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:	Ennis Road Care Facility
Name of provider:	Beech Lodge Care Facility Limited
Address of centre:	Ennis Road, Meelick, Ennis, Clare
Type of inspection:	Unannounced
Date of inspection:	12 May 2025
Centre ID:	OSV-0005768
Fieldwork ID:	MON-0047074

About the designated centre

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

Ennis Road Care Facility is a designated centre located on the outskirts of Limerick city on the old Ennis Road. It is registered to accommodate a maximum of 84 residents. It is a purpose-built single storey facility, where bedroom accommodation comprises 54 single and 15 twin rooms, all with en-suite facilities of shower, toilet and hand-wash basin. Additional toilet facilities are available throughout the centre. Communal areas comprise a spacious dining room, a large garden room (day room), activities room, smoking room, and oratory. Main reception is an expansive space with a grand piano, fire place, and lots of seating hubs; off the main reception is the hairdressers' salon and an area to be developed into a coffee dock. There are additional comfortable seating areas off the activities room. Residents have access to two enclosed gardens with walkways, seating and raised flower beds. Ennis Road Care Facility 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:	79

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 12 May 2025	09:30hrs to 18:15hrs	Sean Ryan	Lead
Monday 12 May 2025	09:30hrs to 18:15hrs	Una Fitzgerald	Support

What residents told us and what inspectors observed

Resident's living in Ennis Road Care Facility were complimentary of the staff who provided them with care and support in a caring and respectful manner. Residents reported satisfaction with most aspects of the service including the provision of health and social care. However, some residents expressed dissatisfaction regarding inconsistent wait times when they required assistance and support from staff. Residents identified that this issue mainly occurred during night-time hours, when multiple residents often required support with their care needs.

Inspectors were met by the person in charge on arrival at the centre. Following an introductory meeting, inspectors walked through the centre and spent time talking to residents and staff, and observing the quality of care provided to residents. An assistant director of nursing, operations manager and a director of the company attended the centre to support the inspection process.

Residents were observed to be comfortable in a variety of communal areas throughout the centre. Some residents were seen meeting with their visitors in the reception area, while others were enjoying refreshments and participating in activities within the communal day rooms. Residents were also observed walking independently through corridors.

Inspectors spoke with a number of residents who had lived in the centre for several years, as well as those who had been recently admitted to the centre. Overall, residents were positive about their lived experience in the centre. They described staff as supportive and kind and said they were encouraged to participate in social and recreational activities. While residents generally felt that there was adequate staff present most days, they stated that there was a lack of coordination among staff that sometimes led to long wait times for assistance, particularly during the night. Two residents discussed this issue in detail, highlighting the impact it had on their experience of care. One resident described waiting a prolonged period for assistance at night when their call bell was out of reach, and staff were attending to other residents elsewhere in the building so were unable to hear them calling. The resident attributed this to the size and layout of the building which resulted in staff not always being nearby at night when needed. Another resident expressed a preference for more flexibility around night-time routines and the availability of support when they needed to use the toilet.

Residents spoke positively about their bedroom accommodation and en-suite facilities. They described their rooms as comfortable and well-maintained, and said that they were encouraged to personalise their own bed spaces. Inspectors observed that bedrooms were personalised with soft furnishings, photographs, artwork and ornaments which contributed to a homely environment. Bedrooms had facilities for residents to charge their mobile phones and computers. Residents also

highlighted that en-suites were accessible and thoughtfully laid-out to meet their mobility needs, which supported their independence and comfort.

The physical environment was colourfully decorated, comfortably furnished, and provided adequate space for both communal and private use. The physical environment was generally clean with the exception of hand-sanatiser dispensers that were visibly unclean on inspection. Inspectors observed that there were parts of the premises that were not appropriately maintained. There were visible scuff marks on doors and walls, chipped paint throughout, and one timber floor in a communal area was notably worn and marked from furniture use. Additionally, not all ancillary areas of the premises were fully secure from residents access. A sluice room that contained chemicals was observed to be unlocked and access to a staff changing areas was not restricted, and the door to this space did not have a functioning lock.

Residents had access to enclosed garden spaces which were secured at the time of inspection. The management team had implemented a system to ensure that doors leading from the garden areas were kept locked to prevent residents from entering undesignated areas of the premises. To the front of the building, the external grounds were observed to be untidy, with weeds visible along footpaths. The centre is located adjacent to a busy dual carriageway. This area did not have secure perimeter fencing or barriers in place.

Inspectors observed a number of doors that were held open with pieces of furniture which prevented the doors from closing. This may compromise the function of the doors to contain the spread of smoke and fire in the event of a fire emergency.

