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:	Firstcare Beneavin House
Name of provider:	Firstcare Beneavin House Limited
Address of centre:	Beneavin House, Beneavin Road, Glasnevin, Dublin 11
Type of inspection:	Unannounced
Date of inspection:	11 September 2025
Centre ID:	OSV-0000694
Fieldwork ID:	MON-0048233

About the designated centre

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

The designated centre is located in north County Dublin and is close to local shops and amenities. There is a car park situated at the front of the building and disabled parking is available. Beneavin House is a purpose built nursing home that provides accommodation for 150 residents over the age of 18 years. The nursing home offers 24 hour care to dependent residents with low, medium, high and maximum dependencies including people living with dementia. Accommodation is provided across four floors which are arranged around a central courtyard garden. Oakfield unit is situated on the ground floor and has 31 single bedrooms and four twin bedrooms. Willowbrook is situated on the first floor and has 35 single bedrooms and five twin rooms. Claremont is situated on the second floor and has 41 single rooms and one twin room. Claremont is divided into two units Claremont and Claremont Walk. Claremont Walk provides accommodation for 11 residents living with dementia and is designed specifically to meet their needs. Most of the bedrooms on Oakfield, Willowbrook and Claremont units have en-suite facilities. Cedars Unit is on the fourth floor and has 19 single and two twin bedrooms. All bedrooms on Cedars are en-suite. Each floor has additional communal bathrooms and wheelchair accessible toilets. There are communal lounges and dining rooms on each floor and Claremont has an additional lounge. There is also a hairdressing salon, an oratory and a family room with overnight facilities which can be organised through the Home manager. Activity rooms and a smoking room for residents are also available.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	116

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
Thursday 11 September 2025	06:55hrs to 16:20hrs	Sinead Lynch	Lead
Thursday 11 September 2025	06:55hrs to 16:20hrs	Manuela Cristea	Support
Thursday 11 September 2025	06:55hrs to 16:20hrs	Geraldine Flannery	Support
Thursday 11 September 2025	06:55hrs to 16:20hrs	Maureen Kennedy	Support

What residents told us and what inspectors observed

This was an unannounced inspection that commenced in the early hours to afford the inspectors the opportunity to talk with day and night-time staff and observe the residents and environment at different times. Each inspector was based on one floor for the duration of the inspection and observed staff practices and residents in their daily routines. Inspectors met with many residents during the inspection, and spoke with 17 residents and six visitors in more detail to gain insight into their experience of living in Firstcare Beneavin House. Inspectors found that in general, staff were working towards improving the quality of life and promote the rights and choices of residents in the centre.

The feedback from residents living in the centre was very positive. The residents spoken with told the inspectors that 'it was a lovely place to live' and that 'the staff are kind and work very hard'.

Relatives informed inspectors that overall, they were satisfied with the standard of care their relatives received, and they had observed a definite 'step-up in care' in recent months.

Staff reported the positive effects that enhanced staffing levels had on the residents, staff and the overall atmosphere in the centre. This was evident to the inspectors on the day, as pleasant, respectful interactions and a relaxed atmosphere was observed.

The premises were warm and welcoming. The corridors were clutter-free, and fire exits were kept clear. Call-bells were answered without delay. Communal areas were seen to be well-used by residents throughout the day. Resident bedrooms were found to be clean and organised, and many were decorated in a manner that reflected the residents' preference, including photographs, soft furnishings and ornaments.

The centre was calm at 07:00 in the morning. The majority of the residents were in bed asleep. A small number of residents had already started their morning routine and were observed sitting in the dining room. Residents informed the inspectors that they enjoyed attending the dining room for the breakfast club, which started at 08:30; this was a new initiative since the last inspection. When inspectors asked if they would like a cup of tea, the residents admitted that they would but did not think it was an option. Other residents said that they enjoyed having their breakfast in bed, as that was their choice. Inspectors noted a range of hot and cold nutritious snacks available in the pantries at all times for residents on each floor.

Inspectors also attended the handover process (the exchange of relevant information about residents between the night-time and day-time staff to ensure continuity of care). In one unit, the inspectors observed that staff were dispersed in a very large room far away from the nurse giving the handover, which meant that

they could miss relevant information in relation to the provision of care. This did not provide the opportunity for all staff to fully engage in this information sharing process. Furthermore, residents who woke up early and were also sitting in the dining room could hear important private details shared about their fellow residents, which was not appropriate. This and other opportunities for improvement in respect of the handover process were discussed with the provider at the end of the inspection.

