms, floor alarms, bed rails, bed wedges and wander bracelets were in use all consent forms identified that the reason for use of restraint was to prevent a fall or prevent injury from a fall which is not in line with the centres own policy or national guidelines on restraint.
- While all restraints used had a consent form signed by either the resident or their family member there was no evidence that the risks of using the restraint device were explained.
- The residents restrictive practice care plans did not outline the circumstances in which the restraint is to be used or the duration of the restraint.
- Four residents who had trialled without using restraint had the trial completed over a period of between two and four nights.
    - The records for one resident simply said that the trial had failed but included no reason as to why or how it had failed.
    - The record of one resident who had their wander guard removed over a period of four nights had their restraint reapplied following a family meeting without identifying why the restraint was required. This was inspite a records which said that they walked the corridors at night but exhibited no exit seeking behaviour.
    - One resident had a trial of removing a floor mat over a period of two nights and did not wake or move for the duration of the trial, however

the decision recorded was to continue the use of the floor mat in order to prevent a fall.

This is a repeat finding from previous inspections.

Judgment: Not compliant

## Regulation 8: Protection

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

Judgment: Compliant

## Regulation 9: Residents' rights

Residents' rights and choice were promoted and respected in this centre. There was a focus on social interaction led by staff, and residents had daily opportunities to participate in group or individual activities. Access to daily newspapers, television and radio was available. Details of advocacy groups was on display in the centre.

Judgment: 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 | Compliant |
| Regulation 21: Records | Substantially compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 31: Notification of incidents | Compliant |
| **Quality and safety** | |
| Regulation 18: Food and nutrition | Compliant |
| Regulation 5: Individual assessment and care plan | Not compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Managing behaviour that is challenging | Not compliant |
| Regulation 8: Protection | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Beechfield Manor Nursing Home OSV-0000013

## Inspection ID: MON-0049498

## Date of inspection: 10/02/2026

**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:

The Director of Nursing will ensure that all records relating to restraint use are complete, accurate, and aligned with regulatory and national policy requirements.
• All restraint documentation has been fully reviewed and updated to ensure inclusion of:
o Rationale for use
o Evidence of least restrictive alternatives trialled
o Duration and review frequency
• A monthly restraint audit and restraint committee meeting has been established to review:
o Appropriateness of restraint use
o Documentation quality
o Opportunities for reduction
• The Clinical Nurse Manager will carry out daily spot checks to ensure compliance with policy and accurate documentation.
• All restraint care plans have now been completed.
• A Restraint committee meeting was held on 09/03/2026 and attended by the clinical management team/staff nurse/DON/and ADON. The Assistant Director of Nursing (ADON) has designated responsibility for oversight of restraint practices.
A positive risk-taking approach will be adopted when trialling the removal of bedrails, ensuring that the potential benefits are carefully balanced against identified risks.
• A multidisciplinary team approach is followed to ensure that restraints are only used as a last measure to ensure resident safety and to maintain their wellbeing. Multi-disciplinary team including GP/Physiotherapy are involved when consent for restraint is taken. Furthermore, Care Plans continue to be reviewed every four months or as required. Restrictive practice will be discontinued if the risk is no longer identified through Trials.

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| Regulation 23: Governance and management | Not Compliant |

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

The registered provider has implemented a strengthened governance framework to ensure effective oversight, accountability, and continuous quality improvement.

• The centre has an audit system in place to monitor the quality and safety of the care provided to residents in line with the centre's policy. The audit process has been recently reviewed by the new Group Quality and Care Manager.

• A revised centre-wide audit schedule has been implemented.
• All audits now include:
o Clear findings
o SMART action plans
o Assigned responsibility and timelines
The Director of Nursing has implemented the structured planned audit schedule developed by the Group Quality and Care Manager. The clinical management team (DON/ADON/CNM) have individualised audit responsibility. The DON oversees the process, review findings, and ensure corrective actions are carried out.

