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:	CareChoice Ballynoe
Name of provider:	Carechoice Ballynoe Limited
Address of centre:	Whites Cross, Cork
Type of inspection:	Unannounced
Date of inspection:	15 July 2025
Centre ID:	OSV-0000210
Fieldwork ID:	MON-0047698

About the designated centre

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

Carechoice Ballynoe (known as Ballynoe) is a designated centre which is part of the Carechoice group. It is located in the rural setting of Whites Cross and is a short distance from the suburban areas of Ballyvolane, Blackpool, and Cork city. It is registered to accommodate 46 residents. Ballynoe is a two-storey facility with lift and stairs to the upstairs accommodation. It is set out in three corridors on the ground floor called after local place names of Glen, Shandon and Lee; and Honan on the first floor. Bedroom accommodation comprises single and twin rooms downstairs and 12 single occupancy bedroom upstairs. Additional shower, bath and toilet facilities are available throughout the centre. Communal areas comprise a comfortable sitting room, Morrissey Bistro dining room, large day room and a large quiet room with comfortable seating. The hairdressing salon is located near the main day room. There is a substantial internal courtyard with lovely seating and many residents have patio-door access to this from their bedrooms; there is a second smaller secure courtyard accessible from the quiet room and a further enclosed space accessible from the main day room. At the entrance to the centre there is a mature garden that can be viewed from the sitting room, dining room and some bedrooms. Carechoice Ballynoe 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:	41

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
Tuesday 15 July 2025	08:50hrs to 16:45hrs	Breeda Desmond	Lead
Tuesday 15 July 2025	08:50hrs to 16:45hrs	Erica Mulvihill	Support

What residents told us and what inspectors observed

This unannounced inspection took place over one day in CareChoice Ballynoe. Inspectors met many residents throughout the day and spoke with 10 residents in more detail to gain insight into their lived experience in the centre. While residents said that some staff were friendly and helpful, seven reported that there were long waiting times for call bells to be answered, and that delays could be as long as an hour to go to the bathroom. A resident reported that some staff will stay and wait until you are finished in the bathroom to assist you back to your bed, but others will leave you and ask you to ring the bell, which takes longer again as you are waiting for them to come back.

CareChoice Ballynoe is a designated centre registered to accommodate 46 residents; there were 41 residents living in the centre at the time of inspection. This is a two-storey building with resident accommodation on both floors. The main entrance is wheelchair accessible and leads into a reception area with a hand-wash hub with appropriate hand-wash signage. The nursing home registration and insurance certificate along with the complaints procedure were displayed near the reception. Other information displayed around reception included safeguarding, human rights, information guide, annual review and the 24-hour snack menu available to residents. There were large notice boards displaying the weekly activities informing residents of the daily programme; a new large TV in reception, displayed a montage of activity photographs, daily menus and the day's activity programme. Directional signage was displayed throughout the centre to allay confusion and disorientation. Butterfly emblems displayed codes to doors and the lift to enable independent access for residents and visitors. Additional signage was added upstairs to alert residents and visitors to the change in camber of the flooring and possibly mitigate falls risk.

On arrival to the centre, inspectors saw residents having their breakfast in the dining room which was beautifully decorated; tables were set with table clothes, napkins with greek-style napkin holders, flower posies and battery operated candles. Staff actively engaged with residents as they came to the dining room and a kitchen staff attended to residents immediately as they came for their breakfast. Residents were seen to have choice for their meal.

Other residents were in the day room with the activities person who was providing one-to-one interaction as well as co-ordinating small group activities. Other residents were reading the newspaper or reading a book. A mobile nail-bar was added to the hairdressers' room since the previous inspection and the hairdresser was on site during the inspection. Staff co-ordinated a 'spa treatment' day with manicures and pedicures and the nail-bar was brought into the main day room for the convenience of residents. In the afternoon, the room was being decorated for the up-coming All Ireland match, Cork V Tipperary.

