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: | Ballinderry Nursing Home |
| Name of provider: | Ballinderry Nursing Home Limited |
| Address of centre: | Ballinderry, Kilconnell, Ballinasloe, Galway |
| Type of inspection: | Unannounced |
| Date of inspection: | 07 April 2026 |
| Centre ID: | OSV-0000318 |
| Fieldwork ID: | MON-0049843 |

## About the designated centre

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

Ballinderry Nursing Home is located in a rural setting, a short drive from the village of Kilconnell and 13 kilometres from the town of Ballinasloe. It is a single storey over basement purpose built premises that is registered to accommodate 44 residents. The centre provides continuing care, convalescent and respite care to residents primarily over 65 years who may have low to maximum care needs. Residents have a choice of areas where they can spend time during the day. There are several sitting rooms, a dining room and outdoor garden space available for use by residents. Bedroom accommodation consists of 14 single and 15 double rooms. The centre aims to provide a quality of life for residents that is appropriate to their care needs and is stimulating and meaningful.

**The following information outlines some additional data on this centre.**

| | |
|---|---|
| Number of residents on the date of inspection: | 39 |

## 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 7 April 2026 | 20:15hrs to 22:50hrs | Sharon Kane | Lead |
| Wednesday 8 April 2026 | 10:00hrs to 18:00hrs | Sharon Kane | Lead |
| Tuesday 7 April 2026 | 20:15hrs to 22:50hrs | Rachel Seoighthe | Support |
| Wednesday 8 April 2026 | 10:00hrs to 18:00hrs | Rachel Seoighthe | Support |

## What residents told us and what inspectors observed

From speaking with residents and from observations made over the course of the inspection, inspectors found that residents were supported to enjoy a good quality of life in the centre. Residents spoken with said they felt safe and well cared for and spoke positively about staff and the care provided. Several residents described staff as "lovely" and said that staff responded promptly to requests for assistance.

This was an unannounced inspection carried out over one evening and one day. On the first evening, inspectors were met by a nurse on duty and, following an introductory meeting, completed a walk-through of the centre. Inspectors observed the overall atmosphere in the centre and spoke with residents and staff. Although the centre was busy, with residents using communal areas and receiving visitors, the atmosphere was calm and relaxed throughout. Two members of the management team attended the centre to facilitate the inspection. The person in charge and members of the management team facilitated the second day of inspection.

Ballinderry Nursing Home is a family-owned, purpose-built nursing home located in Kilconnell, County Galway. The centre is a single-storey building, registered to accommodate 42 residents. There were 39 residents living in the centre on the day of inspection. Overall, the design and layout of the centre were suitable for its stated purpose and met residents' needs. Accommodation comprised of single and twin bedrooms, some of which had en suite facilities. Bedrooms were personalised with residents' photographs and belongings. Communal accommodation included two sitting rooms, a reception area, conservatory, oratory and dining room. There was a sufficient number of toilets and bathrooms available.

During the evening walk-through of the centre, inspectors observed residents being treated with kindness and patience. Staff interactions with residents were respectful, and it was evident that staff were familiar with residents' individual needs and preferences. Inspectors were informed that two nurses and two healthcare assistants were on duty. Care was delivered in a timely manner and residents reported that staff were available when assistance was required. Residents told inspectors they could choose when to retire at night and did not experience delays in receiving care.

On the second day of inspection, the atmosphere remained calm and settled. Residents were observed moving freely throughout the centre, having breakfast in communal areas, or receiving care in their bedrooms. The provider representative facilitated a tour of the premises. Residents were observed participating in activities throughout the day, including attending Mass, playing skittles and receiving hand massage therapy. Residents reported that they enjoyed bingo, quizzes, karaoke and music sessions. Inspectors observed a group singalong attended by residents and visitors during the afternoon. Communal areas were active and appropriately

supervised by staff. Residents described being satisfied with the activity programme, and said that there was sufficient stimulation during the day. Inspectors observed warm and sociable interactions between residents and staff. Residents who remained in their bedrooms were also observed to receive regular staff attention. Members of the management team were visible in the centre and known to residents and staff.

Inspectors identified some fire safety concerns during the walk-through of the premises. Fire doors in the laundry area were held open by wedges, and the magnetic release mechanism on a fire exit door in the designated smoking room failed to release when activated by the fire alarm system. This meant that resident could not exit this door in the event of an emergency.