The mealtime experience had greatly improved since the last inspection. Residents spoke positively about the meals and many voiced compliments about the recent addition of themed parties, including a pyjama party. In the morning, the inspectors observed that tables were nicely set with flowers and colourful serviettes and condiments were provided on the tables. It looked like a special occasion, and the staff informed inspectors that it was a 'fancy breakfast' day. In collaboration with the residents, mealtimes became an activity in itself, and something the residents looked forward to. Some days it was 'breakfast in bed', other days was 'fancy' breakfast clubs held in each of the units, and one day there was a 'special breakfast' where they could be together with the residents from other units.

In the afternoon, a fine dining experience was observed on one of the floors where quality food was served, soft music provided an elegant, ambiance and attentive and courteous staff provided attention to detail in every aspect of the dining experience. There was a pleasant atmosphere, with staff and residents chatting and laughing with each other. Residents were seen engaging well and chatting with each other during meal times, which provided opportunities to strengthen their friendships.

Inspectors observed more meaningful engagement with the residents since the last inspection. An external activity consultant assisted the activity team in the creation of an improved activity programme. Activity staff were on site to organise and encourage resident participation in events, which were varied and adapted for residents who required support to include as many residents as possible. Increased supervision was observed throughout the centre in the communal areas.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre and how governance and management affect the quality and safety of the service being delivered. The areas identified as requiring improvement are discussed in the report under the relevant regulations.

Capacity and capability

Overall, this inspection found that the management team were striving to improve practices, and services and significant improvements were evident across most areas inspected. The inspectors followed up on the compliance plan submitted to the Chief Inspector after the last inspection, and acknowledged that the provider had implemented all actions within the required time frames and was working towards

embedding those changes. Notwithstanding the positive improvements, this inspection found that some further action and greater oversight were required in respect of the management of complaints and notifications submitted to the Office of the Chief inspector of Social services, and some opportunities for improvement as outlined further in the report.

This was an unannounced inspection. The purpose of the inspection was to assess the provider's level of compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centre for Older People) Regulations 2013 to 2025 (as amended). Since the last inspection in June 2025, an additional condition had been attached to the registration of the designated centre which required the registered provider to cease all admissions until such time as sufficient staffing resources were in place in all units and there was effective allocation, supervision and oversight of the care of residents. The registered provider was required to ensure care was grounded in a culture of person-centred care and upholding residents' rights in all aspects of their lives. There were 116 residents in the centre on the day of inspection.

Firstcare Beneavin House Limited is the registered provider of Firstcare Beneavin House, which is part of the Emeis Group. At the operational level, the management team were supported by a dedicated team of staff nurses, health care assistants, activity staff, catering, household, and maintenance staff. Since the last inspection in June 2025, the provider had strengthened the clinical supervision in the centre by rostering an additional senior staff nurse or clinical nurse manager who is supernumerary in the centre at night-time. This was to ensure that the supervision of staff was sufficient and that the needs of residents were being met. The person in charge was supported by two assistant director's of nursing (ADON's) and a regional manager. The management team were clear about their roles and responsibilities.

The inspectors observed that the provider had in place oversight systems such as monitoring of key performance indicators, audits, supervision, records and staff talked about the safety pauses and huddles where learning was shared and reinforced. However, not all these systems were effective at leading to improvements. For example, the auditing of care plans required strengthening and other areas identified as requiring strengthening are further detailed under Regulation 23: Governance and management.

There were sufficient staff on duty on the day of the inspection to support the needs of the residents. The agency staffing usage had been reduced following a recruitment drive. There remained 12 staff vacancies which the provider was actively recruiting for.

The staff were visible within the nursing home, tending to residents’ needs in a respectful manner. Staff had the required skills, competencies and experience to fulfil their roles and responsibilities and in their conversations with the inspectors were found to be knowledgeable about their responsibilities, and the specific needs of the residents. Nursing staff were observed administering medication within the required time-frame with minimal interruptions. While all staff, including agency

staff had access to all relevant information about residents' needs, the handover process required review.

The complaints policy and procedure were reviewed. Complaints were not always managed as per the policy, and at the time of inspection, there were seven open complaints in progress. While investigations into complaints were found to be very detailed, the response times were not always appropriate. This is detailed further under Regulation 34: Complaints procedure.