The building had been re-painted and re-decorated with new curtains, art work and baskets of flowers since the last inspection and looked bright and clean. Some residents had adorned their bedroom doors with garlands and other decorations. The front doors of the bedrooms were painted individual colours, with front door knockers and numbered to assist residents in finding their own bedrooms. Bedrooms on the ground floor were very personalised. Residents had decorated their bedrooms in their own style with many personal items on display in their room. Storage for residents' personal possessions comprised double wardrobes, chest of drawers and bedside lockers; some bedrooms were seen to have a second double wardrobe. Bedrooms had comfortable bedside chairs. Privacy screens in shared rooms were effective and ensured residents' privacy. Communal space downstairs comprises the main day room, smaller comfortable sitting room near the dining room and larger room with kitchenette facilities, however, this room appeared to be used predominantly by staff. The person in charge explained that this room was allocated to staff during the pandemic as part of standard precautions at the time, however, this room remained in use mainly by staff, with staff lunch bags and other staff bags seen on the kitchenette worktop and dining table.

There is stairs and lift access to the upstairs accommodation which comprises 12 single occupancy bedrooms, with toilet, shower and wash-hand basin en suite facilities. Additional bath and shower facilities were available. Communal space upstairs comprises a sitting room and separate dining room with kitchenette facilities; both rooms are bright, comfortable and relaxing. No residents were seen using these communal spaces throughout the inspection. There were two large black bags of a resident's clothes with the resident's name stored in the dining room upstairs.

Inspectors observed that mid morning refreshments of soup, tea, coffee or juices were offered to residents in the day room and their bedrooms. Residents said that the food was delicious. Lunch time was observed and meals served looked very appetising. There were adequate staff to assist residents with their meal and assistance was provided in a relaxed manner and staff were seen to actively engage with residents.

The main enclosed outdoor garden was very well maintained and had ample space with comfortable garden furniture. The residents' smoking shelter was located to the corner in the enclosed garden and had fire safety equipment such as fire aprons, fire blanket, a device for extinguishing and discarding cigarettes, and a call bell for residents' safety.

Inspectors observed that it took time for call bells to be answered in the morning, and this improved during the day. Some of the call bells in toilets were long and did not breakaway when pulled, and so posed a potential ligature risk.

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 a focused unannounced inspection conducted by inspectors of social services to assess compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations following submission (prior to the inspection) to the office of the Chief Inspector of unsolicited information of concern regarding care and welfare of residents in the centre. The unsolicited information reported delays in call bells being answered which resulted in delays in resident care. This was followed up on inspection and delays in call bells being answered was substantiated.

CareChoice Ballynoe is operated by CareChoice Ballynoe Limited. It is part of the CareChoice group which has a number of designated centres throughout the country. There is a clear management structure, which 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). On site, the person in charge is supported by two assistant director of nursing (ADON) and a team of nurses, healthcare assistants, catering, administration, house-hold and maintenance staff.

The person nominated to represent the provider facilitated monthly meetings with the directors of nursing (DONs) for the 14 centres in the group to provide leadership and oversight of services; set agenda items are discussed such as quality improvement with associated key performance indicators such as complaints, wound care, and infection for example, along with audit results, staffing, education, and finances.

While there were management systems in place regarding oversight including a schedule of audit, inspection findings showed that these required attention to ensure the rights of residents'. An urgent action plan was issued to the registered provider regarding Regulation 23: Governance and Management, and Regulation 9: Residents Rights, to ensure better oversight and a more robust system to ensure timely care. Previously there was a 'call bell answering' audit available, this system was being updated at the time of inspection, and this electronic audit was unavailable to definitively demonstrate times for call bells to be answered. A comprehensive response to the urgent action plan was received from the provider giving assurance that issues identified were being addressed immediately following the inspection.

In addition, action was required to ensure the complaints procedure was robust and that all concerns raised by residents were recorded in accordance with specified regulatory requirements. Incident management records were found to be inaccurate, and a notification submitted to the Chief Inspector relating to the sudden death of a resident did not accurately reflect the pertinent information of events leading up to the resident's death.

The duty roster demonstrated adequate staff and skill mix for the size and layout of the centre. A review of the training matrix showed good oversight of training needs. Training was scheduled on site for July, August and September to ensure all staff training remained current. There were no staff undergoing disciplinary evaluations at the time of inspection. A sample of staff records were reviewed and while most of the information required as part of Schedule 2 (Documents to be Held in Respect of the Person in Charge and for each Member of Staff) were available, the curriculum vitae (CV) of one staff was inaccurate. This is further detailed under Regulation 21: Records.

