



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Belmont House Private Nursing Home
Name of provider:	Belmont Care Limited
Address of centre:	Gallopig Green, Stillorgan, Co. Dublin
Type of inspection:	Unannounced
Date of inspection:	10 March 2026
Centre ID:	OSV-0000014
Fieldwork ID:	MON-0047583

About the designated centre

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

Belmont House is a 156-bed centre providing residential, respite and short-stay convalescent care services to male and female residents over the age of 18 years. The centre was originally a Georgian country house and was owned by a religious order. The building has been extended and completely refurbished while retaining some of its older features. It is located on the Stillorgan dual carriageway, close to the village of Stillorgan, with access to local amenities, including shopping centres, restaurants, libraries, public parks and coffee shops and good access to public transport. Accommodation for residents is across five floors. There are also areas for residents to socialise and relax, including activity rooms, a coffee dock and quiet areas. The majority of bedrooms are single rooms, and there are 25 twin rooms. There is 24-hour nursing care with access to both in-house and specialist healthcare as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	120
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 10 March 2026	07:55hrs to 16:35hrs	Aoife Byrne	Lead
Tuesday 10 March 2026	07:55hrs to 16:35hrs	Sharon Boyle	Support
Tuesday 10 March 2026	07:55hrs to 16:35hrs	Sarah Armstrong	Support

What residents told us and what inspectors observed

Overall, Inspectors found that residents living in Belmont House Private Nursing Home were well cared for and well supported to live a good quality of life by a dedicated team of staff that knew them well. Residents were complimentary about staff and the care they provided.

On arrival to the centre, the inspectors completed a walkabout of the premises where they met with the staff on duty. Most residents were still in their beds when inspectors arrived to the centre. A small number of residents were observed to be up and dressed, and were observed taking their breakfast in either their bedrooms or communal dining spaces. After the walkabout, the inspectors met with the Person in Charge (PIC), the Assistant Director of Nursing (ADON) and the supporting clinical oversight manager for an introductory meeting, where the purpose of the inspection was set out.

This was an unannounced inspection completed by three inspectors of social services over the course of one day. The purpose of the inspection was to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). The inspectors also followed up on the compliance plan received from the previous inspections which were held in July and December 2025, statutory notifications submitted by the provider, and unsolicited information received about the centre since the last inspection.

The inspectors spoke with a number of residents on the day of inspection. Residents spoke highly of the staff who supported them. One resident told the inspectors "the staff are excellent, they are very obliging. If I decided I wanted a lunch at 5am in the morning it wouldn't be a problem! They are really great". Another resident told inspectors "the staff are lovely. They come to me very quickly if I call them". The residents who were unable to communicate with the inspectors were observed smiling at staff and appeared content and relaxed. The staff interactions were noted to be kind, respectful and attentive to these residents.

Inspectors observed that there was a weekly activities schedule visible in prominent locations throughout the centre. Residents were also noted to have copies of the weekly schedule in their bedrooms and residents were aware of the types of activities available in the centre. The residents told inspectors that staff kept them informed of the activities schedule, and respected their choice as to whether or not to take part. When asked about the different activities provided, one resident told the inspectors, "I have the list here and I read that, and then I pick and choose what I want to do. There's a history talk on this evening and I think I will go to that". Another resident said "I don't usually do any of the activities, I prefer to do my own thing" adding "I know there is a list of what's on each day if I want to look at it". On the day of inspection, inspectors observed residents taking part in

meaningful activities that were suited to their interests and capacities, including music and singing, and nature talks. Residents had requested bingo be introduced and the first game took place on the afternoon of the inspection. One resident was delegated as the caller, and the inspectors saw the residents were excited at the idea they could win prizes. Other residents who did not wish to take part were observed engaged in other activities including reading the newspapers or playing games on their tablets, in line with their preferences.

One resident told inspectors about a men's shed that had been recently established in the centre. This resident said "there's about 10 of us in the club at the moment, we've only started setting it up. We're talking about organising different trips". When speaking about their involvement in the men's shed, this resident also told the inspectors "it has been great because before now you might only say hello to someone in passing, but through the club we are all starting to actually get to know each other and have proper conversations". One visitor told inspectors that the men's shed was a positive initiative to address issues with loneliness and enhance opportunities for socialisation for the men in the centre.