Several areas of the premises were observed to be in poor condition. Some surfaces and items of equipment were not in a satisfactory state of repair and therefore were not amenable to cleaning. Storage arrangements were not appropriate, as equipment cleaned and ready for resident use was stored in the sluice room. A dedicated external housekeeping room remained non-operational as it did not have a janitorial sink. This was a repeated finding.

The next two sections of the report present the findings in relation to governance and management and how these arrangements impacted on the quality and safety of care delivered to residents.

## Capacity and capability

This was an unannounced inspection carried out to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, as amended. Inspectors also followed up on the provider's compliance plan submitted following an inspection in May 2025, during which non-compliance had been identified in relation to staffing, training and development, governance and management, contracts for the provision of care, records, complaints management, assessment and care planning, premises and fire precautions. Inspectors found that some actions identified in the previous compliance plan had been implemented.

This inspection identified non-compliance under Regulation 23: Governance and Management and Regulation 28: Fire Precautions. Following the inspection, the provider was required to submit an urgent compliance plan to the Office of the Chief Inspector to ensure:

- adequate means of escape from all areas of the centre in the event of fire.
- effective fire safety management systems and fire drills.
- sufficient staffing resources at night, specifically nursing staff levels.

The urgent compliance plan submitted by the provider was accepted by the Chief Inspector.

Ballinderry Nursing Home Limited is the registered provider of this centre. The company comprises of two directors, both involved in the day-to-day operation of the service, one of whom works as a general manager. The person in charge was supported by a clinical nurse manager who deputised in their absence. Staffing resources also included nursing staff, healthcare assistants, housekeeping, catering, activities and maintenance personnel.

Although staffing levels were appropriate on the days of inspection, inspectors found that staffing resources were not consistently sufficient to ensure safe and effective care delivery. A review of staffing rosters identified that, on several nights each week there was only one nurse on duty to deliver nursing care, monitor up to 42 residents and to supervised and support a team of healthcare assistants. This staffing arrangement did not provide adequate assurance that resident safety could be maintained in the event of an emergency or adverse incident and did not support adequate supervision of care assistants or newly qualified nursing staff.

- Management systems were in place to monitor the quality of care; however, inspectors found that these systems were not sufficiently effective. For example:
- Fire safety checks completed weekly had not identified risks associated with the safe evacuation of residents from the designated smoking room.
- Records management systems were not robust, with resident records observed to be stored unsecured in the communal areas.
- Incident management systems were ineffective, as four potential safeguarding incidents had not been managed in line with national safeguarding guidelines or the centres own policy.
- Audit systems were not sufficiently robust. Although care plan audits had been completed, and some quality improvement plans were developed, records reviewed demonstrated that some actions were incomplete. The environmental auditing system was not fully effective. A daily clinical and environmental walkabout carried out by nursing staff identified issues; however, responsibility for addressing issues found were not always assigned to an individual, leading to unclear accountability and incomplete resolution of identified issues.

Staff had access to mandatory and relevant training and demonstrated knowledge of their roles and responsibilities. Clinical oversight was provided by the person in charge and clinical nurse manager. However, the oversight of clinical documentation and the supervision of night time staff was not consistently appropriate.

Inspectors found that records were not maintained in a safe and accessible manner. Records containing personal resident information were stored in an unsecured communal area, and did not ensure that residents' privacy could be maintained. In addition, some records required under Schedule 3 and 4 were unavailable for review on the day of the inspection.

While arrangements were in place to ensure residents were issued with contracts of care on admission, inspectors found that there had been a delay in completing this process for two residents admitted for short-stay admission. Consequently, the terms of their admission had not been agreed in writing.

A review of complaints records found that some complaints were not recorded, managed or responded to, in line with Regulation 34: Complaints.

A directory of residents was maintained in line with regulatory requirements.

## Regulation 15: Staffing

Notwithstanding the findings under Regulation 23: Governance and managment in relation to the staffing resources available in the centre, on the days of this inspection, there was sufficient staff and skill mix to meet the needs of residents.

Judgment: Compliant

## Regulation 16: Training and staff development

The supervision of staff was not appropriate to ensure the delivery of safe and consistent care to residents. For example:

- Insufficient oversight of nursing documentation, resulting in incomplete care plans that failed to accurately reflect residents' needs
- A review of the staffing rosters indicated that there was inconsistent levels of nurse staffing at night to ensure appropriate supervision of staff.