Schedule 5 policies were available to staff and updated according to regulatory requirements. However, some policies were not implemented into practice to ensure the safety and welfare of residents; evidence of this is discussed throughout the report.

Regulation 15: Staffing

A review of the staffing roster showed there was adequate staffing and skill mix for the assessed needs of residents. The roster showed that one of the ADON was rostered to cover at weekends ensuring managerial oversight and support for the service at weekends.

Judgment: Compliant

Regulation 16: Training and staff development

While the registered provider had ensure that staff had access to mandatory and other training, action was required to ensure staff were appropriately supervised, as:

- some staff were wearing face masks even though there was no clinical indication for this practice
- residents reported that some staff did not stay with them when using the bathroom to ensure their safety and well-being.
- feedback from residents reported that there were delays in responding to call bells in a timely manner causing delays in care delivery, as further outlined under Regulation 23: Governance and Management and Regulation 9 Residents rights.

Judgment: Substantially compliant

Regulation 23: Governance and management

Findings of this inspection were that the governance and management systems in place were not effective to ensure the service provided to residents was safe, appropriate, consistent and effectively monitored. For example:

- while there were management systems in place regarding oversight including a schedule of audit, inspection findings found that these were not effective to ensure the rights of residents'. An urgent action plan was issued to the registered provider regarding Regulation 23: Governance and Management, and Regulation 9: Residents Rights to ensure a more robust system to enable better oversight to timely care,
- oversight of the management of complaints was not robust, as some complaints were not recorded, other records were incomplete, and the decision whether to uphold a complaint was questionable; these are further detailed under Regulation 34: Complaints procedure
- oversight of Incident management records required action as some information in records were found to be inaccurate. A notification submitted to the Chief Inspector did not accurately reflect pertinent information. This is further outlined under Regulation 21: Records
- one day room that was registered as resident communal space within the footprint of the floor plans as part of the statement of purpose was observed to be used as a staff rest room and therefore was not available for resident use.

Regarding risk:

- some of the call bells in toilets were long and did not breakaway when pulled, and had the potential to be a possible ligature risk.

Judgment: Not compliant

Regulation 34: Complaints procedure

Action was required to ensure complaints were managed in accordance with regulatory requirements, as follows:

- one complaint record was incomplete; the follow up and actions taken were not detailed in accordance with specified regulatory requirements
- another complaint regarding medication management of a resident was followed up, and was judged as 'unsubstantiated', even though the records showed evidence to the contrary,
- seven residents reported to inspectors they were constantly highlighting the delay in call bells being answered, however, just one complaint relating to

this was recently recorded. This particular complaint was deemed not substantiated, however, there was little evidence to support this outcome
- another resident reported to inspectors that their bedroom equipment was inadequate to meet their care needs, and had reported this to a member of staff, however, this was not recorded in the complaints' log, consequently, this issue was not addressed and the resident had to 'work around' the equipment issue which posed a risk; inspectors observed on this inspection.

Judgment: Not compliant

Regulation 4: Written policies and procedures

Schedule 5 policies were available to staff and updated according to regulatory requirements, however, action was required to ensure policies were implemented into practice as:

- policies relating to Complaints, Residents' Rights, Temporary Absence of a Resident and Records to be maintained in the centre were not implemented to ensure the safety and welfare of residents, as discussed throughout the report.

Judgment: Substantially compliant

Regulation 21: Records

Action was required to ensure records were maintained in accordance with specified regulatory requirements:

- a sample of staff records were examined by the inspector in conjunction with HR personnel, and while most of the information required under Schedule 2 was available, the curriculum vitae of one staff was inaccurate and the qualification declared in the CV was not attained at the time of recruitment.

Judgment: Substantially compliant

Quality and safety

The findings of this inspection showed that while residents' medical needs were being met through good access to health care services, action was required to

ensure the service provided was safe, appropriate, and consistent to enable quality care.