Throughout the day, inspectors observed groups of residents engaged in a variety of activities that they appeared to enjoy. These included arts and crafts sessions, one-to-one conversations with staff, and discussions about small horticultural projects. The atmosphere during these activities was positive and relaxed, and residents appeared to be engaged with each other and the activity.

Inspectors observed visitors coming and going throughout the day, with the majority of residents meeting their visitors in the reception area. These interactions appeared relaxed and social, and there was a welcoming atmosphere in the centre.

The following sections of this report details the findings with regard to the capacity and capability of the provider and how this supports the quality and safety of the service being provided to residents.

Capacity and capability

This unannounced risk inspection was carried out by inspectors of social services to;

- monitor compliance with the Health Act 2007 (Care and welfare of residents in designated centre for older people) Regulation 2013 (as amended).

- review the quality improvement actions submitted by the provider in response to a Provider Assurance Report request issued by the Chief inspector, following the receipt of three monitoring notification relating to the unexplained absence of residents from the designated centre.

The findings of this inspection were that the provider had not taken all necessary action to identify and implement effective risk management systems to ensure the safety and welfare of residents. Inspectors found that there were aspects of the quality and safety of the care that were impacted by ineffective governance and oversight of the service, and ineffective systems of management. While the provider had taken some action to manage risks to residents safety and welfare, with particular regard to residents at risk of leaving the centre unnoticed and unaccompanied, the oversight of the management systems in place did not fully ensure the safe and monitored delivery of care to residents.

Beech Lodge Care Facility Limited is the registered provider of Ennis Road Care Facility. It is a company consisting of two directors, one of whom represents the registered provider. The management structure supporting the designated centre had been increased since the last inspection with the appointment of an operations manager, responsible for non-clinical aspects of the service. Within the centre, a person in charge was supported clinically and administratively by an assistant director of nursing and two clinical nurse managers.

The management systems in place did not ensure that the service provided was safe, consistent and effectively monitored. The centre's risk management policy detailed the systems that should be in place for the oversight, assessment, and monitoring of risk in the centre. This included maintaining a risk register to record all potential risks to residents' safety and welfare. Inspectors found that risks were not always managed in line with the risk management policy. For example, following two incidents involving residents in the centre, no assessment of risk was carried out for a period of three days. This meant that there were no controls or actions in place to manage the risk to residents safety and welfare or to reduce the likelihood of recurrence during that period of time. Furthermore, while the provider had identified that some residents required enhanced supervision due to the risk of leaving the centre unnoticed and unaccompanied, the actions required to manage the risk were not appropriately implemented. This impacted on the provider's ability to monitor, and manage risks to resident's safety and welfare.

The provider had established systems to record, investigate, and learn from incidents and accidents involving residents. Inspectors reviewed the record of incidents and found that a significant incident had not been fully reviewed or investigated. The incident record did not include sufficient detail to understand the factors that may have contributed to the incident occurring or identify potential contributing factors or risks such as unlocked doors to an ancillary area, potential deficits in staff knowledge, or the absence of safety location checks during the period of time in which the incident occurred. This significantly impacted on the registered provider’s ability to identify, learn, respond to, and manage risk in the centre, and maintain a safe and quality care environment for residents.

The provider operated a dual system of paper-based and electronic records management. Inspectors found that the systems of record management, and oversight of clinical records was not fully effective. Records were not always maintained as required by Schedule 2 and 3 of the regulations. This included records to be held for each member of staff, and records regarding the nursing care provided to a resident.

The centre had sufficient staffing resources to ensure effective delivery of care and support to residents. The team providing direct care to residents consisted of registered nurses, and a team of health care assistants. There were sufficient numbers of housekeeping, activities, catering and maintenance staff in place.

A review of staff training records found that all staff had up-to-date training in fire safety, safeguarding of vulnerable adults, and infection prevention and control. Additional training had been provided to staff with regard to supporting residents to manage their behaviours that challenge (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment).

While staff were facilitated to attend further training with regard to the missing persons procedure, inspectors found that the provider had not assessed the effectiveness of this training as some staff did not demonstrate an appropriate awareness of the procedure to commence in the event of a missing person. In addition, there was a lack of clarity regarding the required frequency of safety and location checks for residents with complex supervision needs, and some staff were not fully aware of which residents were at higher risk of leaving the centre unaccompanied.

Inspectors found that the arrangements in place to supervise and support staff were not effective. For example, supervision of nursing documentation was inadequate and did not ensure that accurate records of the care provided were maintained.

Regulation 15: Staffing

On the day of inspection, the staffing level and skill-mix were appropriate to meet the assessed needs of residents.

