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:	Beaumont Residential Care
Name of provider:	Beaumont Residential Care Limited
Address of centre:	Woodvale Road, Beaumont, Cork
Type of inspection:	Unannounced
Date of inspection:	30 June 2025
Centre ID:	OSV-0000198
Fieldwork ID:	MON-0038360

About the designated centre

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

Beaumont Residential Care is a designated centre located within the suburban setting of Beaumont, Cork city. It is registered to accommodate a maximum of 73 residents. It is a two-storey facility with two lifts and five stairs to enable access to the upstairs accommodation. It is set out in three wings: the smaller East Wing is a dementia-specific unit with 10 bedrooms; the ground floor has 19 bedrooms; and the upstairs has 44 bedrooms. Bedroom accommodation comprises single rooms with en-suite facilities of shower, toilet and hand-wash basin. Communal areas in the East Wing comprise a comfortable sitting room, adjacent dining room, sensory room and window seating with views of the lovely enclosed garden. The main day room and dining room are located downstairs along with the reading room, TV room, visitors' room and hairdressing salon. Upstairs there is a lounge, smoking room, kitchenette and seating areas along corridors for residents to rest. Residents have access to two well-maintained enclosed courtyards with walkways, garden furniture and shrubbery. There are mature gardens around the building which can be viewed and enjoyed form many aspects of the centre. Beaumont Residential Care provides 24-hour nursing care to both male and female residents whose dependency range from low to maximum care needs. Long-term care, convalescence care, respite and palliative care is provided.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	72

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
Monday 30 June 2025	09:00hrs to 17:30hrs	Breeda Desmond	Lead
Tuesday 1 July 2025	09:00hrs to 16:00hrs	Breeda Desmond	Lead

What residents told us and what inspectors observed

Overall, the inspector found that, in general, the person in charge and staff supported residents to have a good quality of life. The inspector met with many residents during the inspection, and spoke with two visitors. The inspector spoke with 10 residents in more detail to gain insight into their experience of living there. From what residents said and from what the inspector observed, staff were kind and knew the individual needs of residents. Residents gave positive feedback about the centre and were complimentary about the staff and the care provided and reported that they had choice in their care.

On arrival for this unannounced inspection, the inspector signed in as part of the safety precautions, and completed hand hygiene. Hand sanitising foam, disposable face mask dispenser and hand-wash hub were available at reception. Orientation signage was displayed throughout the building to guide residents to communal areas and bedrooms for example, to allay confusion and disorientation.

An opening meeting was held with the person in charge. There were 72 residents residing in Beaumont Residential Care at the time of inspection. The centre is a large two-storey building with resident accommodation on both floors. The dementia-friendly unit accommodates 10 residents and is located on the ground floor. The premises is homely, warm and comfortable. All areas are easily accessible with two lifts and five stairways.

The main entrance is wheelchair accessible and leads to the main reception area. There was a large notice board with information for residents and relatives including advocacy information, CCTV advisory signage, and the activities programme. Other information displayed included the statement of purpose and residents' guide.

By reception, there was a lovely seating area where residents were seen to enjoy sitting there and watch the comings and goings to the centre, and staff stopped to chat with residents resting there. There were many seating areas along corridors including low deep window sills with cushions for residents to rest while viewing the gardens outside. Gardens are accessible from many points throughout the centre and doors were unlocked enabling independent access to the outdoor spaces. Residents and visitors were seen enjoying the outdoors throughout the day. Garden furniture was painted and the walls surrounding the dementia-friendly unit had murals of Cork city landmarks.

There are several communal rooms available for residents to relax and enjoy on the ground floor with the visitors room, library sitting room, large TV room and main day room; all located in close proximity to the main reception; toilet facilities were available close to these rooms for residents' convenience. There is a smaller sitting room upstairs and residents were seen to relax here throughout the day.

Staff were seen to knock on residents' doors and greet residents in a friendly manner and offered and provided assistance respectfully while at the same time engage in conversation. Staff brought residents to the communal areas and were seen to actively engage with them. Some residents preferred the TV room, others the day room and a few residents relaxed and read the newspaper in the library and chatting with their friends.

The main dining room was to the left of reception. There was art displayed at one end of the dining room which residents had created and looked lovely, colourful and bright. Meal times were observed both upstairs, and downstairs in the dining room. In the morning, one table was set in the main dining room for breakfast and some residents came there following personal care to have their breakfast. The large notice board in the dining room had the menu choice of the meal being served with large pictures and a description of the food being served.

