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:	Ballinamore House Nursing Home
Name of provider:	Raicam Holdings Limited
Address of centre:	Ballinamore, Kiltimagh, Mayo
Type of inspection:	Unannounced
Date of inspection:	18 September 2025
Centre ID:	OSV-0000317
Fieldwork ID:	MON-0043615

About the designated centre

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

Ballinamore House Nursing Home is registered to care for 51 male and female residents who require long-term care or who require care for short periods due to respite, convalescence, dementia or palliative care needs. Care is provided for people with a range of needs: low, medium, high or maximum dependency. The centre is located in a rural setting, a short drive from the town of Kiltimagh in County Mayo. Ballinamore House Nursing Home is a large period property that has been converted for use as a nursing home. Bedroom accommodation consists of 37 single rooms and seven double rooms. There are four sitting areas where residents can spend time during the day. Other facilities include two dining rooms with two serving areas, four dayrooms, a visitor's room, a kitchen and two reception areas. There is a stair lift and a passenger lift access between floors. The lift can be used in the event of a fire. In the statement of purpose, the provider describes the service as aiming to provide a high standard of care in accordance with evidence-based practice and to provide a living environment that, as far as possible, replicates residents' previous lifestyle and ensures residents live in a comfortable, clean and safe environment.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	40

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 18 September 2025	07:45hrs to 16:30hrs	Celine Neary	Lead

What residents told us and what inspectors observed

This unannounced inspection was conducted with a focus on safeguarding and the measures the provider had in place to safeguard residents from abuse. The purpose of the inspection was to ensure that residents felt safe in the centre and their human rights were respected and promoted.

The inspector arrived at the centre at 07:45 am. The inspector was greeted by the person in charge and then attended the nursing handover report with the staff. This gave the inspector an insight into the care provided overnight and the well-being of each resident discussed. The inspector then conducted a walkaround of the premises. This gave the inspector the opportunity to observe interactions between staff and residents and staff practice. The inspector observed that residents were offered choice in when and how they started their day, and staff interacted with residents in a respectful and kind manner. Later in the morning, the inspector met with the provider representative and the person in charge. The inspector requested a number of documents, and these were all provided for review in a timely manner.

There were 40 residents living in the centre and 11 vacancies. One resident was in the hospital during this inspection.

There are four communal areas for residents to use on the ground floor, consisting of a sensory room, a sitting room, a reception area and a dining room. The reception area had been recently redecorated, and the staircase had been freshly painted and refurbished to a high standard.

A Chapel was tastefully converted into a spacious dayroom and dining area on the first floor, which included a kitchenette for residents and staff to use. The dining area was bright and had been arranged opposite the kitchenette, operated by attentive catering staff. Residents were seen to frequent this area throughout the day, chatting to staff, and the inspector saw that residents could avail of snacks and drinks regularly.

The basement area contained the kitchen, cleaning room, offices, store rooms and staff changing rooms.

New and existing bedrooms were personalised with items of significance, such as family pictures and soft furnishings. The bedrooms were laid out to ensure there was suitable storage space for residents' clothing and personal items.

There was an internal courtyard garden, which was decorated with wall-murals and garden furniture. However, there were no plants, shrubs or garden ornaments to add interest to this area. Access to this enclosed courtyard garden was controlled by a key code lock. The policy in the Nursing Home is that this door is disabled and left

open during the day and there is a signing chart beside this door which supports this action.

Residents also had access, with assistance, to another garden area at the front of the premises, which contained a gazebo, garden furniture and a barbecue. This area was used regularly by residents and staff during the fine weather.

Residents could receive visitors in the centre within communal areas or in the privacy of their bedrooms. Multiple families and friends were observed visiting throughout the day of inspection without any restriction.

There was an on-site laundry service located on the external grounds of the premises, where residents' personal clothing, towels and bed linen were laundered.

The inspector identified several fire safety concerns during the walk-through of the premises. There were two large comfort chairs and several wheelchairs stored in the corridors, which could obstruct the safe and timely evacuation of residents in the event of a fire. Additionally, a laundry trolley was positioned at the top of a stairwell, posing a risk to the evacuation of both residents and staff in case of an emergency. Furthermore, equipment was stored under some stairwells, which could increase the risk of combustion and hinder the safe evacuation of residents during a fire emergency. These matters were brought to the attention of the person in charge and the provider, to ensure the safety of the residents was maintained. Actions taken by the provider included the removal of chairs within the corridors and the equipment which was stored under these stairwells.