The person in charge had notified the Chief Inspector of Social services of any allegations or incidents of abuse in the centre. However, some of these notifications were not submitted within the required two-day time frame, with some of them notified 23 and 27 days post the incident, after the provider's internal audits identified the failure to notify.

Each resident had a contract of care in place that was signed and included their terms of residence; however not all contracts included the room number and occupancy as required.

Regulation 15: Staffing

A sample of staff duty rotas was reviewed, and in conjunction with communication with staff, residents and visitors, the inspectors found that the number and skill-mix of staff were sufficient to meet the needs of the residents, having regard to the size and layout of the centre.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that staff had access to appropriate training. On the day of the inspection there were staff rostered to ensure that the care of residents was appropriately supervised. Rosters that were reviewed evidenced that supervisory staff were rostered on a 24/7 basis.

Training records were well-maintained and made available to the inspectors on request. Inspectors were assured that staff had completed all mandatory training and had access to other relevant training to support them in their role.

Judgment: Compliant

Regulation 23: Governance and management

Notwithstanding the improvements, the management systems in place were not sufficiently robust to ensure that the service provided is safe, appropriate, consistent and effectively monitored. For example:

- The oversight of care plans required further review as evidenced under Regulation 5: Individualised assessment and care plan, and Regulation 7: Managing behaviour that is challenging.
- While the provider's own systems identified delays in submitting notifications,a more proactive approach to ensuring compliance with regulatory requirements was needed to prevent recurrences.
- Complaints were not always managed in line with the complaints policy or process, and the registered provider had not identified this failure through their internal management systems.
- The handover process required review to ensure it was effective and that staff upheld residents' right to privacy at all times.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The contracts for the provision of services did not always reflect the room number and the occupancy of the bedroom each resident was residing in. For example:

- Three contracts for double occupancy rooms did not state that they were for shared occupancy.
- The system for changing residents' contracts of care was not robust. Inspectors saw three examples where the residents' original contract of care did not reflect the room that the resident was residing in at the time of inspection.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Notwithstanding that the person in charge had submitted all the required notifications to the Chief Inspector of Social Services, they were not submitted within the required time frame. Two allegations of abuse were notified 23 and 27 days post the incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

There were seven open complaints at the time of inspection. All complaints were being investigated; however, the complaints process was not always followed in a timely fashion. There were two complaints that remained open since June 2025.

The management of complaints was not sufficiently robust and from a sample of more than 12 complaints reviewed the following was identified:

- Three complainants were not provided with an acknowledgement in writing.
- On one occasion the letter of acknowledgement was sent to another person and not to the complainant.
- Out of the seven complaints open, four were not followed up on in line with the process and were not responded to within the regulatory time frames. Some complaints remained open for prolonged periods of time. At the time of inspection, there was a complaint that had been open since June.

Judgment: Not compliant

Quality and safety

Overall, the inspectors found significant improvements in the quality of care and quality of life that the residents living in the centre experienced. It was evident, that staff worked hard to meet residents' needs and there were many creative attempts to enhance residents' experience, including an enhanced meaningful activities programme and mealtime experience. Notwithstanding the many improvements observed, some further action was required in some areas, specifically individual care planning and assessments and managing behaviour that is challenging to ensure that the care provided was safe and appropriate at all times.

Residents' care plans and daily nursing notes were recorded on an electronic documentation system. Care planning training had been completed since the last inspection to support staff nurses in the creation of meaningful person-centred care plans. Individual nurses had been assigned to specific residents to ensure a person-centred approach. While this had led to some improvements, a renewed focus was required to ensure each resident's needs were appropriately assessed and effectively responded to, as further outlined under Regulation 5.

It was observed that the nursing team in the centre worked in conjunction with all disciplines as necessary, including in-house visits from tissue viability nurse (TVN),

speech and language therapist (SALT), physiotherapy and palliative care team. Medical cover was available daily, including out-of-hours.

Residents with responsive behaviours (how residents living with dementia or other conditions may communicate or express their physical discomfort, or discomfort with their social or physical environment) had care plans in place. Staff spoken with on the day outlined to the inspectors their knowledge of appropriate interventions to support residents with responsive behaviour. However, the care plans in place did not always reflect the de-escalation techniques that staff should use to prevent the behaviour escalating.