Judgment: Substantially compliant

## Regulation 19: Directory of residents

The directory of residents contained all the information specified in paragraph 3 of Schedule 3 of the regulations.

Judgment: Compliant

## Regulation 21: Records

The management of records was not in line with the regulatory requirements. For example:

- Records containing resident details were stored unsecured in a communal area, which did not protect residents' privacy or confidentiality.
- Duty rosters reviewed did not accurately reflect the hours worked by staff, and not all staff who worked in the centre were listed on the duty roster, as is required by Schedule 4(9).
- Four safeguarding investigation reports were not available for review as is required by Schedule 3(4)(j)

Judgment: Not compliant

## Regulation 23: Governance and management

The provider did not ensure that there were sufficient resources to ensure effective delivery of care. For example:

- Records showed that there were inadequate nursing staff resources available in the centre. This meant that on some nights there was only one nurse rostered to care for up to 42 residents, to supervise the health care team, and to respond in the event of an adverse incident. This posed a potential risk to the care and wellbeing of residents during night-time hours.

The registered provider was issued with a request for an urgent compliance plan to ensure that there were sufficient resources to ensure the effective delivery of care, specifically in relation to night time nurse staff levels. This plan was submitted following this inspection and accepted by the Chief Inspector.

The management systems in place did not fully ensure that the service provided was effectively monitored. For example:

- The monitoring and oversight of fire safety was not effective and did not ensure the safety of the residents. The centre's fire safety management system did not identify that the means of escape from the designated smoking room were inadequate.
- Record management systems did not ensure that residents' records were stored in a manner that was safe and accessible.
- The system in place to monitor the service delivery was not fully effective. While clinical and environmental audits were completed, associated action plans were not allocated to a member of staff for completion. Audit records did not clearly demonstrate that identified actions had been implemented or reviewed

Judgment: Not compliant

## Regulation 24: Contract for the provision of services

Systems were in place to ensure that residents were provided with a written contract of care on admission. However, inspectors found that there had been a delay in issuing contracts of care to two residents admitted for short-stay periods. As a result, the terms on which these residents would reside in the centre had not been agreed in writing at the time of their admission.

Judgment: Substantially compliant

## Regulation 34: Complaints procedure

A review of the complaint management system found that some complaints were not recorded and managed in line with the centre's own policy, and the requirements of the regulation. For example, records showed that not all complaints or expressions of dissatisfaction with the service had been investigated and therefore, there was no plan in place to address the issues of concern. In addition, inspectors were informed by a resident that they had communicated a complaint to staff in the centre, which had been addressed. This was confirmed by the person in charge, however, the complaint was not recorded.

Judgment: Substantially compliant

## Quality and safety

Overall, inspectors found that residents were supported to enjoy a good quality of life in the centre. Staff interactions with residents were consistently observed to be respectful and kind. However, the management of the care environment, particularly in relation to fire precautions, premises, and infection prevention and control, and assessment and care planning were not aligned with the requirements of the regulations. The failings regarding fire precautions, resulted in the provider being requested to submit an urgent compliance plan by 13 April 2026.

A review of a sample of residents' records found that care planning arrangements were not in line with the requirements of the regulations. Care plans were not consistently updated following changes in residents' condition, hospital admission or completion of nursing assessments. Consequently, care plans did not always provide

current guidance to staff regarding care interventions. Some assessed needs were not supported by corresponding care plans. For example, a resident with complex care needs, presenting with responsive behaviours did not have an individualised care plan to guide staff responses. While staff demonstrated awareness of the resident's needs and daily notes evidenced appropriate care interventions, there was no documented guidance outlining triggers, preventative strategies or de-escalation techniques. This posed a potential risk to the consistency of care delivery.

Fire safety systems were reviewed. While routine fire equipment checks were completed, inspectors found that in certain areas of the centre, the arrangements in place to evacuate residents in the event of a fire emergency was not effective. The emergency exit door from the smoking room was not connected to the fire alarm system and did not automatically open when the alarm sounded. While the provider completed weekly checks of the emergency exit doors, this issue had not been identified, and therefore, no action had been taken to address the risk. Staff demonstrated poor knowledge in relation to the actions to take to evacuate residents from the smoking room in the centre. Fire drills of this area had not been completed. In addition, two fire doors in the laundry area were wedged open and one contained a large hole, posing a potential risk to the effectiveness of the door to contain smoke and fire in the event of an emergency. An external housekeeping room did not contain fire detection. This was a repeated finding.