Residents were well-dressed and appeared relaxed and content in their surroundings. Staff were present to assist and support residents in their communal day rooms. Residents told the inspector that "I am happy enough here", "they help me when I ask" "the food is good" and "I feel safe here".

The inspector observed one resident walking around the ground floor area into various communal areas with a purpose. Staff responded to this resident in a kind and respectful manner. This behaviour continued throughout the day, and staff attended to this resident to provide reassurance and distraction to help them settle into their new home. However, one resident told the inspector that this resident had entered their bedroom uninvited that morning. This was discussed with management on the day of inspection.

The inspector saw residents taking part in activities during the day, such as arts and crafts, magic table games and baking. An event which included high tea and a music session was scheduled and took place that afternoon. An activity schedule was on display in both areas and residents told the inspector that they enjoyed the various activities and events that took place. They told the inspector that they had been to the cinema and the theatre and enjoyed walks around the external grounds from time to time.

Not all staff followed infection control guidelines in relation to the use of PPE (personal protective equipment) and hand hygiene when providing care and support to residents. Although alcohol-hand gel dispensers were readily available along

corridors for staff use, the inspector did not observe staff utilising these during the morning care routine. The inspector observed staff disposing of soiled incontinence wear from residents bedrooms, gloves and aprons, into a bin in a communal toilet and shower area, which could increase the risk of cross contamination.

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

Capacity and capability

Overall, the inspector found that there was a clearly defined management structure in the centre, which included the arrangement to report safeguarding concerns if they arose. The current oversight and monitoring of safeguarding concerns in place were effective, but some improvements were required in relation to fire safety, infection prevention and control and the management of residents with responsive behaviours.

The registered provider of this designated centre is Raicam Holdings Limited. The person representing the provider entity worked full-time in the centre and was involved in the day-to-day management of the centre. There was a clearly defined management structure in place, which comprised of the centre's person in charge, an assistant director of nursing and a clinical nurse manager. The registered provider maintained good oversight of the service provided as they worked daily in the centre and ensured that there were adequate resources allocated to staffing, equipment, facilities and catering arrangements.

They were supported by a team of nurses, health care assistants, activity, catering, domestic and maintenance staff. Staff were clear about reporting structures and had the information they needed to carry out their work safely and effectively. On the day of the inspection, there were sufficient numbers of suitably qualified staff available to support residents' assessed needs.

There were management systems in place to oversee the service and the quality of care, which included a programme of auditing in clinical care and environmental safety. A sample of these audits was reviewed and was seen to assess compliance, identify areas of improvement and set out actions to address these issues.

The provider had arrangements in place to monitor and oversee safeguarding processes within the centre. All allegations of abuse were notified to the Chief Inspectors Office and fully investigated in line with the centre's own safeguarding policies and procedures. Where referrals were required to the safeguarding team, these were completed in a timely manner.

An annual review of the quality and safety of the service had been developed. This included an overview of the service, a quality improvement plan and residents' feedback on the service they received.

All staff had completed their mandatory training; however, some staff required refresher training in adult safeguarding of residents. There were systems in place for the supervision and support of all staff. However, staff were knowledgeable about the care and support needs of each resident, and of the reporting procedures in place should a safeguarding concern arise in the centre.

The inspector also reviewed a sample of staff files and saw that Schedule 2 records were available and An Garda Síochána (police) vetting disclosures in accordance with the National Vetting Bureau Act 2012 was in place prior to the staff member's start date within the centre. The registered provider also had a process to ensure that these disclosures were renewed every three years.

Regulation 15: Staffing

From a review of the staff rosters and staffing observed on the day of inspection it was evident that there was sufficient nursing and care staff on duty with appropriate knowledge and skills to meet the needs of residents, taking into account the size and layout of the centre. There was at least one nurse on duty at all times.

Judgment: Compliant

Regulation 16: Training and staff development

Twelve staff had not undergone refresher training and were out of date with adult safeguarding.