Residents also complimented the choice and quality of the food provided in the centre, with comments such as; "the food is very good here, I can make no complaints about it", and "I like the food, there's a choice of different things each day." On the day of inspection, for their lunch, residents had soup followed by a choice of roast chicken in white wine sauce or beef stew, served with roasted vegetables, mashed and roasted potatoes. Residents could choose between profiteroles or jelly and ice-cream for dessert. In the dining rooms, inspectors observed that the tables were nicely set with tablecloths, cups, saucers and wine glasses. The daily menus were also displayed on each table. Some residents expressed frustration to the inspectors regarding changes to the main dining room while kitchen renovation works were ongoing. Three residents told the inspectors the use of the dining room to store dishes and crockery was associated with increased noise levels which impacted their ability to have a proper conversation with each other. Three other residents told inspectors that due to changes in the layout of the dining room they felt they had been pushed into a corner and that now the residents felt "crammed" into the room.

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

Capacity and capability

Overall, there was evidence of improvement since the previous inspection, including progress made by the provider in addressing some areas of non-compliance following the inspections in July and December 2025. Improvements were found in

Regulation 5: Individual assessment and care planning, and Regulation 31: Notification of incidents. While the registered provider had implemented measures to address governance and management concerns identified through previous inspections and internal audits, this inspection found that the supervision of staff and oversight arrangements were not sufficiently effective to detect the issues identified during this inspection. Specifically in the areas of Regulation 24: Contract for the provision of service, Regulation 15: Staffing and Regulation 16: Training and staff development.

Belmont Care Limited is the registered provider of Belmont Private Nursing Home. The centre is one of the 25 nursing homes that are part of the Emeis Group. The person in charge (PIC) is supported by assistant directors of nursing (ADON), clinical nurse managers (CNMs), registered nurses, care assistants, an activities coordinator, housekeeping, catering, laundry, administrative and maintenance staff. Additional support was provided by management from the wider Emeis group such as regional directors.

There were governance systems in place such as clinical governance meetings, staff meetings and residents meeting. Inspectors reviewed the records of these meetings. Since the previous inspection in December 2025, the provider had introduced additional clinical oversight to support and enhance the quality of clinical care provided to residents, with a particular focus on pressure ulcer prevention, as well as supporting staff training and the review of care plans. As a result, inspectors found there was positive changes made to some of these areas.

The quality and safety of care was monitored through a programme of monthly audits, and there was evidence of trending of the audit findings. However, not all audits were supported by action plans, which limited the effectiveness of these systems in driving and monitoring quality and safety improvements within the center. An annual review was prepared of the quality of care delivered to residents in 2025, and this included evidence of feedback and consultation with residents gathered throughout the year.

Notwithstanding the introduction of the clinical oversight manager, inspectors found that the oversight of rosters and supervision of staff arrangements were insufficient. The routine redeployment of CNMs to staff nurse duties resulted in reduced supervision of staff across the centre. This is further discussed under Regulation 15: Staffing and Regulation 16: Training and staff development.

The management team had a good understanding of their responsibility in respect of managing complaints. The inspectors reviewed the records of complaints raised by residents and relatives and found they were appropriately managed. Residents spoken with were aware of how to make a complaint and whom to make a complaint to.

The inspectors reviewed eight contracts of care and found that not all contracts contained the information required by the regulations. This will be discussed under Regulation 24: Contract for provision of services.

Regulation 15: Staffing

The number and skill mix of staff in the centre was not appropriate having regard to the size and layout of the building. This was evidenced by the inspectors' findings on the day of the inspection, where the only CNM scheduled to work and provide supervision to staff across the five floors, was redeployed to staff nurse duties. Inspectors found that the redeployment of CNMs to staff nurse duties and staff nurses to healthcare assistant duties was part of routine rostering practices and not a measure taken in response to unplanned staff absences. As a result staff were not consistently working within their designated roles as set out in the Statement of purpose against which the centre is registered.

Judgment: Not compliant

Regulation 16: Training and staff development

While staff had access to appropriate training, they reported to inspectors the difficulty in applying their learning in practice due to the allocation of duties and changes to their roles within the centre. This was particularly relevant where CNMs were frequently redeployed to staff nurse duties and staff nurses rostered to work as healthcare assistants. Additionally, both staff feedback and inspectors findings indicated that the frequent redeployment of CNMs adversely impacted on the oversight of staff practices across units. This was evidenced by the following;

- Enhanced supervision arrangements identified in staff performance support plans, were not in place.
- Records of mattress checks which were completed daily did not include the residents' weights, and a sample reviewed across multiple units, found that mattress settings for residents with existing pressure ulcers, or assessed as high risk were set incorrectly. Despite the efforts by the management team to reduce the risk of pressure ulcers from developing or deteriorating, these mattresses were not an effective preventative measure.
- Inspectors observed the disposal of dirty water from the floor buffer into a communal toilet used by residents, this practice does not ensure that appropriate infection prevention and control standards are implemented by all staff.