Although the premises generally met residents' needs, inspectors identified areas that were observed to be in a poor state of repair. Wall and floor surfaces were scuffed and damaged in places and were not amenable to cleaning. Some resident furniture was worn and not maintained. Equipment cleaned and labelled as ready for use was stored in the sluice room, posing a risk of cross-infection. This was a repeated finding.

Infection prevention and control systems were not in line with regulatory requirements. Some equipment and surfaces were not maintained to facilitate effective cleaning. Several foot-operated clinical waste bins were not functioning correctly. The housekeeping room remained incomplete as it did not contain a janitorial sink. This was a repeated finding.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff attended education in safeguarding. Residents reported that they felt safe living in the centre. However, a review of resident records indicated that there were four potential safeguarding incidents that had not been recognised as such, and there was no evidence that preliminary screening investigations were carried out in line with national safeguarding policy and the centre's own safeguarding policy.

A review of resident documentation regarding any admission, absence or discharge of the resident from the centre found records were appropriately managed. Relevant information was provided to the receiving hospital and staff ensured that all relevant clinical information was obtained from a discharging service or hospital. Records of transfer documents were stored electronically.

Residents had access to their General Practitioner (GP), as required. Arrangements were in place for residents to access the expertise of health and social care professionals for assessment and treatment, as required. This included access to the services of dietitian, physiotherapy and tissue viability nurses.

Visitors were observed attending the centre throughout the inspection and visitors spoken with confirmed that visiting arrangements were flexible.

## Regulation 11: Visits

Visiting arrangements were flexible, with visitors being welcomed into the centre throughout the day of the inspection. Residents who spoke with inspectors confirmed that they were visited by their families and friends.

Judgment: Compliant

## Regulation 17: Premises

There were areas of the building that did not meet the requirements under Schedule 6 of the regulations, For example:

- Floor coverings in some resident bedrooms were damaged.
- Floor covering at one final fire exit was worn and not amenable to cleaning.
- Call bells were not accessible in two communal rooms, the chapel and the conservatory.
- Some items of resident furniture such as armchairs were observed to be worn.
- Wall surfaces in some resident bedrooms were scuffed.
- Radiators in en suites and bathroom were rusted.
- Insufficient storage for resident equipment, such as basins available for residents use, were observed to be stored on floors of bedrooms and en-suites.

Judgment: Substantially compliant

## Regulation 25: Temporary absence or discharge of residents

Where a hospital admission was required for any resident, the person in charge ensured that all relevant information about the resident was provided to the

receiving hospital, and that all relevant information was obtained on the resident's return to the centre.

Judgment: Compliant

## Regulation 27: Infection control

The infection prevention and control procedures in place in the centre were not fully in line with the national standards. For example;

- The dedicated house keeping room was not fully operational as it had no running water. This is a repeated finding.
- Clean resident equipment, labelled ready for use, was stored in the centres sluice room, posing a potential risk of cross infection. This is a repeated finding
- A shared bathroom was not visibly clean. There was debris noted underneath the shower wall unit, a bath was visibly unclean and an attached shower hose was rusted.
- Several foot-operated bins, provided for the disposal of continence wear, were not in working order.

Judgment: Not compliant

## Regulation 28: Fire precautions

The provider had not ensured that the means of escape from all areas in the centre were adequate. This was evidence by:

- The fire exit door leading from the designated smoking room to the external area failed to release when the fire alarm was activated. This posed a potential risk to the safety of residents in the event of a fire emergency in the designated smoking room.

Fire safety management and fire drills were not fully effective. This was evidenced by:

- The provider had not ensured that all staff working in the centre were aware of the procedure to be followed in the event of a fire in the designated smoking room. Some staff were not familiar with the operation of the fire exit door leading from the designated smoking room, personal emergency evacuations plans did not included the procedures to be followed in the event of a fire emergency in the designated smoking room, and the centre's own

internal fire safety management system did not identify that the means of escape from the designated smoking room were inadequate.