Judgment: Compliant

Regulation 16: Training and staff development

Staff supervision arrangements were not appropriate to protect and promote the care and welfare of all residents. This was evidenced by;

- poor oversight of the residents' clinical documentation to ensure the assessment and care planning were accurate and up-to-date to reflect the current care needs of the residents.
- poor supervision of staff to ensure that records of care provided to residents were maintained in line with the residents assessed needs and care plans.
- poor fire safety supervision as evidenced by fire doors wedged open.

Judgment: Not compliant

Regulation 21: Records

A review of the records in the centre found that the management of records was not in line with the regulatory requirements. For example;

- Records of specialist treatment and nursing care provided to residents were not appropriately maintained in line with the requirements of Schedule 3(4)(b). For example, records of repositioning charts for residents of high risk of impaired skin integrity and records of enhanced supervision of residents with complex supervision needs were not maintained in line with the residents care plan.
- A copy of correspondence from the designated centre relating to each resident was not maintained in line with the requirements of Schedule 3(6). For example, records of transfer letters that contained key clinical and care information communicated to receiving health care services were not available for review for two residents transferred to hospital.
- A staff personnel files did not contain all the necessary information required by Schedule 2 of the regulations. For example, a staff personnel file did not contain two written references, or evidence of the person's identity including their full name, address, date of birth and a recent photograph. The file did not contain a full employment history, together with a satisfactory history of any gaps in employment.

Judgment: Not compliant

Regulation 23: Governance and management

The registered provider had failed to ensure there were effective governance and management systems in place to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. This was evidenced by;

- Risk management systems were not effectively implemented to ensure timely identification and management of clinical and operational risks that had the potential to impact on residents safety and welfare. Risk assessments that

were carried out following incidents in the centre did not comprehensively evaluate potential risks which impacted on the timely development of appropriate risk management actions.

- The management systems in place to respond to incidents involving missing persons was not robust. While there was a policy and procedure in place, inspectors found that the procedure could not be effectively implemented. For example, while the procedure required staff to have access to closed circuit television (CCTV) footage in the event of a missing person, staff were unable to access the CCTV system. This was indicative of a lack of a clear and functional policy, procedure, and process to underpin a safe and effective management system.
- Ineffective systems to ensure key clinical information regarding residents' care needs were effectively communicated to staff. For example, all staff were not informed of incidents involving residents leaving the designated centre unaccompanied. Consequently, staff did not demonstrate the required knowledge of some residents individual support needs to effectively manage the risks to residents.
- Poor oversight of record management systems to ensure compliance with the regulations. For example, there was poor oversight of records pertaining to nursing documentation as detailed under Regulation 21, Records.

Judgment: Not compliant

Quality and safety

While the day-to-day interaction between residents and staff was kind and respectful throughout the inspection, inspectors found that there were aspects of the quality and safety of care provided to residents was compromised as a result of ineffective systems of governance and management described in the capacity and capability section of this report. Inspectors found that the assessment of residents' needs to ensure the delivery of safe, high-quality, person-centred care to residents and the transfer of residents from the centre were not in compliance with the regulations.

Inspectors reviewed a sample of assessments and care plans and found that, while each resident had a care plan in place, the care plan was not always informed by an assessment of the residents care needs. The care plans of residents assessed as being at risk of falling, and residents who required close supervision and monitoring were not updated in a timely manner following a change in the residents care needs. Consequently, care plans did not always reflect person-centred, evidence-based guidance on the current care requirements of the residents.

Residents were provided with unrestricted access to a general practitioner (GP) as required or requested. Where residents were identified as requiring additional health and social care professional expertise, there was a systems of referral in place.

Inspectors were not assured that the transfer of residents from the centre were carried out in line with the requirements of the regulations. Transfer records were not consistently maintained to demonstrate that the transfer process ensured information pertinent to the care of the resident was communicated to the receiving health care facility.

Residents told the inspectors that they felt at home in the centre and that their privacy and dignity was protected. Residents were free to exercise choice about how to spend their day and were encouraged to enjoy and participate in activities.

Regulation 25: Temporary absence or discharge of residents

The provider did not ensure that all relevant information about a resident was provided to the receiving hospital.