Additionally, copies of the Health Act and the regulations or the Authority's standards were not available to staff on each unit. It is acknowledged that a staff member addressed this on the day of the inspection.

Judgment: Not compliant

Regulation 23: Governance and management

Since the previous inspection in December 2025, it was evident that while there were some improvements made in relation to increased oversight on the operational systems, the increased governance and management systems had not been fully effective. This was evidenced by;

- The oversight systems in place to ensure that staffing levels and skill mix was appropriate to the size and layout of the centre and that effective supervision of staff was maintained, were ineffective. As a result, there was evidence that supervision arrangements were inadequate to consistently support staff. Additionally, the redeployment of CNMs and staff nurses blurred the lines of authority and accountability, resulting in uncertainty among staff regarding the management structure and their respective roles and responsibilities.
- While audits were occurring such as; audits of medication management, complaints, falls and infection prevention and control, there were no corrective action plans in place, and no evidence that improvements were implemented following findings.
- Oversight systems in place to ensure the implementation of the compliance plan from the previous inspections were insufficient. The provider had committed to painting and decorating works in the Beech and Maple units, by September 2025. However, inspectors observed that these works had not occurred. In addition, significant wear and tear was evident throughout the centre, including chipped paint on doors, architraves, skirting boards and handrails and areas of recently plastered walls remained unpainted.
- Inspectors reviewed a sample of staff complaints which showed that staff had repeatedly raised concerns about staffing levels. However, following investigation by management, these concerns persisted.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The inspectors reviewed a sample of residents' contracts of care. Contracts did not contain all the required information. For example:

- Three contracts did not specify the occupancy of the resident's room.
- One contract had the incorrect resident's room number.
- Three contracts had not been signed for weeks or months after the resident's admission to the designated centre

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record of all incidents occurring in the centre was maintained and all required notifications were submitted to the Chief Inspector within the time frames set out in Schedule 4 of the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

A clear complaints procedure was in place and this was displayed prominently in the centre. The record of complaints was reviewed by the inspector. These records identified that complaints were recorded and investigated in a timely manner and that complainants were advised of the outcome of their complaint. A record of the complainant's satisfaction with how the complaint had been managed was also documented. Staff complaints followed the same complaints procedure as residents and visitors.

Judgment: Compliant

Quality and safety

Inspectors found that residents living in Belmont House Private Nursing Home were found to receive a good standard of care in general. Feedback from residents was all positive and the inspectors observed these units to have a relaxed atmosphere on the day of inspection, with call bells being responded to promptly by staff.

Staff demonstrated a good knowledge of residents' assessed needs. Comprehensive assessments had been completed for residents on admission to the centre, and care plans were developed for residents within 48 hours of their admission. Care plan documentation reviewed was found to be written in a person-centred manner and was suitably detailed to guide staff in providing good quality, safe care aligned to residents' needs and preferences. The inspectors reviewed a variety of care plans including wound management, food and nutrition, moving and handling, sensory and communication, and spirituality and end of life care plans. All care plans reviewed contained up-to-date information, and where residents had been reviewed by a GP or other allied healthcare professional, such as a tissue viability nurse or dietitian, recommendations by those professionals had been accurately incorporated

into those residents' care plans. In addition, referrals to GP and allied healthcare professionals were found to be made in a timely manner.

Some residents in the centre had specific communication needs, for example, due to impaired hearing ability or vision impairment, whilst others had difficulties expressing themselves. Detailed sensory and communication care plans were in place for these residents, which clearly described the residents' communication needs and communication barriers, and provided detailed information for staff in how to effectively communicate with the resident. In addition, inspectors observed staff engaging with residents on the day of inspection and found that where residents had communication difficulties, staff were communicating with the resident in a manner aligned to the residents care plan.