A sample of resident care documentation was reviewed. Validated risk assessment tools were available. Daily narrative notes were maintained for both day and night duty and these were seen to be comprehensive in the sample examined. These reports showed two-hourly comfort and safety checks. Following assessment, residents had timely referrals to allied health professionals such as physiotherapy, tissue viability, dietician and speech and language where required. There was evidence that reports from these health professionals informed care planning to enable better outcomes for residents. There was a physiotherapist on site five days a week. They completed a post falls assessment following any resident that sustained a trip or a fall. This review template was seen to be detailed and included a review of medications including the amount of prescribed medications, pain management and psychotropic prescriptions. An occupational therapist was on site five hours per week to support residents.

Each resident had a nutritional assessment completed using a validated assessment tool. Any concerns regarding any weight changes with residents were closely monitored. Notwithstanding these good findings, some care plans and assessments were not updated in accordance with regulatory requirements to ensure residents could be cared for in accordance with their current needs. This is further discussed under Regulation 5: Individual assessment and care plan.

Following review of the restraint register and observation of the inspectors during the inspection, it was noted that a restraint-free environment was promoted along with alternatives and the least restrictive practices were promoted.

A sample of transfer letters for occasions when a resident was temporarily transferred to acute care were reviewed. While one was comprehensive, the second one did not include details of a resident's fall and associated injuries that occurred the day prior to admission, to ensure the resident would be cared for in accordance with their current needs.

Regulation 25: Temporary absence or discharge of residents

Action was required to ensure residents could be cared for in accordance with their current need when transferred to another care facility, as:

- one resident's transfer letter did not include pertinent information regarding events prior to the resident's transfer to ensure they could be cared for appropriately in the receiving hospital.

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:

- one resident's post fall assessment stated there was no injury sustained, however, their notes reported there was an injury
- some assessments and care plans did not correlate with residents' medical histories, for example, some histories stated the resident had a cognitive impairment, however, their assessment stated they did not have a cognitive impairment, and so the level of risk would be assessed lower, which may result in less than optimum interventions to enable best outcomes for the resident,
- in daily care records, one resident was observed to have responsive behaviours and behavioural monitoring assessments were not carried out as noted in the care plan. Upon further review, a significant decline in cognition was noted in an updated assessment tool, but this was not reflected in their care plan to inform staff of the residents changing needs.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical assessment and review by the general practitioner (GP). A range of allied health professionals were also available to residents such as access to physiotherapy daily, occupational therapy weekly, dietician, tissue viability, chiropody and palliative care for example. Records reviewed showed ongoing timely referral and review of residents as required.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

Action was required to ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging:

- one residents' care plans of March 2025 directed that behavioural support monitoring charts were to be completed if there was a change in the resident's behavioural presentation. The daily narrative notes showed significant changes in the resident's behaviour, and a significant cognitive decline was recorded in the resident's cognitive screening assessment. However, behavioural support monitoring was not implemented to ensure

timely interventions to support the resident to enable best outcomes for the resident.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The provider had not ensured that residents' rights were upheld and the ability of each resident was respected:

- seven residents reported waiting times for call bells to be answered, which in turn, delayed care being delivered. One resident reporting they could be waiting for up to an hour to go to the bathroom. Residents spoken with said they had reported there were delays in answering call bells to staff but it had not been addressed which resulted delays in their care needs being attended to, and their rights not being upheld,
- the inspectors observed, and were informed by a resident, that their bedroom equipment did not meet their needs; while they had reported this to staff, this had not been actioned to ensure the resident's comfort and safety, and the resident's 'work-around' to use this equipment posed a risk to the resident.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Regulation 21: Records	Substantially compliant
Quality and safety	
Regulation 25: Temporary absence or discharge of residents	Substantially 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	Substantially compliant