At dinner time, tables were set prior to residents coming for their meals with table cloths, cutlery, napkins and condiments. The dining room was full at lunch and tea time and staff actively engaged with residents during mealtime. At dinner time, residents were offered choice with each course and each course was served separately. Residents gave very positive feedback regarding the quality of food served and menu choice, and said that they looked forward to their meals. One resident said that the soup was salty and so she preferred not to have any starter even though other choices were available. The person in charge followed this up with the inspector at lunch time and validated the resident's feedback. Staff providing assistance with meals did so appropriately. The mid-morning and mid-afternoon snack trolley had different choice of snacks for residents and staff facilitating the trolley round did so in a relaxed social manner actively engaging with residents as they offered choice and assistance.

The activities staff provided a variety of group and 1:1 activities in the day rooms and in residents' bedrooms in accordance with their preferences. There was music, sing-songs, games, skittles, poetry and newspaper reading. Some residents preferred to relax in the TV room with their visitors and the inspector sat and chatted with them. The space available to residents in the TV room was reduced as the room was partially segregate to accommodate shelving to store the activities paraphernalia.

The inspector met residents and visitors in the enclosed garden, and as staff were passing, they stopped to chat and ask if people needed anything and offered beverages. Visitors were seen throughout the day visiting their relatives and friends. Visiting was facilitated in the library, quiet sitting room, residents' bedrooms, and garden, in accordance with their preferred wishes.

Residents bedrooms were seen to be decorated in accordance with their wishes and preferences. Many had lots of photographs, vases of flowers, salt lamps, ornaments and mementos on display shelves. Many of the bedrooms had deep window seats with long cushions to sit and relax and many residents added their own soft furnishing to the window seat and room, making them homely, comfortable, and bright. Call bells were available in bedrooms, bathrooms and communal rooms.

Surfaces of furnishings such as bedside lockers, bed frames, display shelving and window sills were seen to be worn.

The dementia specific unit is key-pad access to ensure the safety of residents. Tables were set in the dining room for residents to have their dinner with cutlery, condiments and napkins. This unit had colourful murals painted on corridors and some communal rooms. Corridors here were recently painted and some flooring replaced. When the inspector visited this unit, residents were in the day room with soft music playing and a member of staff caring for them. The sluice room for this unit was located just outside the unit and was key-pad access.

There were large mobile trolleys on each corridor with clean towels, face cloths, bed linen and incontinence wear for morning care. Laundry bins facilitated clothes to be segregated at source with three different colour-coded containers. Mobile bins were available so that rubbish could be easily disposed of following delivery of morning care; and easily moved when staff were working their way along corridors.

Staff had access to clinical handwash hubs on corridors on both floors. There were hand sanitising dispensers in residents' bedrooms as well as on corridors with advisory signage demonstrating appropriate usage; some of these dispensers were broken and were replaced during the inspection.

The hairdressers' room was located on the ground floor and had been refurbished following the findings of the last inspection. There were beautiful paintings on walls, a colour coordinated flower garland surrounding the large mirror and a five feet tall Cinderella slipper with stiletto heel, and glass shelving that displayed the nail bar equipment. Residents said they loved the 'transformation' of the room. The hairdresser attended the centre on Wednesdays; staff brought residents here on other days as well to up-style their hair as part of personal care delivery.

The main laundry was located near the kitchen where personal laundry and bed linen were laundered. Designated staff were responsible for laundry services. The smoking room upstairs had a fire blanket and emergency call bell, and fire apron; this was being relocated at the time of inspection to the enclosed garden.

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 impact the quality and safety of the service being delivered.

Capacity and capability

This was an unannounced inspection conducted by an inspector of social services to inform the application to renew registration of Beaumont Residential Care, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations, and to follow up on previous inspection findings. Two pieces of unsolicited information were received relating to

care and welfare of residents; these were followed up whereby a provider-led report was requested and assurances were provided. This included action plans to enable quality improvements such as unannounced night visits by the person in charge, a review of their staff induction programme which is much more comprehensive; and additional training provided on site for staff. These were verified on inspection.

Issues identified for action from the previous monitoring inspection were followed up and areas addressed included staff training and aspects of the following: premises upgrading, care documentation, mealtimes, infection control, complaints procedure, fire safety precautions, and medication management records. Areas for improvement identified on this inspection included the premises, infection control, complaints procedure, records to be maintained relating to medication management, fire safety precautions, and notifications to be submitted to the regulator.

Beaumont Residential Care is operated by Beaumont Residential Care Limited. It is part of the CareChoice group which has a number of designated centres throughout the country. The governance structure comprises the board of directors, and the CEO is the person nominated to represent the registered provider. The management team within the centre is supported by a national management team of quality, finance, facilities, and local human resources staff (HR).

The person in charge was supported by two assistant director of nursing (ADON) and a team of nurses, healthcare assistants, catering, administration, household and maintenance staff. Improvement was noted regarding staffing, including during twilight hours and night duty where an additional nurse was rostered for the dementia unit and a HCA rostered from 2pm - 10pm to enhance supervision and evening time activities.