Residents' had access to a range of meaningful activities whilst living in the centre. There was a weekly activities schedule maintained and this was displayed on numerous noticeboards throughout the centre, with additional printed copies distributed to residents. All residents who spoke with inspectors were aware of the activities programme, whether they actively participated in group activities or not. There was also a "Belmont Radio Show" which aired every Wednesday. Residents were invited to submit song requests and messages which would be read out live on air.

Resident forum meetings were held regularly in the centre. However, despite these meetings, inspectors found that residents had not been kept up-to-date with ongoing works to the kitchen in the centre. A letter had been issued to residents and families in January 2026 regarding the works, informing them that a further update would be provided the following week. However, inspectors found that no further communication had been issued, and the next planned update was scheduled to be delivered to residents on 25 March 2026. Residents who spoke to inspectors during the lunch time meal, told the inspectors that they were not aware of the current levels of progress with these works, and spoke of how it was a cause of disruption for them at meal times, particularly the high levels of noise and the storage of large boxes of delph and cutlery in the main dining room.

While the feedback received by residents in the annual report, identified there were issues with the laundry and residents' clothes missing, these issues had been resolved on the day of the inspection. Residents who spoke to inspectors said there was no issue with clothes going missing. There was a labelling process in the laundry and a new system to ensure that any items that did not have a label were labelled and returned to the correct resident.

Regulation 10: Communication difficulties

Person-centred communication care plans were in place for residents with specialist communication requirements. These care plans reflected the residents' current

communication needs and staff were knowledgeable in how to communicate effectively with those residents.

Judgment: Compliant

Regulation 12: Personal possessions

Residents had adequate storage for their belongings and retained control over their clothes and personal items. There was a robust process in place to ensure that residents' clothes were labelled, laundered and returned to them.

Judgment: Compliant

Regulation 13: End of life

End of life and spirituality care plans were in place for residents. These care plans were found to be person-centred and contained detailed information about the residents' end of life wishes.

Judgment: Compliant

Regulation 27: Infection control

Following up on the compliance plan from July 2025, the provider had progressed all actions required to comply with the regulations. For example:

- The inspectors observed that staff were completing good hygiene practices after care provision.
- In relation to the handling of used linen, it was observed that linen skips were brought to resident's rooms as required.

Despite these positive practices observed, the inspectors observed the disposal of dirty water from a floor buffer into a communal toilet used by residents. Inspectors were told that this was a standard practice, however this is not in line with guidelines and does not ensure effective prevention from transmission of infections.

Judgment: Compliant

Regulation 28: Fire precautions

Following up on the compliance plan from July 2025, the provider had completed the majority of actions they had committed to. However, the registered provider did not make adequate arrangements for detecting and containing fires. For example:

- The door to a hoist room on the fourth floor where a hoist was charging could not close and did not have a fire door in place. This posed a risk to the potential spread of fire and smoke.
- There were a number of fire doors that were damaged and gaps observed. This created a potential pathway for the spread of fire and smoke to the escape route.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Residents' health and social care needs were assessed on admission to the centre. Person-centred care plans were developed in line with residents' comprehensive assessments and were available within 48 hours of admission. There was evidence that care plans were reviewed no later than at four monthly intervals, or more frequently where required in response to changes in needs. Residents and their families, where appropriate, were involved in the care planning process.

Judgment: Compliant

Regulation 9: Residents' rights

Residents had opportunities to participate in activities in accordance with their interests and capacities. Residents had access to TV, newspapers and radio and were supported to access independent advocacy services. Residents' forum meetings were taking place in the centre, however, despite these meetings, inspectors found that communication with residents regarding ongoing works to the kitchen were not sufficient and residents had not been kept up to date with the progress of these works. In addition, inspectors also found that the reconfiguration of the layout of the dining room to facilitate these works was having a negative impact on the residents' meal time experience as equipment and supplies, including boxes of delph, were being stored in the dining room which was encroaching on the space for use by residents.