For example, records of transfer letters sent with two residents who were transferred to hospital were not maintained in the designated centre. This meant that there was no documented record of the information shared with the receiving hospital regarding the rational for the referral, the residents health care needs, or the current health status of the residents at the time of transfer.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A review of residents' assessments and care plans found that they were not compliant with the regulatory requirements. For example;

- Care plans were not informed by a comprehensive assessment of the residents care needs. For example, a residents' care plan did not accurately reflect the needs of the resident and did not identify interventions in place to protect residents when identified as being at a high risk of falls following a fall incident. Consequently, staff did not have accurate information to guide the care to be provided to the residents.
- Care plans were not reviewed or updated in a timely manner following changes to a resident's care needs. For example, a care plan to support a resident's increased monitoring and supervision needs was not developed until three days following an incident. Consequently, staff did not have the required information to support the resident's assessed needs.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to medical assessments and treatment by their General Practitioners (GP), as required or requested.

Residents also had access to a range of allied health care professionals such as physiotherapist, dietitian, speech and language therapy, tissue viability nurse, psychiatry of old age, and palliative care.

Judgment: Compliant

Regulation 9: Residents' rights

There were facilities for residents to participate in a variety of activities such as art and crafts, live music events, gardening, and exercise classes. Residents complimented the improved provision of activities in the centre and the social aspect of the activities on offer.

Residents attended regular meetings and contributed to the organisation of the service. Residents confirmed that their feedback was used to improve the quality of the service they received.

Residents were provided with information about services available to support them. This included independent advocacy services.

A variety of daily national and local newspapers were available to residents. Religious services were facilitated regularly.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

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

Compliance Plan for Ennis Road Care Facility OSV-0005768

Inspection ID: MON-0047074

Date of inspection: 12/05/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Strengthening of Governance and Oversight • A Chief Operations Officer (COO) has been appointed and will commence daily in house oversight from 04/08/2025. • The COO will provide structured governance of both clinical and operational aspects of the facility through weekly reviews of relevant data and key metrics. • The management team consists of a PIC, ADON, 2 CNM's and an SSN. 2. Care Plan Audits and Quality Improvements • Care Plan Audit Frequency: Increased from quarterly to monthly as of May 2025. • A clear audit action plan and follow-up timeline have been implemented to ensure measurable improvements. • Audit Focus Areas: o May 2025 Audit: Focused on residents at risk of falls and those with wound care plans. o June 2025 Audit: Continued focus on falls risk and wound care, building on previous findings and improvements. Leading to 1:1 weekly training session with individual nurses on their care plans. 3. Nurse Training and Clinical Practice Development • 14/05/2025: Training delivered to nurses on immediate assessment and timely updates to care plans following any change in resident condition – marked as complete and ongoing. • 19/06/2025: Care plan training delivered at the nurses, reinforcing documentation and quality care standards. • 26/06/2025 onwards: Weekly in-person training sessions with nurses commenced, with: o Individual action plans per nurse. o Follow-up dates set for care plan-related actions. • All training sessions have been recorded in the Training Matrix. • Newly employed nurses now receive 1:1 care plan training from Clinical Nurse Managers (CNMs) as part of their induction.	

4. Daily Management Supervision and Quality Checks
• From 07:00 daily, increased management supervision is in place to:
o Monitor resident repositioning schedules.
o Ensure night duties are completed to a high standard.
o Conduct documented spot checks on residents under increased supervision protocols.
o Unannounced monthly management audits will take place one night in a month from July 2025.
5. Fire Safety Enhancements
• Fire door activation devices have been sourced and installed on designated fire doors requiring regular daytime access, ensuring both safety compliance and operational functionality.
• Regular supervision is taking place of any resident that is at risk of leaving the home unsupervised.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. Enhanced Nursing Oversight for Pressure Area Care
• As of 13/05/2025, new nursing oversight templates were implemented specifically for pressure area care.
• These templates support the management team in ensuring that residents with enhanced supervision needs and complex care requirements are being supported in line with their individualised care plans.
• Templates are reviewed daily by management for consistency, quality, and adherence to care plans.
2. Regulation 25 Compliance
• See Regulation 25 Action Plan for detailed steps taken to ensure compliance, including staff training, documentation standards, and transfer protocols.
3. HR File Management and Oversight
• All staff files will be audited by management to ensure compliance with relevant regulations.
• Each new staff file will be reviewed and signed off by the Person in charge or their deputy.
• The staff file observed during the inspection has now been completed and contains all the necessary documentation.

Regulation 23: Governance and management	Not Compliant

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

1. Strengthened Governance and Oversight

• A new Governance and Oversight Weekly Template has been implemented in collaboration with the Provider as of 02/07/2025.

• This template provides structured oversight with a particular focus on risk management across all key operational and clinical areas of the facility.

2. Risk Management Processes

• A full audit of all resident-related risks will be conducted by the Person in Charge/Assistant Director of Nursing in collaboration with the Health and Safety Officer and Clinical Nurse Managers. This will involve a review of individual risk assessments, incident logs, care plans, and environmental walkabouts.