The on-site management team were supported by the provider nominee who facilitated monthly meetings with the directors of nursing (DONs) for the 14 centres in the group. As well as providing collegial support, set agenda items were discussed to provide leadership and oversight of services, such as quality improvement with associated key performance indicators and audit results, staffing, education, and finances.

Schedule 5 policies were available to staff and updated according to regulatory requirements. The statement of purpose required updating to reflect the requirements of Schedule 1. The complaints procedure was displayed at reception, and an easy to read complaints procedure was exhibited at the time inspection to enable residents easier access to the procedure. A review of the complaints records, minutes of meetings and notifications showed that concerns were not followed up appropriately to ensure safeguarding of residents; this is further detailed under relevant regulations; the associated notifications were not submitted in accordance with regulatory requirements.

Registration Regulation 4: Application for registration or renewal of registration

The registered provider had applied to renew the registration of the centre for 73 beds. The appropriate fees were paid, the application form was submitted with the required information set out. Floor plans and statement of purpose were updated following the inspection to reflect the centre and service provided.

Judgment: Compliant

Regulation 14: Persons in charge

There was a person in charge and she worked full time in the centre. She was a registered nurse with the required managerial and nursing experience specified in the regulations.

Judgment: Compliant

Regulation 15: Staffing

A review of staff was undertaken following the findings of the last inspection and improvement was noted on this inspection with an additional nurse rostered in the dementia friendly unit over 24hrs; and a HCA from 14:00hrs to 22:00hrs to support supervision and activities in the day room in the main unit.

Judgment: Compliant

Regulation 16: Training and staff development

A review of staff training records demonstrated that mandatory and other training was provided for staff. There was training scheduled in July and August to ensure all staff training remained current, including restrictive practice training due for 13 staff. Other training provided on-site included outside agencies providing information on palliative and end of life, and acquired brain injury care requirements.

Judgment: Compliant

Regulation 21: Records

Action was required to ensure medication administration records were maintained in accordance with professional guidelines as follows:

- while staff signed electronic records immediately following administration of medications, hard copy records were not signed until after the medication rounds which is contrary to medication administration professional guidelines
- one resident was on a blood pressure tablet as required (PRN), however, there was no medication plan as part of the medication records; the maximum dose was not detailed and the parameters for administration did not form part of the prescription; blood pressure monitoring was not recorded as part of these notes (they were recorded separate to the medication records at the nurses' station), so the rationale for administering the additional blood pressure tablet could not be determined, which had the potential for medication errors,
- medications requiring crushing were not individually prescribed.

Judgment: Substantially compliant

Regulation 22: Insurance

A valid insurance certificate was in place in accordance with regulatory requirements.

Judgment: Compliant

Regulation 23: Governance and management

The management systems in place did not ensure that the service provided is safe, appropriate, consistent and effectively monitored, as:

- a review of complaints records and minutes of governance meetings showed that safeguarding concerns were not recognised as such, not followed up as safeguarding, and not notified to the Chief Inspector,
- the policy relating to safeguarding was not implemented into practice as records relating to a current investigation were incomplete, they did not include meetings with management HR or the person in charge as described by the regional manager, or accurately reflect the matter being investigated
- issues identified on inspection relating to infection prevention and control and residents' care records for example were not identified as part of the audit process to enable quality improvements.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose required updating to reflect the specified requirements as set out in Schedule, as follows:

- the organisational structure to reflect current management structure, and structure to commence with the registered provider
- requirements regarding residents access to the national screen programme required review
- frequency of residents' meetings to be included.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The incident and accident records, complaints and minutes of management meetings were examined and two safeguarding concerns were not recognised as such, consequently, they were not notified to the Chief Inspector in accordance with regulatory requirements.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was necessary to ensure complaints were recorded in accordance with specified regulatory requirements as follows:

- some records seen were incomplete and did not provide a comprehensive account of actions taken
- it was not indicated whether an acknowledgement of the complaint was issued to the complainant in accordance with regulatory requirements
- one complaint did not indicate whether staff were asked to verify the associated documentation, to be assured that records were an accurate reflection of events.

Judgment: Substantially compliant

Regulation 4: Written policies and procedures

Action was required to ensure Schedule 5 policies were implemented into practice, as:

- the policy relating to safeguarding was not implemented into practice as records relating to a current investigation were incomplete, they did not include meetings with management HR or the person in charge as described by the regional manager, or accurately reflect the matter being investigated.

Judgment: Substantially compliant

Quality and safety

In general, a human rights-based approach to care delivery was promoted by staff and management, and choices of residents were seen to be respected.