• A Post Fall Log has now been introduced to ensure that the deterioration is identified promptly. The ADON will review this log as a part of Falls documentation audit. The gaps in documentation and monitoring of a resident post fall will be disseminated to ensure learning by all staff.
• Senior Management Clinical review is now increased in frequency from weekly to daily to identify gaps in assessments and care plans and correct it promptly. This will ensure timely identification of gaps.
• The DON facilitated on-site training delivered by Nutricia to enhance staff knowledge and support best practice in nutritional care. Catering department and Clinical staff have attended Nutricia Dysphagia training on 11/2/26 post inspection. Staff are now aware of prompt identification of swallowing issues and continue to refer to Speech and Language professionals as required.
• A general meeting was conducted on 13/3/26 to highlight key areas like Falls, Restraint, Dysphagia, Mealtime Choices, Behavior that Challenge. Nursing staff have been instructed to complete a choking risk assessment for any resident on a trial of modified diet or fluids until reviewed by a Speech and Language Therapist (SALT).
• Toolbox talk were delivered to refresh the knowledge of Nurses around Blood Sugar Monitoring and Insulin Administration.
• All Blood sugar levels recordings for residents who require same now align with their care plan.
• Annual Review- The DON developed a quality improvement plan as part of the annual review, informed by findings from resident feedback and satisfaction surveys. Residents' meetings were completed, and their views have been incorporated into the plan to support the ongoing service improvement.

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|---|---|
| Regulation 5: Individual assessment and care plan | Not Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

The Director of Nursing will ensure that all care plans are accurate, up-to-date, and reflective of residents' assessed needs.
• A full review of all care plans is been completed to:
o Eliminate conflicting information
o Ensure alignment with assessments
• All residents with specific clinical needs (e.g. seizures, dysphagia) now have:
o Individualised care plans
o Risk assessments
• The Clinical Nurse Managers conduct monthly audits of care plans with:
o Immediate correction of deficits
• ADON/DON conduct weekly oversight reviews.
• All residents with a diagnosis of seizure have now individualized care plans and risk assessments that are regularly reviewed and updated by nurses. All resident's medical diagnosis is documented during pre-admission assessment with their medical history recorded in care monitor.
• Some residents are on enhanced supervision if risk is identified. This is now corrected to remove conflicting information.
• All residents mobility care plan has been reviewed and updated in line with their current status. Physiotherapy is involved as required in response to any changes in resident's mobility.

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| 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:

The Director of Nursing will ensure that behaviour support practices are person-centred, evidence-based, and aligned with national policy on restraint.

• A comprehensive review of all residents using restraints was completed on 7/11/2025 and restraints numbers were reduced following the meeting. The next meeting was scheduled for 9/3/26 and same completed. Following this review, trial removals were conducted if safe for the residents, resulting in a further reduction of restraint use.
• A range of measures are in place to support residents, with the least restrictive option selected following a comprehensive assessment of risks and benefits, in line with the centre's restraint policy. Least restrictive interventions, such as bed and chair alarms, are

implemented where there is a risk of injury or where residents may be unable to seek assistance, in order to support timely intervention and reduce the risk of harm, particularly for frail residents with cognitive impairment.
• Care plans have been updated accordingly and ongoing monitoring done by the DON/ADON ensuring resident's safety while promoting least-restrictive practices. Monthly restraint audits done by ADON and regular clinical spot checks are conducted by the Clinical management team.
• A general meeting was conducted on 13/3/26 to highlight key areas like Falls, Restraint, Dysphagia, Mealtime Choices, Behavior that Challenge. Nursing staff have been instructed to complete a choking risk assessment for any resident on a trial of modified diet or fluids until reviewed by a Speech and Language Therapist (SALT).
• All consent used have been reviewed by DON/ADON ensuring the purpose of restraint has been explained to the residents and their families.
• The restrictive care plans are reviewed by DON/ADON, ensuring clear documentation outlining the circumstances in which the restraint is being used.

• DON/ADON ensures trial of removal of restraint will be clearly documented in residents care plans. An enhanced restraint removal has been implemented as a positive risk-taking approach without compromising resident safety.

## 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 | 31/03/2026 |
| 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 | 31/03/2026 |
| Regulation 23(1)(f) | The registered provider shall ensure that the review referred to in subparagraph (e) is prepared in consultation with residents and their families. | Not Compliant | Orange | 31/03/2026 |

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| Regulation 23(1)(h) | The registered provider shall ensure that a quality improvement plan is developed and implemented to address issues highlighted by the review referred to in subparagraph (e). | Not Compliant | Orange | 31/03/2026 |
| 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 | 19/04/2026 |
| 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. | Not Compliant | Orange | 31/03/2026 |
| 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 | Not Compliant | Orange | 31/03/2026 |

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| | manage behaviour that is challenging. | | | |
| Regulation 7(3) | The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time. | Not Compliant | Orange | 31/03/2026 |