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	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 27: Infection control	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Belmont House Private Nursing Home OSV-0000014

Inspection ID: MON-0047583

Date of inspection: 10/03/2026

Introduction and instruction

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

This document is divided into two sections:

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

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

A finding of:

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>Following review of rosters, from 13th April 2026, the daily management roster ensures that there are four supernumerary managers on duty each day (Monday to Friday), typically in one of the following combinations:</p> <ul style="list-style-type: none"> • 1 Director of Nursing (DON), 1 Assistant Director of Nursing (ADON) and 2 CNMs, or • 1 DON, 2 ADONs and 1 CNM. <p>At the weekends, 2 supernumerary managers are rostered each day, namely a ADON and a CNM.</p> <p>This structure provides consistent oversight, clear lines of accountability, and ensures that managerial duties are carried out as intended.</p> <p>In the event of an unplanned nurse absence, such as a short notice sick call, a risk assessment is completed. Attempts are made to secure cover through internal staff first, followed by external agency support where required. This process ensures that any temporary change in CNM allocation is risk managed, documented, and justified, and that the centre continues to operate safely and in accordance with its Statement of Purpose.</p>	
Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p>	

Following review of rosters, from 13th April 2026, the daily management roster ensures that there are four supernumerary managers on duty each day (Monday to Friday), typically in one of the following combinations:

- 1 Director of Nursing (DON), 1 Assistant Director of Nursing (ADON) and 2 CNMs, or
- 1 DON, 2 ADONs and 1 CNM.

At the weekends, we roster 2 supernumerary managers each day, namely a ADON and a CNM.

This structure provides consistent oversight, clear lines of accountability, and ensures that managerial and resident duties are carried out as intended.

Daily mattress checks are now completed by the nursing team, and a scheduled audit process has been implemented by the clinical management team to ensure accuracy and consistency in mattress settings- complete

Enhanced training has been delivered to the hospitality team to reinforce high standards of infection prevention and control within the home. Daily oversight is now provided by the clinical management team to ensure sustained compliance- complete

A copy of the Health Act and the regulations were available to all staff in the reception area of the home, however a copy is now available per floor- complete

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

Following review of rosters, from 13th April 2026, the daily management roster ensures that there are four supernumerary managers on duty each day (Monday to Friday), typically in one of the following combinations:

- 1 Director of Nursing (DON), 1 Assistant Director of Nursing (ADON) and 2 CNMs, or
- 1 DON, 2 ADONs and 1 CNM.

At the weekends, we roster 2 supernumerary managers each day, namely a ADON and a CNM.

This structure provides consistent oversight, clear lines of accountability, and ensures that managerial duties are carried out as intended.

The PIC is reviewing all audit findings to ensure that robust, measurable actions are implemented and fully closed out. This review will be completed by 31st May 2026.

Audits and follow-up actions will also be reviewed and discussed during monthly clinical governance meetings- complete and ongoing

The clinical management team has also completed audit training to strengthen the quality and consistency of our internal monitoring processes- complete

Painting in the home will be completed by the 31st July 2026.

A tool was introduced to the home in January to capture maintenance issues in the home, this is being reviewed by the PIC daily and further discussed and actioned at monthly governance meetings- complete and ongoing
 From 1st April 2026, the PIC will continue to monitor occupancy and resident dependency levels to ensure staffing remains responsive and proportionate and will respond to staff complaints in a timely and efficient manner.

Regulation 24: Contract for the provision of services	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:

All contracts have now been reviewed and required information has been confirmed to be in place- complete

From 27th April 2026, a system is in place to ensure that all contracts are maintained up to date with the required information.

Regulation 28: Fire precautions	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 28: Fire precautions:

The door to the hoist room has now been fixed to ensure it can be closed securely- complete

A full fire door audit has been completed and remedial works will be completed by the 30th June 2026.

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

The dining room has been reconfigured to ensure that the space is dedicated solely to dining and to support a positive mealtime experience. All storage items previously held in this room have been removed, and the environment is now fully aligned with best practice for mealtime dignity and comfort- complete

Communication with residents and families has been enhanced to promote consistent, transparent, and supportive engagement. The use of our communication app has been strengthened following a dedicated information session with families, during which guidance and training was provided to ensure all parties can use the platform effectively-complete.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Not Compliant	Orange	01/05/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	01/05/2026
Regulation 16(2)(a)	The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.	Not Compliant	Orange	01/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to	Not Compliant	Orange	01/05/2026

	ensure the effective delivery of care in accordance with the statement of purpose.			
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	Yellow	31/07/2026
Regulation 23(2)	The registered provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.	Substantially Compliant	Yellow	01/05/2026
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that	Substantially Compliant	Yellow	01/05/2026

	resident shall reside in that centre.			
Regulation 28(1)(a)	The registered provider shall take adequate precautions against the risk of fire, and shall provide suitable fire fighting equipment, suitable building services, and suitable bedding and furnishings.	Substantially Compliant	Yellow	30/06/2026
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.	Substantially Compliant	Yellow	01/05/2026