Observation on inspection showed that staff had good insight into responding to residents' needs, including communication needs and staff responded in a respectful manner. Care plan documentation included behavioural support plans and observational tools to help identify reasons for anxiety or distress, with suggestions to mitigate recurrence. The daily narrative demonstrated good monitoring of care needs as well as monitoring residents' responses to interventions including pain management. A sample of care planning documentation was examined and these showed mixed findings. While validated risk assessments were in place, these were not routinely completed comprehensively to inform care planning; this is further discussed under Regulation 5: Individual assessment and care plan. Residents had good access to health care, allied health professionals, and personal assistants to support them.

A comprehensive nurses' signature list as specified in an Bord Altranais medication guidelines, was available as part of the medication administration records. A record was maintained of residents with medication patches with the location of the patch and dosage, and this was recorded twice daily. The medication management system was partially electronic and partially written records depending on the general practitioner (GP). Staff spoken with were knowledgeable regarding both systems. However, paper-based medication administration records were not maintained in accordance with professional guidelines; this and other findings are further discussed under Regulation 21: Records.

Refurbishment of the premises was ongoing with rooms repainted and flooring replaced for example. Other improvements agreed to following the the previous inspection were delayed, nonetheless, assurance was provided that these works would commence in August 2025 with details of the project brief for the remedial works and commencement dates shown to the inspector.

Anti-microbial stewardship was introduced following the findings of the last inspection and relevant staff were monitoring antibiotic usage; there were no residents prescribed prophylactic antibiotics in the centre at the time of inspection. A register was maintained of residents with multi-drug resistant (MDROs) infections in line with best practice to enable appropriate precautions to be implemented. Hand hygiene training was provided to staff on site. Hand-wash hubs were available along corridors. Nonetheless, issues relating to infection prevention and control were identified and these are discussed under Regulation 27: Infection control.

A review of fire safety precautions was required regarding evacuating residents to be assured that residents could be evacuated in a safe and timely manner. This is further detailed under Regulation 28: Fire precautions.

Regulation 11: Visits

Visitors were seen to be welcomed into the centre and were known to staff and lovely social interaction was observed. Information pertaining to infection transmission precautions was displayed at the entrance to the centre. The inspector observed that visitors were familiar with these precautions and completed hand hygiene and signed-in as part of health and safety precautions on entry to the centre.

Judgment: Compliant

Regulation 12: Personal possessions

Residents' bedrooms had adequate space to maintain their clothes and personal possessions, including double wardrobes, bedside locker and lockable storage space. Some residents had an additional chest of drawers. Laundry was completed on site and no issues were highlighted with the laundry service provided, either in complaints reviewed or on inspection.

Judgment: Compliant

Regulation 13: End of life

Action was required to ensure residents would be cared for in accordance with their wishes and preferences as end of life assessment and care plans were not comprehensively completed in the sample reviewed. One assessment stated that their end of life care 'was not discussed yet', however, their care plan had some information on their wishes and care preferences should they become unwell. Some

resuscitation decisions were not included in the care records even though they were available as part of their medical notes.

Judgment: Substantially compliant

Regulation 17: Premises

Notwithstanding the planned project upgrades to the premises commencing August 2025, action was required to ensure the premises conformed to matters set out in Schedule 6 of the regulations as follows:

- some flooring was marked and stained
- some wall surfaces underneath the window seats in bedrooms were in a poor state
- upgrading and securing the outdoor garden space as agreed on the last inspection
- relocating the smoking room as part of fire safety precautions and quality of life of residents with bedrooms alongside the current location
- there were inadequate storage facilities to accommodate items such as activities equipment as part of the TV room was segregated, reducing the size of the TV room for residents.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

While improvement was noted in the dining experience for residents, further action was necessary:

- residents started coming to the dining room at 12MD, however, they were not served the first course of their meal until 12:40hrs which is a long time to wait to be served
- one resident reported that they did not have the soup as it was too salty; the inspector and person in charge verified this. Many residents were receiving treatment for blood pressure and others for renal dysfunction, however, a recipe for soup regarding the amount of bouillon to be added was not available to ensure appropriate preparation of soup regarding salt concentration. Staff outlined that milk was added to soup to reduce its saltiness.

Judgment: Substantially compliant

Regulation 27: Infection control

The following issues were identified regarding infection prevention and control, and required action:

- many of the protective surfaces of furniture and shelving in bedrooms were worn so effective cleaning could not be assured; these were not identified in the most recent environmental audit completed
- the hand wash sink in the sluice room near the dementia unit did not comply with current clinical hand wash sink mandated guidelines as the outlet was metal and directly underneath the water flow from the tap; this was not identified as part of the infection prevention and control audit completed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Action was necessary to ensure fire safety precautions as follows:

- aside from training, an evacuation of the largest compartment had not been undertaken; cognisant that the largest compartment comprised 10 residents, the registered provider could not assure themselves that residents could be safely evacuated as many of the evacuation drills comprised just one residents, and some involved two or three residents.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required to ensure residents' assessment and care planning documentation was maintained in accordance with regulatory requirements to enable individualised care, as follows:

- care plans for residents who were assessed as requiring restraint required review as there was lack of understanding of restrictive practices and bed-rail restraint; while the assessment indicated that the bed-rail was a restraint, it stated that it was not a restrictive practice, even though the resident was unable to remove the bed-rails independently
- documentation indicated that no alternatives to bed rails were trialled as part of promoting a restraint-free environment
- conflicting information was seen in assessments - while the resident's dependency assessment stated the resident was 'chair-fast' due to severe

limited mobility, their mobility assessment reported they were slightly limited in their mobility, so the reader was unsure the level of assistance the resident required and could lead to staff not using the correct aids when mobilising a resident
- residents' falls risk assessment did not include their past medical history, consequently their assessment was under-scored and deemed low risk, however, if their medical history was included in the assessment, they would have been assessed as high risk and appropriate safety precautions could be implemented to help reduce the risk of falls,
- the medication assessment and care plan did not detail anything specific regarding their 'as required' PRN prescription to inform individualised and safe care
- the resident's medical notes showed that a resident had minor surgery, which required dressings and antibiotic treatment, however, there was no record of dressings completed and the care plan was not updated to reflect any of this treatment.

Judgment: Not compliant

Regulation 6: Health care

Residents had good access to GP services and GPs attended the centre on a regular basis. Residents had access to allied health professionals such as speech and language, dietician, chiropody, specialist services and community palliative care.

Judgment: Compliant

Regulation 9: Residents' rights

Residents reported lots of activities and their ability to choose which they attended. Additional staff were rostered form 2pm - 10pm to support residents in day rooms to enjoy activities and provide comfort checks.

The summer party was scheduled a fortnight after the inspection and residents said they were looking forward to it and hoped the weather would be better than last year.

The centre’s newsletter was a relatively new publication that was issued on a monthly basis. It had lots of photos of the different occasions, activities and outing that occurred, for example, for the Bealtaine festival, they pressed an array of spring flowers; their ceramics art was displayed on the wall and was gorgeous; photos of ‘World Nurses Day’ and a nod to World Cocktail Day – 'Mocktails and Memories' with residents with large gin glasses, colourful straws and large punch bowls. Other

articles featured in the monthly news letter were the upcoming activities, the regular events and zodiac signs for the month along with a festive poem.
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	
Registration Regulation 4: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Substantially compliant
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Beaumont Residential Care OSV-0000198

Inspection ID: MON-0038360

Date of inspection: 01/07/2025

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: Beaumont Residential Care is committed to ensuring that Medication Administration Records (MARs) are completed and maintained in strict accordance with professional and regulatory guidelines. To provide assurance of compliance, the following measures are in place: • Policy and Procedure: Our medication management policy reflects current professional guidance and has been recirculated to all nursing staff as a reminder of correct medication administration protocols. • Scope of Practice: The NMBI Guidance for Registered Nurses and Midwives on Medication Administration has been recirculated to all nursing staff. This guidance is also discussed at nurses' meetings to reinforce adherence to professional standards. • Staff Training and Competency: All staff involved in medication administration received training and have successfully completed a competency assessment before undertaking this responsibility. Refresher training is scheduled annually and following any medication error. In addition, a staff education session was held immediately after the inspection to address the gaps identified. • Record-Keeping Standards: Documentation gaps identified during inspection were addressed directly with the relevant staff member. All staff have been reminded that each administration must be documented in real time to ensure accuracy and completeness of MARs. • Medication Requiring Crushing: A full review is underway to ensure that where medication is ordered to be administered in a crushed format, the prescription sheet explicitly reflects this order for each individual medicine. The rationale for crushing is documented in both the resident's medical notes and nursing care plan. • PRN Medication Review: All PRN medications are reviewed by the resident's GP, and prescriptions updated to include maximum dose and other relevant information. Clear protocols guide their use, and staff document both administration and effectiveness. Where PRN medication is administered, the required pre- and post-assessments are completed and recorded contemporaneously on the electronic system. • Care Plans and Medication Administration Guidelines: All medication care plans, and electronic Kardex medication guidelines are being reviewed to ensure inclusion of all	

relevant information, including PRN medications, indications, maximum doses, and nursing responsibilities. This promotes consistency and coordinated care delivery.
• Monitoring and Audit: The Clinical Management Team carries out daily checks to confirm that MARs are up to date. In addition, monthly audits are conducted, with any discrepancies investigated and corrective actions taken promptly.
• Accountability and Escalation: Any concerns regarding MAR completion are reported immediately. Corrective actions are implemented without delay, and learning is shared across the nursing team to prevent recurrence.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Beaumont Residential Care is committed to ensuring that robust management systems are in place so that the service remains safe, appropriate, consistent, and subject to continuous monitoring. The following measures are in place:

• A clear complaints policy and procedure are in place, accessible to all staff.
• All complaints are logged, investigated promptly, and outcomes recorded with actions taken.
• Complaints are reviewed weekly by the Clinical Management Team to identify patterns, with learning shared to prevent recurrence.
• Where a complaint requires notification to the Chief Inspector, this is submitted in a timely manner.
• The safeguarding incident referenced in the inspection report was fully investigated, and all relevant information relating to the investigation, meetings, and action plan has been updated.
• All staff receive mandatory safeguarding training, supported by competency checks to ensure awareness and confidence in recognising and reporting concerns.
• All safeguarding concerns are recorded and escalated in line with local policy.
• Investigations are conducted promptly, with outcomes documented and learning disseminated to staff. Oversight is provided by the DON, Regional Clinical Operations Directors, and the Governance Team.
• Safeguarding concerns are discussed regularly at governance meetings to ensure accountability and transparency.
• An IPC policy, aligned with national guidelines, is implemented and reviewed annually or as updates occur.
• Staff receive training in hand hygiene, PPE use, and outbreak management, with compliance monitored through spot checks by the Clinical Management Team.
• Environmental audits and cleaning schedules are maintained, with findings documented and acted upon.
• The audit process is under review to strengthen its effectiveness and ensure that any gaps in IPC policy implementation are promptly identified and addressed.

• A structured system of monthly audits is in place, with recurrent themes reported to senior management and discussed at the quarterly Quality & Safety Committee at group level.
• Findings are reviewed at governance meetings, where actions are agreed, tracked, and monitored for completion.
• Trends and themes from complaints, incidents, and audits are analysed to drive continuous improvement, with outcomes and learning shared with staff to strengthen practice.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The Statement of Purpose is being updated to reflect the current management structure, commencing with the Registered Provider as the accountable lead. This will ensure that lines of responsibility and governance are clear throughout the service. The SOP is scheduled to be reviewed at least annually, and sooner if there are any regulatory changes, organizational restructuring.

The revised SOP will also include:

• Amendments regarding access to national screening programmes, as suggested on the day of inspection. The procedures will outline how residents are supported to access routine national health screening, with clear responsibilities allocated to ensure monitoring and follow-up.
• Specification of the frequency of residents' meetings, to guarantee regular opportunities for resident voice, feedback, and engagement in service development.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Beaumont Residential Care assures that robust systems are in place to ensure all incident and accident records, complaints, and meeting minutes are routinely reviewed to identify and address any potential safeguarding concerns.

• The two safeguarding incidents referenced in the inspection report were subsequently notified to the Chief Inspector, and all follow-up actions have been completed.
• All incidents, accidents, complaints, and meeting records are regularly reviewed by the

management team to identify patterns, trends, or concerns that may indicate safeguarding issues.
• Where safeguarding concerns are identified, these are recorded, investigated, and escalated in line with local policy.
• Any safeguarding concerns meeting the threshold for statutory reporting are notified to the Chief Inspector without delay, in full compliance with regulatory requirements.
• A safeguarding log is maintained and reviewed at governance meetings to ensure transparency, accountability, and continuous learning.
• Staff receive mandatory safeguarding training, including guidance on recognising concerns that may arise through incidents, complaints, or resident feedback, and how these must be reported.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Beaumont Residential Care assures that all complaints are recorded and managed in full compliance with regulatory requirements. In response to the inspection findings regarding incomplete records and lack of comprehensive documentation, the following measures have been implemented:
• All complaints are logged in the complaints register and include a full account of the investigation process, findings, actions taken, and an accurate record of all related events.
• All complaints will be acknowledged in writing in line with policy, with a copy of the acknowledgement retained on file.
• Complainants will be informed of the outcome in writing in accordance with regulatory requirements, with this correspondence retained in the complaints record.
• The Clinical Management Team will review all complaints prior to closure to ensure completeness and accuracy. In addition, audits of complaint records are conducted to ensure compliance and to identify themes for learning.
• Oversight will be provided by the Regional Director of Clinical Operations and the Governance Team, who ensure that all complaints are appropriately recorded, investigated, and responded to in line with the Health Act 2007.
• Lessons learned from complaints are shared with staff through meetings and supervision sessions to promote continuous improvement in service delivery.

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
We recognise that written policies must be fully embedded into practice to ensure safe, consistent, and compliant service delivery. To provide assurance, the following measures are in place:
• All safeguarding incidents have been reviewed to ensure records are complete, accurate, and reflect investigation details, findings, and action plans.
• The safeguarding policy is disseminated to all staff and readily accessible at all times.
• Safeguarding training forms part of staff induction, with regular refresher training completed by all staff to maintain knowledge and awareness.
• The Clinical Management Team monitors adherence through supervision, direct observation of practice, and reflective discussion, addressing any gaps immediately.
• Implementation of the safeguarding policy is tested through audits, with findings reviewed and tracked at governance meetings to ensure accountability and continuous improvement.