Staff supervision was not fully effective, as the inspector observed inadequate infection control staff practices, which posed a risk of cross-infection between the residents.

Staff did not have access to the regulations, relevant standards or guidance published from time to time by the Government or statutory agencies in relation to designated centres for older people.

Judgment: Not compliant

Regulation 21: Records

The inspector reviewed a sample of staff personnel files. These contained the necessary information, as required by Schedule 2 of the regulations, including evidence of a vetting disclosure, in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, two references of previous employment and employment histories for each staff member employed.

Judgment: Compliant

Regulation 23: Governance and management

While the centre had management systems in place, some improvements were required to ensure that care delivery was effectively monitored and the care provided was safe. For example:

- The oversight of the safeguarding training was not adequate, which did not ensure that staff had sufficient knowledge on how to recognise and manage potential safeguarding risks and concerns. In addition, staff supervision required strengthening, as discussed under Regulation 16: Training and staff development.
- There was a number of peer to peer incidents in this centre involving residents who expressed responsive behaviours, as discussed under Regulation 7: Managing behaviour that is challenging and Regulation 8: Protection.
- The oversight of hand hygiene, disposal of clinical waste and the appropriate use of personal protective equipment (PPE) required a review to ensure that all residents are safeguarded from cross-infection as discussed under Regulation 27: Infection control.
- The completion of the infection control audits required a review as the hand hygiene and infection prevention and control practices observed on the day of the inspection did not correspond with the findings of the centre's own audits, which scored 100% compliance.
- The oversight of fire evacuation practices and storage required a review. The provider was required to address an immediate risk that was identified on the day of the inspection. The manner in which the provider responded to the risk did provide assurance that the risk was adequately addressed. This is discussed under regulation 28: Fire precautions.

Judgment: Not compliant

Regulation 34: Complaints procedure

The centre had a robust complaints policy and procedure in place. The person in charge was the nominated person with responsibility to investigate and manage complaints. The provider representative provided oversight of the complaints procedure and ensured the required records were maintained. A summary of the complaints procedure was displayed in the centre and was included in the statement of purpose.

Residents could tell the inspector who they would talk to if they had a concern or complaint.

There was one open complaint since the last inspection, and the provider had responded to the complaint in line with their policies and procedures.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents living in the centre were satisfied with their care, and they spoke highly of the staff who cared for them. Residents had good access to health care services, including general practitioners, dietitians, speech and language and tissue viability services. However, improvements were required in relation to infection prevention and control, fire precautions, managing behaviour that is challenging and protection in order to come into full compliance with the regulations.

The documentation of residents' care plans had improved since the last inspection. A review of the assessment and care plans found that each resident had an up-to-date and person-centred care plan in place that was based on the individuals assessed needs and preferences. Wound care plans were of a high standard and clearly detailed the treatment plans in place.

Staff described how residents received a good level of ongoing support from visiting general practitioners (GPs) and social and health care professionals.

There were a number of peer-to-peer incidents, which occurred since the last inspection. Although each one was responded to in an appropriate manner and specific safety measures were put in place, the recurrence of similar incidents did not provide assurances that all residents were safeguarded from residents who displayed these signs of responsive behaviours (how persons with dementia or other conditions may communicate or express their physical discomfort or discomfort with their social or physical environment) or mental health care needs.

The provider did not act as a pension agent for any residents living in this centre. Safe procedures were in place to manage and safeguard residents' petty cash and valuables, which documented and recorded the signatures of two staff members to

ensure an accurate trace and record of all incoming lodgements and outgoing withdrawals.

The provider was required to make improvements to ensure that infection prevention and control procedures were consistent with the National Standards for Infection Prevention and Control in community settings.

The centre was provided with fire-fighting equipment and a fire detection and alarm system. Fire training, including drills was carried out regularly, and staff were aware of the procedures to take in the event of a fire emergency. There was inappropriate storage of large equipment along the corridors and at stairwells. This is addressed under Regulation 28: Fire precautions.

Opportunities to participate in recreational activities in line with residents' choice and ability were provided. The programme of activities included music, garden walks, exercises, art, poetry, magic table interactive games and outings in the local community. Residents had access to local television, radio, newspapers and the internet.