Poor fire safety practices were observed by the inspectors during the inspection. For example:

- Two fire doors were wedged open in the centres' laundry rooms. This posed a potential risk in relation to the containment of flame and smoke in the event of a fire, as doors would not close automatically.
- Gaps were noted under one fire door in the clean laundry room, and there was a visible hole where a lock had been removed.

An urgent compliance plan was requested by the Chief Inspector to ensure that:

- The means of escape from all areas in the centre were adequate for safe evacuation of residents in the event of a fire.
- Fire safety management and fire drills are effective, and that all persons working at designated centre, are aware of the procedure to be followed in the case of a fire

The Chief Inspector accepted the plan submitted by the provider.

Judgment: Not compliant

## Regulation 5: Individual assessment and care plan

Care plans were not always updated when there was a change in a residents condition. For example;

- A residents skin integrity care plan was not updated following discharge from hospital, where recommendations were made in relation to the management of a pressure related injury.
- A resident's end of life care plan was not updated to reflect recommendations made by an allied health professional.

Judgment: Substantially compliant

## Regulation 6: Health care

Residents had timely access to general practitioners (GP), specialist services and health and social care professionals such as physiotherapy, dietitian and speech and language therapy, as 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 | Substantially compliant |
| Regulation 19: Directory of residents | Compliant |
| Regulation 21: Records | Not compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 24: Contract for the provision of services | Substantially compliant |
| Regulation 34: Complaints procedure | Substantially compliant |
| **Quality and safety** | |
| Regulation 11: Visits | Compliant |
| Regulation 17: Premises | Substantially compliant |
| Regulation 25: Temporary absence or discharge of residents | Compliant |
| Regulation 27: Infection control | Not compliant |
| Regulation 28: Fire precautions | Not compliant |
| Regulation 5: Individual assessment and care plan | Substantially compliant |
| Regulation 6: Health care | Compliant |

# Compliance Plan for Ballinderry Nursing Home OSV-0000318

## Inspection ID: MON-0049843

## Date of inspection: 08/04/2026

**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:<br><br>Care plans will be audited and reviewed as and when a residents condition changes, when recommendations are made from the MDT and on return from hospital to ensure that they accurately reflect the residents current needs and guide their care.<br>Any actions identified from audits will be assigned to a named nurse and monitored by management to ensure timely completion.<br><br>The inconsistent nurse staffing levels at night are being addressed through recruitment of a new staff nurse, who will be garda vetted and orientated by 9th July 2026 in addition to the two newly recruited staff nurses who will ensure adequate oversight on night duty | |
| Regulation 21: Records | Not Compliant |
| Outline how you are going to come into compliance with Regulation 21: Records:<br>We acknowledge the concern raised under Regulation 21 regarding the storage of records in a communal area. Immediate corrective action was taken following the inspection, and all documentation is now securely stored within a locked storage cabinet in line with confidentiality and data protection requirements. Complete 08/06/2026<br><br>We have amended the roster to include all staff members employed at the designated centre. Rosters will be updated to reflect actual hours worked and all staff on duty. | |

A safeguarding screening tool will be included in the pre-assessment of all new residents and ongoing review stages to identify and assess risk.

All safeguarding concerns will be logged, investigated and documented in line with our safeguarding policy.

| | |
|---|---|
| Regulation 23: Governance and management | Not Compliant |

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Night-Time Nursing Arrangements

The provider will ensure when one registered nurse is rostered on night duty, an additional registered nurse will be rostered on call and available to attend the centre without delay if such need arises.

The PIC will monitor implementation of this contingency plan and put in place an additional rota for an on-call nurse. The PIC will also review handover documentation, incident reports, and medication management records to ensure appropriate oversight of staff on night duty, timely medication administration, and the safe management of any adverse incidents or sudden deterioration in a resident's condition.

To support safe and effective medication administration, the day nurse will complete an additional hour and will work in conjunction with the night nurse to ensure medications are administered safely and within required time frames.

This contingency plan will remain in place until the second registered nurse is recruited to fulfil the requirement of 2 rostered nurses on night duty. Compliant by the 9th of July 2026.

We acknowledge the concern raised under Regulation 23 regarding the storage of records in a communal area. Immediate corrective action was taken following the inspection, and all documentation is now securely stored within a locked storage cabinet in line with confidentiality and data protection requirements.