Regulation 13: End of life	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: End of life:
• A full review of all end-of-life care plans and assessments has commenced to ensure they reflect residents' wishes and preferences.
• Each resident will have a comprehensive end-of-life assessment capturing their values, treatment preferences, and decisions regarding transfer to acute services if their condition deteriorates. These decisions are made in consultation with the resident (where possible), their representatives, and healthcare professionals, including their GP.
• Resuscitation decisions will be documented in both the medical records and the resident's care plan. End-of-life care plans and resuscitation decisions will be reviewed routinely every four months and whenever the resident's condition changes.
• Staff receive targeted training on care planning to ensure residents' end-of-life wishes and preferences are accurately recorded and respected.
• Monthly care plan and assessment audits are conducted by the Clinical Management Team to ensure end-of-life care plans are consistently documented, evaluated, and in line with policy requirements.

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• A full review of the environment has been completed. Areas with floor markings, stained floors, and scuffed walls have been identified. A program of repair, replacement,

and redecoration is underway to ensure all surfaces are safe, hygienic, and well-maintained.
• Plans to upgrade the outdoor garden have been approved, with works pending. The upgraded garden will provide a secure, spacious, and accessible area, offering a therapeutic and enjoyable experience for residents and their families.
• The smoking room has been relocated to a more appropriate area, reducing fire risk and improving the quality of life for residents in nearby bedrooms.
• Activities equipment previously stored in the TV room has been relocated to a designated area, creating more space and enhancing the communal environment for residents.
• The premises will continue to be reviewed through regular audits and quarterly governance checks. Any required repairs or improvements will be logged, actioned, and followed up within clear timescales to prevent deterioration.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:
• The dining room remains open 24 hours a day, allowing residents to attend according to their own preferences for meals, snacks, or social interaction. Staff support residents with mobility needs to access the dining room safely.
• A review of meal service times is underway to ensure residents are served promptly and do not experience unnecessary delays. Residents choosing to dine at their preferred time are accommodated, whether in the dining room, their own room, or other suitable communal areas. These preferences are clearly documented in each resident's care plan.
• Menus are reviewed by the Group Catering Manager and audited by a dietitian to ensure all dietary requirements are met. Gaps identified during the inspection, such as overly salty soup, were immediately addressed with the chef. All catering staff have received training in food handling, preparation, and dietary modifications.
• Catering staff are fully aware of residents on dietary restrictions and ensure that recipes and meals meet each individual's nutritional needs, following current dietary and nutritional guidance. Residents' nutritional requirements are assessed and regularly reviewed.
• Nutrition and hydration care plans are audited every four months and whenever changes in residents' needs are identified, ensuring meals provided align with assessed requirements. Resident feedback on meals and dining experiences is gathered through meetings and satisfaction surveys.
• Clinical Management Team members conduct regular spot checks of meal services to ensure dietary requirements are met and residents enjoy a pleasant dining experience.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:
• We have implemented robust actions to ensure compliance with IPC requirements, including protective surfaces, shelving, and clinical hand wash sinks.
• Environmental audits were conducted to identify areas where surfaces and shelving are worn. A program of repair and replacement is in progress to ensure effective cleaning and maintenance.
• The sink identified as non-compliant with mandated guidelines will be replaced with a model that meets required standards. This work is scheduled and will be signed off by management upon completion.
• IPC audits are conducted regularly, with outcomes reported at governance meetings. Any structural or equipment issues identified during audits are logged immediately, with clear timescales for resolution.
• Additional training will be provided for auditors completing IPC and environmental audits to ensure the process is robust and deficits are identified effectively.
• Staff are instructed to report any IPC or environment related concerns promptly to the Maintenance and Clinical Management Teams for timely follow up.
• The IPC Lead and management team review all environmental aspects of infection control monthly to ensure ongoing compliance with mandated guidelines.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• A post-inspection, review of fire precautions was conducted to confirm that robust systems are in place to ensure residents can be safely evacuated in the event of a fire, including full evacuation of the largest compartment.
• Fire drills, in addition to training, are carried out at scheduled intervals. These include full compartment evacuation simulations involving residents to evaluate response time and compliance with the fire evacuation strategy. Drills are documented, timed, and evaluated. Full compartment drills were completed on 4th July and 15th August 2025, with additional drills scheduled every month. A complete site evacuation is scheduled for September 15, 2025.
• All staff receive fire safety training during induction and through annual refresher courses. Training covers compartment evacuation, safe use of evacuation equipment, and role allocation during a fire incident.
• Lessons learned from fire drills are reviewed by management and fire safety officers. Actions are implemented immediately where improvements are required, and outcomes are shared with staff. Additional refresher training is provided where gaps are identified.
• Records of fire drills, staff attendance, timings, and any corrective actions are maintained and available for inspection to demonstrate ongoing compliance and readiness.