Regulation 10: Communication difficulties

The inspector saw that residents, who required assistance with their communication needs, were supported by staff, and appropriate tools such as picture cards were readily available in the communal day rooms, if required. Assessments and referrals, where required, had been completed. Residents with hearing difficulties were supported with the care of their hearing devices.

Judgment: Compliant

Regulation 27: Infection control

The provider generally met the requirements of Regulation 27; Infection control and the National Standards for infection prevention and control in community services (2018). The inspector acknowledges that the provider added a number of extra hand sanitisers in the building; however, further action is required to be fully compliant, such as:

- The oversight and supervision of staff performing hand hygiene in between residents' care and the appropriate use of PPE. The inspector observed that staff did not sanitise their hands when going from one resident's room to another. The inspector observed a staff member wearing gloves along the corridor, following providing care to a resident in their bedroom, and then entering a room of another resident.

- There were a limited number of clinical hand-washing sinks available to staff in between residents' bedrooms.
- The disposal of clinical waste in communal toilet/shower rooms required review, as the risk of cross-contamination to residents using these rooms or residents with cognitive impairment.
- Incontinence wear was stored in boxes in communal toilet/shower rooms, which also increased the risk of cross contamination.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The inspector observed that two large comfort chairs, wheelchairs, and hoists were stored along some corridors in the centre. Additionally, a laundry trolley was also stored at the top of a stairwell in the main house. These arrangements posed a significant risk that a timely and safe evacuation in the event of a fire emergency would not be possible, with this equipment impeding and potentially blocking fire escape routes.

In addition, the inspector observed equipment inappropriately stored underneath the stairwell at reception and stairwell five. Such as a bed frame, three large comfort chairs, a hoist containing a battery, wheelchairs and boxes with supplies for activities. In the event of a fire this equipment can combust and accelerate a fire and potentially block these escape routes. An immediate action was issued to the provider and this equipment was removed on the day of inspection.

Judgment: Not compliant

Regulation 5: Individual assessment and care plan

A comprehensive, person-centred assessment was completed for each resident which identified their physical, social, psychological and emotional needs. This assessment informed the development of the resident's care plan, which addressed the assessed needs of the resident with particular focus on individual preferences.

Residents who displayed signs of responsive or challenging behaviours had specific care plans in place to identify triggers and guide staff in de-escalating these episodes.

Where there was a safeguarding concern regarding a resident, care plans were in place to ensure staff were aware of the care required for the resident.

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

There had been a number of peer-to-peer incidents in this centre, involving residents who experienced challenging behaviours. While the staff responded to these incidents in an appropriate manner, appropriate preventative measures were not in place to reduce the frequency and number of these incidents and to alleviate the impact of these responsive behaviours on other residents' quality of life, including their right to a safe and peaceful enjoyment of their living environment.

Judgment: Substantially compliant

Regulation 8: Protection

Staff had received training in safeguarding of vulnerable persons, but 12 staff required a refresher training.

Not all residents were safeguarded from residents who expressed behavioural issues or mental health needs, as there had been seven peer-to-peer incidents involving eight residents which related to physical and emotional incidents.

Judgment: Substantially compliant

Regulation 9: Residents' rights

The rights of residents were upheld. There were opportunities for recreation and activities. Residents were encouraged to participate in activities in accordance with their interests and capacities. Residents were viewed participating in activities as outlined in the activity programme displayed in each unit. Residents with dementia were supported by staff to join in group activities in smaller groups or individual activities relevant to their interests and abilities.

Residents had a choice in how and where they spent their day. There was a choice offered at mealtimes, and residents were consulted regarding their preferences.

Monthly residents' meetings were held to gain feedback from residents regarding the care and service provider. The provider had also been proactive and engaged an independent listening person to hold regular meetings with residents to discuss a range of topics.