Residents' rights and choice were promoted and respected within the centre. Activities were provided in accordance with the needs and preferences of residents and there were daily opportunities for residents to participate in group or individual activities. Residents had access to a range of media, including newspapers, telephone and TV. There was access to advocacy services with contact details displayed in the centre. There were resident meetings to discuss key issues relating to the service provided.

Residents' nutritional and hydration needs were met. Residents' nutritional status was assessed monthly, and healthcare professionals, such as dietitians, were consulted if required.

The inspectors observed that staff did know how to communicate respectfully and effectively with residents while promoting their independence. Staff were aware of the communication needs of the residents, and care plans were person-centred regarding the specific communication needs of individuals.

Residents' families and friends were observed to visit residents on the day of the inspection. Residents met their visitors in their bedrooms or in the communal spaces in the centre. Visitors confirmed they were welcome to the home at any time.

Appropriate arrangements were in place to ensure that when a resident was transferred or discharged from the designated centre, their specific care needs were appropriately documented and communicated to ensure their safety. Staff confirmed, that they completed and sent 'The National Transfer Document' with the resident to the hospital. Copies of documents were available for review, and they contained all relevant resident information.

Regulation 10: Communication difficulties

The inspectors observed that residents with communication difficulties had their communication needs documented in their care plan. Staff knew about the residents' communication needs and ensured aids were available to enable the residents' effective communication. White board and markers were seen in the

bedrooms of residents with a hearing impairment. Residents with hearing impairments expressed satisfaction with being able to communicate.

Judgment: Compliant

Regulation 11: Visits

The registered provider had arrangements in place for residents to receive visitors which were aligned with the centre's visiting policy. There was adequate space for residents to receive their visitors in areas other than their bedrooms if they wished.

Judgment: Compliant

Regulation 12: Personal possessions

Residents were facilitated to have access to and retain control over their personal property and possessions. They had access to a lockable space to store and maintain personal possessions. Clothes were laundered regularly and promptly returned.

Judgment: Compliant

Regulation 13: End of life

The centre had a comprehensive End-of-Life policy to guide staff, and the inspectors saw evidence of this being implemented in residents' care plans.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents had access to a safe supply of fresh drinking water at all times. They were offered a choice at mealtimes and were provided with adequate quantities of wholesome and nutritious food. There were adequate numbers of staff to meet the needs of residents at meal times, and the mealtime experience had significantly improved.

Judgment: Compliant

Regulation 25: Temporary absence or discharge of residents

The person in charge ensured that where a resident was discharged from the designated centre, it was done in a planned and safe manner.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Notwithstanding the positive improvements since the last inspection, action was required to ensure care plans were in line with the assessed needs of the residents. For example;

- Specific care needs were not always documented in the care plan. A mis-match of information was noted between the information available to the staff in the handover document and the residents' care plan, which may cause confusion. For example, specific supervision requirements documented in the handover document as per the residents' individual needs were not documented in the residents' care plan. Also, individual personal care needs accurately depicted on the hand-over document were not documented in the care plan.
- For one resident, the care plan had not been updated after they had been reviewed by an allied health professional. This resulted in a failure to provide a complex overview of the current condition of the resident or the most up-to-date plan of care.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had a medical review completed within a four-month time period, or sooner, if required. There was evidence that residents had access to their general practitioner (GP) of choice and members of the allied health care team as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Residents who displayed responsive behaviour had care plans in place. While there was evidence of assessment and analysis tools used for managing behaviour that is challenging, some gaps were identified where the assessment did not always inform the strategy to manage the resident. For example, for one resident who required 1:1 supervision, a known trigger and de-escalation technique to effectively respond to behaviours were not outlined in the care plan to direct the care of the resident.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents' rights were upheld in the centre, and all interactions observed during the day of inspection were person-centred and courteous.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 11: Visits	Compliant
Regulation 12: Personal possessions	Compliant
Regulation 13: End of life	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 25: Temporary absence or discharge of residents	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Firstcare Beneavin House OSV-0000694