Ballinderry Nursing Home acknowledges the findings of the inspection and is committed to achieving full compliance in a timely and sustainable manner, while ensuring the safety and wellbeing of all residents

Fire Door – Smoking Area

The issue identified in relation to the smoking area fire door magnet not releasing appropriately has been fully addressed and was fully addressed before the end of the inspection. Upon identification of the fault, a subcontractor attended
the centre immediately and rectified the issue. The fire door is now fully operational and compliant.
Ongoing monitoring of all fire doors has been reinforced as part of routine maintenance and safety checks to ensure continued compliance.

Fire Drill – Smoking Area
Ballinderry acknowledges that a fire drill specific to the smoking area had not been completed. This has now been prioritised.
A schedule of fire drills is currently in progress, which will include scenarios specific to the smoking area. These drills are being conducted across a series of dates to ensure that all staff, including night staff, participate and are made fully aware of policy and procedure in the event of a fire.

All staff will have completed a relevant fire drill, including the smoking area scenario, Records of these drills, including learning outcomes and any actions identified, will be maintained and reviewed by management. (Completed 20th of April 2026)
Going forward, the smoking area will form part of our fire drills. Staff knowledge will be monitored during routine fire drills and during spot checks carried out by management audits.

Regular environmental / clinical audits will continue to be undertaken to monitor the quality, accuracy, Any actions identified through the audit process will be assigned to a named staff member with clear timelines for completion. Ongoing oversight and monitoring will be carried out by management to ensure actions are completed in a timely manner.

| | |
|---|---|
| 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:

The admissions process has been reinforced with the administration and admissions teams to ensure that all contracts, including those for short-stay admissions, are completed promptly and consistently going forward. All residents contracts are now insitu

| | |
|---|---|
| Regulation 34: Complaints procedure | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All complaints, including informal concerns and expressions of dissatisfaction, will be recorded and maintained within the centre's complaints log in line with the centre's complaints policy.

Each complaint will have a documented investigation completed, with clear records maintained regarding the findings, outcome, actions taken, and any learning identified.

Where required, an action plan will be implemented and monitored to completion.
All staff will receive education during induction and ongoing training regarding the management of complaints, including the requirement to appropriately document, escalate, and report all complaints and concerns to ensure they are managed in accordance with the centre's complaints policy and regulatory requirements.

The complaints log will be subject to regular management review and oversight to ensure complaints are managed consistently, appropriately documented, and responded to within the required timeframes.

| | |
|---|---|
| Regulation 17: Premises | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
A comprehensive environmental audit of all resident bedrooms, communal areas, fire exits, bathrooms, and en-suite facilities will be undertaken. Any identified issues, including damaged floor coverings, worn furnishings, scuffed wall surfaces, or rusted radiators, will be repaired, refurbished, or replaced as required to ensure the environment remains safe, comfortable, and well maintained for residents.

The provider will ensure that adequate and appropriate storage facilities are available for resident equipment, including wash basins and other regularly used items, to prevent storage on bedroom or en-suite floors. All resident equipment will be stored in a safe, hygienic, and organised manner that supports effective cleaning and infection prevention and control practices.

Routine maintenance and environmental safety checks will be further strengthened and monitored to ensure the premises are maintained to a consistently high standard and remain safe, clean, and fit for purpose at all times.

| | |
|---|---|
| Regulation 27: Infection control | Not Compliant |

Outline how you are going to come into compliance with Regulation 27: Infection control:
We acknowledge the findings identified under Regulation 27 relating to infection prevention and control arrangements within the centre.
At the time of inspection, the dedicated housekeeping room was not fully operational due to the temporary absence of a running water supply. This issue was addressed immediately following the inspection, and a functioning running water supply is now fully in place.

We also acknowledge that a small number of clean resident care items, including commodes, were stored within the sluice room at the time of inspection. These items were removed immediately and relocated to a designated clean storage area in line with infection prevention and control best practice and environmental hygiene standards.
In addition, foot-operated clinical waste bins have been purchased, replaced, and are now fully in situ throughout the centre to further support effective infection prevention and control practices.