Residents had access to independent advocacy services if required.
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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication difficulties	Compliant
Regulation 27: Infection control	Substantially compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and care plan	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ballinamore House Nursing Home OSV-0000317

Inspection ID: MON-0043615

Date of inspection: 12/09/2025

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 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. All staff are now up to date with adult safeguarding and refresher training. The training matrix has been reviewed and will continue to be monitored monthly to prevent a reoccurence of this oversight. 2. Safeguarding will remain on the agenda at all goverance and staff meetings and the safeguarding officer has added the training matrix to her monthly audits to reinforce its importance. 3. Daily walk arounds by the CNM/ADON and DON are in place to address IPC Practices 4. Weekly IPC audits will be commenced until management are of the view that the situation is fully addressed 5. All staff are receiving refresher input on safeguarding and other training areas, and this is reiterated at all change over meetings. 6. The regulations were in place in the Nurses' Room in a filing cabinet, however, these have been made more visible with signage indicating their location both on the staff notice board and in the relevant area of the Nurses' Room	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Safeguarding All Staff are now up to date with adult safeguarding and refresher training. The training matrix has been reviewed and will continue to be monitored monthly to prevent a	

reoccurence of this oversight. The Safeguarding Officer completes monthly audits and within those audits she address staff about there Knowledge around safeguarding. This will continue
Daily walk arounds are completed by the CNM/ADON and DON to address IPC Practices
We respectfully note concerns raised around safeguarding. Since September 2024 seven NF06 peer-to-peer incidents have been reported. Each incident was fully addressed and notified promptly in line with regulations –

The responsiveness to all our incidents in our view demonstrates a strong safeguarding culture within the centre; incidents are acted on immediately, specialist supports are sought, and notifications are submitted transparently. We acknowledge that twelve staff were overdue refresher safeguarding training, this was an oversight, and they all have now completed their training.

IPC/Clinical Waste

Daily walk arounds by the CNM/ADON and DON are in place to address IPC Practice.
Weekly IPC audits will be completed until management are of the view that the situation is fully addressed.
All staff are receiving refresher IPC in-house training, and aspects of this training are reiterated at all change over meetings.
The Inspector raised concerns about clinical waste disposed of in bathroom bins. In practice, these bins which contain no infectious waste are emptied up to 7 times a day, and staff would remove any soiled items immediately from the bathrooms after incontience wear changing.
All clinical waste that is produced in the building is put into the clinical waste bin in the Nurses' Room and this is removed to the clinical waste bin outside.
The bathroom bins are all low bins and a neutral colour and residents do not interfere with the bins, however, we appreciate there is no guarantee that residents will never interfere with the bins. Therefore, we have tried to source bins with a locking mechanism, however, such cannot be sourced and we have now introduced the system that morning staff on top of the cleaners ensure all bins are emptied into a black bag in their area as they go through their routine and this is disposed off the floor immediately.
Fire
Immediate action has been taken in the building to clear the areas mentioned in the report around storage. Appropriate signage has been put in place to ensure staff are fully aware that such areas are to be kept clear. The linen trollies have also been relocated during the day.
Our fire consultant has been informed of the report finding and he is due to visit the centre and complete an audit on 29/10/2025.

Regulation 27: Infection control	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Infection control:

Hand Hygiene /and use of PPE
We acknowledge what the inspector viewed on the day and we have addressed this as below:
• All staff have been reminded about hand hygiene and apporiate use of PPE and inhouse refresher courses have been commenced in resepct of both areas.
• The bi-monthly hand hygiene audits will continue and this is also tied into the weekly IPC audit until management are of the view that this issue is addressed.
Clinical Handwashing Sinks
At present there is three clinical handwashing sinks in the building. There is plumbing in place for two more clinical handwashing sink and these are due to be fitted in January.
Disposal of Clinical waste
The Inspector raised concerns about clinical waste disposed of in bathroom bins. In practice, these bins which contain no infectious waste are emptied up to 7 times a day, and staff would remove any soiled items immediately from the bathrooms after incontience wear changing.
All clinical waste that is produced in the building is put into the clinical waste bin in the Nurses' Room and this is removed to the clinical waste bin outside.
The bathroom bins are all low bins and a neutral colour and residents do not interfere with the bins, however, we appreciate there is no guarantee that residents will never interfere with the bins. Therefore, we have tried to source bins with a locking mechanism, however, such cannot be sourced and we have now introduced the system that morning staff on top of the cleaners ensure all bins are emptied into a black bag in theie area as they go through their routine and this is disposed off the floor immediately.
Incontinence Wear stored in Bathrooms
Incontinence wear is stored in two bathrooms in the centre out of 15 bathrooms.
This incontinence wear is kept here in lidded storage boxes to ensure residents incontience needs are addressed in a timely fashion. It is important that staff have easy access to such.
Residents also have a supply of incontience wear in their rooms, however this supply in the bathrooms is to ensure that residents are not left waiting for incontience wear to be changed. This situation has been risk assessed and the conclusion of this risk assessment was that the risks associated with incontinence wear in two bathrooms outweighs the risk of residents being left for periods awaiting incontinence wear to be retrieved from their bedroom.