Compliance Plan for CareChoice Ballynoe OSV-0000210

Inspection ID: MON-0047698

Date of inspection: 15/07/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • We have reinforced both training and increased supervision to ensure best practice is sustained. • All mandatory training and assessments are completed and up to date for every staff member. Refresher training has been provided in infection prevention and control, PPE usage and call response protocols. Point of Care Assessments (POCA) are completed and documented as required. • Daily floor supervision and spot checks are conducted by the DON and ADONs to monitor practice in real time. • An individual risk assessment is completed for each resident to determine the appropriate level of support required during toileting. The decision for staff to remain with a resident in the bathroom is made on a case-by-case basis, guided by individual needs and a thorough risk assessment, with the objective of ensuring safety, well-being, and the preservation of dignity. • Refresher trainings on call bell response have since been delivered by the onsite trainer, and the DON/ADONs continue to reinforce response standards during every handover and safety huddle. • Weekly call bell audits are conducted, with results reviewed at handovers and governance meetings. Non-compliance is addressed through one-to-one staff supervision, reflective practice discussions, and documentation of reasons for any delays.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• All complaints and concerns are recorded and investigated in line with Carechoice Complaints Policy CL004, with outcomes clearly communicated to the complainant.
• The documentation gaps identified in complaints records have been reviewed and fully addressed. Going forward, all informal concerns will be recorded, and all complaints will include details of the actions taken, the outcome, and whether the complaint was upheld.
• The Governance Team monitors the complaints management process and compliance with policy through monthly review of clinical KPIs. Any gaps identified are discussed with the DON/ADON during governance meetings.
• Monthly audits are conducted by the DON and ADONs across key areas including medication management, falls, wounds, infection prevention and control, complaints, and care planning. Findings are reviewed at governance meetings, with clear actions documented and tracked through to completion.
• Incident management processes have been reinforced to ensure all records are complete and include all pertinent information. Where incidents require a notification to the Chief Inspector, the documentation is now verified for accuracy prior to submission.
• Staff have received refresher training in incident reporting, residents' rights, and call bell response to ensure that the gaps identified during inspection do not reoccur.
• Environmental issues highlighted during inspection have been addressed. The communal space previously observed as unavailable has been reinstated for resident use, with alternative staff rest arrangements put in place. Environmental audits now confirm that communal areas remain consistently available.
• All call bells in the centre are anti-ligature and meet current safety standards. An external company has been contracted to conduct a survey of all call bells to ensure correct length and compliance with safety standards. Weekly call bell audits now include a ligature safety check for additional assurance.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• All complaints and concerns, including informal issues, are now recorded in the Complaints Register. Each entry includes details of the investigation findings, follow-up actions, outcome and rationale, the decision on whether the complaint is upheld, and any learning identified. The Director of Nursing (PIC) reviews every complaint to ensure the process complies with regulatory standards and Carechoice Complaints Policy CL004.
• The gaps identified regarding incomplete complaint records have been addressed, and the register has been updated with full details.
• The Clinical Management Team conducts daily walkarounds to engage with residents, gather feedback on call bell response times, and address any other aspects of the service provided. In addition, the upgraded call bell system now enables real-time monitoring of call bell responses.

• In relation to the complaint concerning bedroom equipment, a new bed was provided to the resident, and the concern has been logged in the complaints record. • Staff have received refresher training in complaint handling and documentation to ensure all concerns are captured accurately and consistently. Complaints are reviewed at governance meetings to support learning and continuous service improvement.

Regulation 4: Written policies and procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 4: Written policies and procedures: • To address the gaps identified in policy implementation, staff have received education on the relevant policies and procedures and are supervised in their roles to ensure compliance with regulatory standards. • Enhanced spot checks have been introduced by the management team to evidence policy implementation in real time, with findings reviewed at governance meetings. • Monthly audits continue to confirm that all Schedule 5 policies are fully embedded in practice and that documentation consistently reflects compliance.	

Regulation 21: Records	Substantially Compliant
Outline how you are going to come into compliance with Regulation 21: Records: • CareChoice Ballynoe acknowledges this finding and has ensured that all staff records are now accurate, complete, and fully compliant with Schedule 2 requirements. • The CV has since been updated, and the certificate placed on file. • A full audit of all staff records has been completed to verify accuracy and completeness. Future recruitment files will include enhanced verification of qualifications and pending certificates to prevent any perception of inaccuracy.	

Regulation 25: Temporary absence or discharge of residents	Substantially Compliant
Outline how you are going to come into compliance with Regulation 25: Temporary absence or discharge of residents:	

• One resident's transfer letter did not include sufficient information about events prior to transfer, which could have impacted the ability of the receiving facility to provide safe and appropriate care. On review, the transfer documentation in question the wording could have been clearer to demonstrate all pertinent events, such as recent falls. • Staff have been reminded that all recent changes in condition or events must be explicitly recorded in the transfer letter. ADONs will supervise all transfers to ensure that all necessary information is included in the transfer documentation. • A full audit of recent transfers has been completed to confirm that documentation is accurate and complete. Copies of all transfer letters are now retained in residents' files to ensure full traceability. • Weekly spot checks of transfer documentation are conducted by the Clinical Management Team to maintain sustained oversight and ongoing compliance.