• The centre's Risk Register will be fully updated to reflect all identified risks. Each risk is now categorised with clear risk ratings and control measures. Risks are reviewed weekly at the clinical governance meeting

• All residents' individual risk assessments are being reviewed and updated to reflect current needs, these are now reviewed 4 monthly or sooner if needs change.

• All Nursing Staff will receive refresher training on risk identification, documentation, and escalation procedures. A mandatory training module on risk management has been added to the induction and annual training schedule.

• A short daily safety meeting is now held at each shift handover to identify and address emerging risks.

• The centre's Risk Management Policy will be reviewed and updated to reflect best practices. This includes a clear escalation pathway and roles/responsibilities.

• The Person in Charge will ensure monthly audits on risk assessments and report outcomes to senior management. Any gaps identified will result in immediate action and re-training where needed.

3. Staff Training – CCTV System

• In-person training on the use and operation of the facility's CCTV system was provided to all nursing staff on 14/05/2025 and 15/05/2025.

• A formal CCTV usage protocol was developed and shared with all nursing staff at the nurses' meeting on 19/05/2025 to ensure appropriate and consistent use in line with privacy and safety policies.

4. Communication of Resident Care Needs

• All changes in resident care needs are communicated to staff through:

o Daily handovers each morning and evening.

o Updates to the daily handover sheet provided to incoming staff.

o The Handover sheets are dated. A soft copy is retained and reviewed during the auditing process to ensure that all staff are fully informed of the care needs of the resident.

o 1:1 handover with the Senior Healthcare Assistant for each HCA.

• All learning from incidents is shared with staff as they occur at the safety pauses and at the monthly staff team meetings, supporting continuous improvement and reflective practice.

Regulation 25: Temporary absence or discharge of residents	Not Compliant

Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:
13/05/2025 – Implementation of New Transfer Documentation Process
• A revised process for handling National Transfer Forms was communicated to all nursing staff.
• All transfer documentation is now required to be scanned and emailed to the designated management email address.
• A soft copy is saved for every patient transfer to the electronic recording system, providing consistent management oversight.
15/05/2025 – Policy Update: Transfer, Discharge, and Overnight Leave
• The Transfer, Discharge, and Overnight Leave Policy was reviewed and updated.
• The updated policy was disseminated to all relevant staff members to ensure compliance and awareness.
19/05/2025 – Nurse Training: Regulation 25 and Documentation Requirements
• A dedicated training session was conducted for all nursing staff.
• The session focused on Regulation 25, emphasizing the importance of uploading the National Transfer Form to our electronic recording system prior to resident transfer.

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:
1. The nursing home will ensure all resident care plans are informed by a comprehensive assessment. 2. An audit of all care plans is being conducted to identify and correct any inaccuracies or outdated information. 3. Care plans for residents involved in recent incidents is prioritised for urgent review and updating.
4. Weekly audits of a sample of care plans will monitor ongoing compliance with Regulation 5.
5. Shift leaders will use checklists to verify post-incident care plan updates are completed. 6. Weekly multidisciplinary meetings will review incidents and ensure care plans reflect appropriate interventions. 7. Progress will be tracked through weekly compliance reports submitted to senior management. The plan's effectiveness will be reviewed monthly and adjusted based on audit results and regulatory guidance.
Training and Staff Development
• A targeted training session was delivered on 19/05/2025 to all nursing staff, focusing on:
o Immediate assessment following any change in a resident's condition.

o The requirement to promptly update care plans in response to these changes.
o This training is marked as complete and ongoing.
• 19/06/2025: Care plan training was conducted for all nurses, reinforcing documentation standards and care quality expectations.
• Going forward, all new nursing staff will receive 1:1 training on care planning as part of induction, delivered by the Clinical Nurse Managers (CNMs).
• All training sessions have been recorded in nurse meeting notes and sign sheets.
Governance and Monitoring
• Care plan review has been integrated into the weekly Clinical Governance Meetings and weekly KPI review process, ensuring continuous oversight and improvement.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	04/08/2025
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.	Not Compliant	Orange	31/08/2025
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 effectively monitored.	Not Compliant	Orange	31/07/2025
Regulation 25(1)	When a resident is temporarily absent from a designated centre for	Not Compliant	Orange	19/05/2025

	treatment at another designated centre, hospital or elsewhere, the person in charge of the designated centre from which the resident is temporarily absent shall ensure that all relevant information about the resident is provided to the receiving designated centre, hospital or place.			
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	31/07/2025
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.	Substantially Compliant	Yellow	31/07/2025