Regulation 28: Fire precautions	Not Compliant

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

Immediate action has been taken in the building to clear the areas mentioned in the report around storage. Appropriate signage has been put in place to ensure staff are fully aware that such areas are to be kept clear. The linen trollies have also been located during the day.
Our fire consultant has been informed of the report finding and he is due to visit the centre and complete an audit on 29/10/2025.

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:

We respectfully note concerns raised around safeguarding. Since September 2024 seven NF06 peer-to-peer incidents have been reported. Each incident was fully addressed and notified promptly in line with regulations
The responsiveness to all of these incidents in our view demonstrates a strong safeguarding culture within the centre; incidents are acted on immediately, specialist supports are sought, and notifications are submitted transparently. We acknowledge that twelve staff were overdue refresher safeguarding training, this was an oversight, and they all have now completed their training.

All Residents with responsive behaviour have a Responsive Behaviour Care Plan in place and this is reviewed monthly as part of the safeguarding audit.

The centre does everything within its power to prevent responsive behaviour by using the PINCH ME tool and assessing trigger factors, however, it is difficult to predict these behaviours, such incident can only be pre-empted to prevent further escalation of any situation. It is the ethos of the centre to ensure everybody has a safe and peaceful living environment and that all of residents' rights are considered and respected.

Going forward, the centre will of course consider the impact of any new residents to our home and how their behaviour may unsettle residents who already live here.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

We respectfully note concerns raised around safeguarding. Since September 2024 seven NF06 peer-to-peer incidents have been reported. Each incident was fully addressed and notified promptly in line with regulations

The responsiveness to all of these incidents in our view demonstrates a strong safeguarding culture within the centre; incidents are acted on immediately, specialist supports are sought, and notifications are submitted transparently. We acknowledge that twelve staff were overdue refresher safeguarding training, this was an oversight, and they all have now completed their training.

All Residents with responsive behaviour have a Responsive Behaviour Care Plan in place and this is reviewed monthly as part of the safeguarding audit.

The centre does everything within its power to prevent responsive behaviour by using the PINCH ME tool and assessing trigger factors, however, it is difficult to predict these behaviours, such incident can only be pre-empted to prevent further escalation of any situation. It is the ethos of the centre to ensure everybody has a safe and peaceful living environment and that all of residents' rights are considered and respected.

Going forward, the centre will of course consider the impact of any new residents to our home and how their behaviour may unsettle residents who already live here.

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)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	20/09/2025
Regulation 16(1)(c)	The person in charge shall ensure that staff are informed of the Act and any regulations made under it.	Not Compliant	Orange	15/09/2025
Regulation 16(2)(a)	The person in charge shall ensure that copies of the Act and any regulations made under it are available to staff.	Not Compliant	Orange	15/09/2025
Regulation 16(2)(b)	The person in charge shall ensure that copies of any relevant standards set and published by the Authority under section 8 of the Act and approved by the Minister under section 10 of	Not Compliant	Orange	15/09/2025

	the Act are available to staff.			
Regulation 16(2)(c)	The person in charge shall ensure that copies of relevant guidance published from time to time by Government or statutory agencies in relation to designated centres for older people are available to staff.	Not Compliant	Orange	15/09/2025
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	07/12/2025
Regulation 27(a)	The registered provider shall ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff.	Substantially Compliant	Yellow	07/12/2025
Regulation 28(1)(c)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	07/12/2025

Regulation 28(1)(c)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	07/12/2025
Regulation 28(2)(i)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	07/12/2025
Regulation 7(2)	Where a resident behaves in a manner that is challenging or poses a risk to the resident concerned or to other persons, the person in charge shall manage and respond to that behaviour, in so far as possible, in a manner that is not restrictive.	Substantially Compliant	Yellow	12/09/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Substantially Compliant	Yellow	12/09/2025
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	12/09/2025