Immediate corrective actions were implemented following inspection, and ongoing monitoring and oversight arrangements have been reinforced to ensure continued compliance with infection prevention and control standards and best practice guidance.

| | |
|---|---|
| Regulation 28: Fire precautions | Not Compliant |

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

Ballinderry Nursing Home acknowledges the findings of the inspection and is committed to achieving full compliance in a timely and sustainable manner, while ensuring the safety and wellbeing of all residents

Fire Door – Smoking Area
The issue identified in relation to the smoking area fire door magnet not releasing appropriately has been fully addressed and was fully addressed before the end of the

inspection. Upon identification of the fault, a subcontractor attended
the centre immediately and rectified the issue. The fire door is now fully operational and compliant.
Ongoing monitoring of all fire doors has been reinforced as part of routine maintenance and safety checks to ensure continued compliance.

A daily inspection of emergency doors is carried out to ensure effective fire safety practices. All staff will be educated on the potential risk in relation to the containment of flame and spoke in the event of a fire and to ensure all doors remain closed at all times.

An audit of all fire doors has been completed and an external subcontractor has been employed to repair fire door that needed urgent attention which has been completed (Visible hole).

Subcontractor will rectify non- compliances regarding basement fire doors . Completed by 27/07/2026.

Fire Drill – Smoking Area
Ballinderry acknowledges that a fire drill specific to the smoking area had not been completed. This has now been prioritised.
A schedule of fire drills is currently in progress, which will include scenarios specific to the smoking area. These drills are being conducted across a series of dates to ensure that all staff, including night staff, participate and are made fully aware of policy and procedure in the event of a fire.

All staff will have completed a relevant fire drill, including the smoking area scenario, Records of these drills, including learning outcomes and any actions identified, will be maintained and reviewed by management. (Completed 20th of April 2026)
Going forward, the smoking area will form part of our fire drills. Staff knowledge will be monitored during routine fire drills and during spot checks carried out by management audits.

| | |
|---|---|
| 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:
Resident care plans will be reviewed and updated following any significant change in a resident's condition and following return from hospital admission, to ensure they accurately reflect the resident's current assessed needs and effectively guide the delivery of care.

Regular audits of care plans will be undertaken to monitor the quality, accuracy, and

completeness of documentation. Any actions identified through the audit process will be assigned to a named nurse with clear timelines for completion. Ongoing oversight and monitoring will be carried out by management to ensure actions are completed in a timely manner and that care documentation remains current, person-centred, and reflective of residents' changing needs.

## 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 | 31/07/2026 |
| Regulation 17(2) | The registered provider shall, having regard to the needs of the residents of a particular designated centre, provide premises which conform to the matters set out in Schedule 6. | Substantially Compliant | Yellow | 30/09/2026 |
| Regulation 21(1) | The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector. | Not Compliant | Orange | 08/06/2026 |
| Regulation 21(6) | Records specified in paragraph (1) shall be kept in such manner as to | Substantially Compliant | Yellow | 08/06/2026 |

| | | | | |
|---|---|---|---|---|
| | be safe and accessible. | | | |
| Regulation 23(1)(a) | The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose. | Not Compliant | Red | 31/07/2026 |
| 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. | Substantially Compliant | Yellow | 09/06/2026 |
| 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 reside in that centre. | Substantially Compliant | Yellow | 09/06/2026 |
| Regulation 27(a) | The registered provider shall | Not Compliant | Orange | 09/06/2026 |

| | | | | |
|---|---|---|---|---|
| | ensure that infection prevention and control procedures consistent with the standards published by the Authority are in place and are implemented by staff. | | | |
| Regulation 28(1)(b) | The registered provider shall provide adequate means of escape, including emergency lighting. | Not Compliant | Red | 13/04/2026 |
| Regulation 28(1)(e) | The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that the persons working at the designated centre and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire. | Not Compliant | Red | 13/04/2026 |
| Regulation 28(2)(i) | The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires. | Substantially Compliant | Yellow | 27/07/2026 |
| Regulation 34(6)(a) | The registered provider shall ensure that all complaints received, the outcomes of any | Substantially Compliant | Yellow | 30/06/2026 |

| | | | | |
|---|---|---|---|---|
| | investigations into complaints, any actions taken on foot of a complaint, any reviews requested and the outcomes of any reviews are fully and properly recorded and that such records are in addition to and distinct from a resident's individual care plan. | | | |
| 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 | 15/07/2026 |