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:

• Restrictive Practices: All restrictive practice assessments and care plans will be reviewed to ensure they reflect all relevant information and comply with the Restrictive Practice Policy. The service aims to maintain a restraint-free environment, using only the least restrictive form of intervention when necessary. Staff will receive training emphasizing human rights, consent, and the principle of least restriction. Alternatives to restrictive practice will be considered, trailed, and documented before any intervention is implemented.

• Mobility and Dependency: All residents' mobility and dependency assessments will be reviewed to reflect current levels and ensure appropriate assistive devices are prescribed by the MDT. Changes in baseline mobility and dependency will be recorded in care plans and progress notes and discussed during daily handovers, so staff are fully informed of the assistance required.

• Falls Risk: Residents at risk of falls will be reassessed to ensure assessments include relevant medical history and accurate risk identification. Care plans will be updated to reflect falls risk, prevention measures, and intrinsic/extrinsic factors contributing to falls, ensuring safety precautions are implemented effectively.

• Medication Management: All review of all medication care plans will be conducted to ensure that it clearly reflects prescribed PRN and high-risk medicines. PRN medication documentation will detail circumstances for administration, trial of non-pharmacological interventions prior to administering PRN, frequency, maximum dose, and monitoring of effectiveness to ensure safe and appropriate use.

• Wound Care: Gaps identified in wound documentation have been reviewed, corrected and findings shared with relevant staff. All wounds will be documented on the electronic system to improve oversight and monitor condition progress. Care plans will reflect assessed wound care needs, updated promptly following any change, and reviewed at four-month intervals or as circumstances change. Appropriate referrals to MDT ie, TVN specialist, dietician is wound management whenever required and recommendations are followed up and recorded promptly.

• Governance and Oversight: Weekly and monthly KPI reviews of Medication Errors, Responsive Behaviours, Infections, Complaints and Wounds are completed by the Clinical Management Team to provide enhanced oversight and governance. Additionally, audits are conducted in line with the scheduled audit plan to identify any gaps in management, documentation, or follow-up. Any identified issues are addressed immediately, and lessons learned are shared with the team to drive continuous improvement in practice.

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 13(1)(a)	Where a resident is approaching the end of his or her life, the person in charge shall ensure that appropriate care and comfort, which addresses the physical, emotional, social, psychological and spiritual needs of the resident concerned are provided.	Substantially Compliant	Yellow	30/09/2025
Regulation 17(2)	The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6.	Substantially Compliant	Yellow	01/12/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with	Substantially Compliant	Yellow	15/08/2025

	adequate quantities of food and drink which are properly and safely prepared, cooked and served.			
Regulation 18(1)(c)(iii)	The person in charge shall ensure that each resident is provided with adequate quantities of food and drink which meet the dietary needs of a resident as prescribed by health care or dietetic staff, based on nutritional assessment in accordance with the individual care plan of the resident concerned.	Substantially Compliant	Yellow	15/08/2025
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	31/10/2025
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	Not Compliant	Orange	30/09/2025

	effectively monitored.			
Regulation 27(b)	The registered provider shall ensure guidance published by appropriate national authorities in relation to infection prevention and control and outbreak management is implemented in the designated centre, as required.	Substantially Compliant	Yellow	30/09/2025
Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	15/08/2025
Regulation 28(1)(e)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	15/08/2025
Regulation 28(2)(iv)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, of all persons in the	Substantially Compliant	Yellow	16/09/2025

	designated centre and safe placement of residents.			
Regulation 03(2)	The registered provider shall review and revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	15/09/2025
Regulation 31(1)	Where an incident set out in paragraphs 7 (1) (a) to (i) of Schedule 4 occurs, the person in charge shall give the Chief Inspector notice in writing of the incident within 2 working days of its occurrence.	Not Compliant	Orange	15/08/2025
Regulation 34(2)(g)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant when the complainant will receive a written response in accordance with paragraph (b) or (e), as appropriate, in the event that the timelines set out in those paragraphs cannot be complied with and the reason for any delay in complying with the applicable timeline.	Substantially Compliant	Yellow	15/08/2025

Regulation 34(6)(a)	The registered provider shall ensure that all complaints received, the outcomes of any investigations into complaints, any actions taken on 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.	Substantially Compliant	Yellow	15/08/2025
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	15/08/2025
Regulation 5(2)	The person in charge shall arrange a comprehensive assessment, by an appropriate health care professional of the health, personal and social care needs of a resident or a person who intends to be a resident immediately before or on the person's admission to a designated centre.	Not Compliant	Orange	31/10/2025

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	31/10/2025