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 post-fall assessment recorded as 'no injury', while notes documented that there was an injury was reviewed by DON. Staff have been reminded to update post-fall assessments promptly if new findings emerge, to ensure consistency across all records. • Some assessments and care plans did not align with residents' medical histories, particularly around cognitive status. Following inspection, every resident's care plan has been thoroughly reviewed by the DON and ADONs within the last four weeks to ensure alignment with both historical diagnoses and current functional status. Risk assessments have been adjusted where necessary to provide optimum care to the resident. • The care records of the resident who was observed to have responsive behaviours where behavioural monitoring had not been completed as directed in the care plan was further reviewed. This has been addressed, the care plan updated to reflect a decline in cognition, and behavioural monitoring reinstated. Staff have been reminded to escalate and record all behavioural changes promptly.	
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: • Staff did not consistently document behavioural support monitoring when a resident's behaviours changed has been reviewed. In the highlighted case, the resident was under	

active supervision and their needs were managed safely; however, behavioural monitoring charts were not commenced despite changes in behaviour. The resident's cognitive decline has since been reflected in their updated care plan, and behavioural monitoring has been reinstated in full.
• All behavioural support plans have been reviewed by the DON and ADONs to ensure they contain clear guidance on when monitoring should commence. Staff have been reminded that charts must be initiated immediately when behaviours change, and documentation must clearly demonstrate escalation steps.
• To further strengthen compliance, weekly audits of behavioural monitoring records are carried out by the ADONs to ensure consistency with care plans and progress notes. Any changes in behaviour or cognition are promptly escalated to the DON and the multidisciplinary team. In addition, all staff have received refresher training in recognising, documenting, and escalating behaviours that challenge.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• Residents' rights were not consistently upheld, with some residents reporting delays in call bell response and one resident's bedroom equipment not meeting their needs. CareChoice Ballynoe acknowledges these findings and has strengthened systems to ensure that residents' rights, dignity, and safety are consistently respected.
• Seven residents reported concerns about delayed call bell responses, and one resident stated they could wait up to an hour. While audits and CCTV confirmed that call bells were typically answered within a safe timeframe of under four minutes, we recognise that residents that their concerns were not always addressed to their satisfaction. The call bell system has since been upgraded to provide automated, auditable data on response times. Additionally, resident meeting was held to discuss these gaps and residents are made aware of the actions taken to address any delays in call bell response time.
• Weekly call bell audits are reviewed by the DON and ADONs, with feedback provided to staff in real time to support immediate corrective actions.
• Staff have received refresher training in call bell response and residents' rights to ensure consistent practice and uphold resident safety and dignity.
• CareChoice Ballynoe is fully committed to upholding residents' rights and ensuring that all resident's abilities and needs are respected. All call bell related concerns are now formally recorded in the complaints register with supporting evidence attached where relevant.
• In relation to bedroom equipment, immediate action was taken: a new bed was provided, and the matter was logged in the complaints register for full accountability. Routine environmental and comfort checks are now conducted to ensure equipment consistently meets residents' needs, with findings reviewed at governance meetings.

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.	Substantially Compliant	Yellow	22/07/2025
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	31/07/2025
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	Substantially Compliant	Yellow	16/07/2025

	from a designated centre for 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 34(2)(f)	The registered provider shall ensure that the complaints procedure provides for the provision of a written response informing the complainant of the outcome of the review.	Substantially Compliant	Yellow	31/07/2025
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	Not Compliant	Orange	31/07/2025

	resident's individual care plan.			
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	16/07/2025
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.	Substantially Compliant	Yellow	18/07/2025
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	31/08/2025
Regulation 7(1)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	16/07/2025

	have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.			
Regulation 9(1)	The registered provider shall carry on the business of the designated centre concerned so as to have regard for the sex, religious persuasion, racial origin, cultural and linguistic background and ability of each resident.	Substantially Compliant	Yellow	18/07/2025