Inspection ID: MON-0048233

Date of inspection: 11/09/2025

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 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: From 1st October 2025, the PIC holds weekly meetings with all heads of department to oversee and review operational matters, discuss quality and safety initiatives, and monitor progress on agreed action plans to improve the following; care planning, complaints management, issuing of contracts of care and timely submission of regulatory notifications- complete and ongoing The PIC and ADONs attend daily staff handovers to improve oversight of residents' care needs, identified risks, safeguarding concerns, and any complaints. This practice ensures effective communication, promotes accountability, and enables prompt follow-up on any issues. This also provides the PIC with the opportunity to discuss any changes within the home, reinforce key updates, and ensure clear and effective lines of communication across the team. Complete and ongoing By 1st December 2025, the regional director will review auditing in the home to ensure that audits are identifying gaps in care plans, contracts of care, management of complaints and timely submission of notifications. Any identified improvement plans will be in place and actioned by 31st December 2025	
Regulation 24: Contract for the provision of services	Substantially Compliant
Outline how you are going to come into compliance with Regulation 24: Contract for the provision of services:	

From 1st October 2025, the PIC holds weekly meetings with all heads of department to oversee and review operational matters, discuss quality and safety initiatives, and monitor progress on agreed action plans to improve the following; care planning, complaints management, issuing of contracts of care and timely submission of regulatory notifications- complete and ongoing
The PIC and ADONs attend daily staff handovers to improve oversight of residents' care needs, identified risks, safeguarding concerns, and any complaints. This practice ensures effective communication, promotes accountability, and enables prompt follow-up on any issues. This also provides the PIC with the opportunity to discuss any changes within the home, reinforce key updates, and ensure clear and effective lines of communication across the team. Complete and ongoing

By 1st December 2025, the regional director will review auditing in the home to ensure that audits are identifying gaps in care plans, contracts of care, management of complaints and timely submission of notifications. Any identified improvement plans will be in place and actioned by 31st December 2025

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
From 1st October 2025, all incidents and complaints are reviewed daily by the PIC and ADONs (in the PICs absence) to identify any issues that meet the criteria for notification. This process ensures that all relevant notifications are submitted within the required timeframe- complete

Following review, from 1st October 2025, a notification tracking log has been introduced to monitor submission timelines and ensure ongoing compliance – complete
From 1st October 2025, the Regional Director completes a weekly report to ensure the timeliness and accuracy of notifications – complete

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All outstanding complaints have been reviewed to ensure appropriate communication, documentation, and outcomes for each case, in line with the agreed policy- complete
From 1st November 2025, the PIC will review all open complaints weekly to monitor progress and ensure timely follow-up and resolution. These reviews will be discussed

with the Regional Director to ensure oversight and accountability.
The PIC, ADONs, and CNMs have completed training in complaints management to reinforce best practice in documentation, timely follow-up, and communication- complete

Regulation 5: Individual assessment and care plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:
The PIC will oversee a review of all residents' care plans to ensure that all personal care needs, supervision requirements, and allied health recommendations are accurately documented. This will be completed by 30th November 2025

The CNMs will ensure that all information shared during handovers is cross-checked and reflected in residents' care plans and on handover sheets for their designated floors by 30th November 2025

The CNMs and ADON will provide refresher coaching and support for all nursing and care staff on the importance of maintaining accurate and up-to-date care plans and ensuring consistency with handover information by 30th November 2025.

From 1st November 2025, a monthly audit of care plans is completed by the ADONs/CNMs to ensure only the most relevant information that reflects the recommendations from allied health professionals is included. Audit results will be discussed at staff huddles, daily handover and staff meetings to identify where nurses require further support in completing care plans. Complete and ongoing

Regulation 7: Managing behaviour that is challenging	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Managing behaviour that is challenging:
A review of all responsive behaviour care plans has been completed to ensure that each plan clearly outlines the resident's identified triggers, early warning signs, and effective de-escalation strategies to guide staff in providing consistent, person-centred support- complete and ongoing

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 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	31/12/2025
Regulation 24(1)	The registered provider shall agree in writing with each resident, on the admission of that resident to the designated centre concerned, the terms, including terms relating to the bedroom to be provided to the resident and the number of other occupants (if any) of that bedroom, on which that resident shall	Substantially Compliant	Yellow	31/12/2025

	reside in that centre.			
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	31/10/2025
Regulation 34(2)(b)	The registered provider shall ensure that the complaints procedure provides that complaints are investigated and concluded, as soon as possible and in any case no later than 30 working days after the receipt of the complaint.	Not Compliant	Orange	30/11/2025
Regulation 34(2)(c)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant whether or not their complaint has been upheld, the reasons for that decision, any improvements recommended and details of the review process.	Not Compliant	Orange	30/11/2025
Regulation 34(2)(g)	The registered provider shall ensure that the	Not Compliant	Orange	30/11/2025

	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.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	30/11/2025
Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/11/2025