Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	The Court - Kingsriver
Name of provider:	Kingsriver Community Holdings Company Limited by Guarantee
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	16 September 2025
Centre ID:	OSV-0007915
Fieldwork ID:	MON-0048287

About the designated centre

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

The Court - Kingsriver is a designated centre operated by Kingsriver Community Holdings CLG. The designated centre provides a community residential service for up to seven adults with a disability. The centre comprises of three houses within a close proximity to each other in an urban area in County Kilkenny. Each house comprises of a sitting room, dining area, kitchen, bathrooms and individual resident bedrooms. The designated centre is staffed by a team leader, social care workers and health care assistants. The staff team are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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 16 September 2025	10:30hrs to 17:45hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted to monitor on-going compliance with the regulations with a specific focus on safeguarding. This inspection was carried out by one inspector over one day.

The centre supported seven residents across three houses. This was the first inspection of the centre in its current configuration since the provider applied to vary conditions of registration. In May 2024, the provider added an additional house to the centre and increased the capacity of the centre to seven. At the time of inspection six residents were living in the centre and there was one vacancy.

The inspector had the opportunity to meet with the four of the six residents living in the centre over the course of the inspection. One resident was away visiting family and a second resident was in day services at the time of the inspection. The residents used both verbal and alternative methods of communication, such as vocalisations, facial expressions, behaviours and gestures to communicate their needs. The inspector also met with the team leader and two staff members.

In the morning, the inspector visited the first house which was home to one resident. As noted the resident was away visiting family on the day of the unannounced inspection. The house is a two storey terraced house which consisted of a sitting room, kitchen/dining room, sun room, office, one resident bedroom, prayer room and two guest bedrooms. The inspector was informed that new carpet had been installed and painting had been completed internally. Overall, the premises was clean and decorated in a homely manner.

In the afternoon, the inspector visited the second home which was home to four residents. It was a two storey house in a new estate and consisted of sitting room, kitchen/dining room, utility room, four resident bedrooms and office. The inspector met with three residents as they returned from day services. As noted one resident was attending day services at the time of the inspection. They spoke positively about living in the house and the care and support received. One resident showed the inspector their bedroom which was decorated in line with their tastes. Another resident noted that they planned to visit home that evening. The residents stated that they liked their home. The residents were observed interacting positively with peers, the staff team and management throughout the inspection.

Later in the afternoon, the inspector visited the third house which was home to one resident. It was a two storey house which consisted of a sitting room, kitchen/dining room, resident bedroom, guest room and office. The inspector had a cup of tea with resident and spoke about their day and an appointment they had attended that morning. The resident showed the inspector their home and noted that the house had been painted and energy upgrades including the installation of new windows, doors and insulation. They spoke of their home and how the planned their day. The resident spoke positively about the care and support provided in the house. The

resident highlighted improvements in the level of control of their finances and was working with the provider regarding this.

In summary, based on what the residents communicated with the inspector and what was observed, it was evident that the residents received a good quality of care and support. The residents appeared content and comfortable in their home and the staff team were observed supporting the residents in an appropriate and caring manner. However, there were areas which required some improvement including training and development, risk management and oversight of restrictive practices.

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

Capacity and capability

There was a clearly defined management system in place which ensured the service provided quality safe care and was effectively monitored. On the day of inspection, there were sufficient numbers of staff to support the residents' assessed needs. However, some improvement was required in staff training and development.

There was a clear management structure in place. There was evidence of regular quality assurance audits taking place to ensure the service provided was effectively monitored. These audits included the annual review 2024, provider unannounced six-monthly visits and local audits.

There were appropriate staffing arrangements in place to support the residents' with their assessed needs. Staff training records were reviewed which indicated that the staff team were up-to-date with their training needs. The staff team engaged in formal supervision and some improvement was required to ensure all staff were appropriately supervised.

Regulation 15: Staffing

There was a planned and actual roster maintained in the centre. From a review of the previous two months of rosters, the inspector found that there was an established staff team in place. At the time of the inspection, the designated centre was operating with no vacancies. Annual leave and sick leave was covered by the existing staff team and regular relief staff. This ensured continuity of care and support to the residents.

On the day of the unannounced inspection, the registered provider ensured that there were sufficient staffing levels to meet the assessed needs of the residents.

Across the three houses, the six residents were supported during the day by at least eight staff members in line with their assessed needs. At night, the six residents were supported by two waking night staff and sleepover. The staff team were observed treating and speaking with the residents in a dignified and caring manner throughout the inspection.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of the training records, it was evident that the staff team in the centre had up-to-date training in areas including fire safety, safe administration of medication, manual handing and safeguarding. Overall, this meant the staff team were provided with the required training to ensure they had the necessary skills and knowledge to support and respond to the needs of the residents. At the time of the inspection, some staff were joining the staff team and some training had yet to be completed including deescalation and intervention techniques and safe administration of medication. The provider demonstrated that this training had been scheduled.

There was a supervision system in place and all staff engaged in formal supervision. From a review of a sample of supervision records for three staff members, some improvement was required to ensure supervision meetings were occurring in line with the provider's policy. For example, supervision meetings for one staff member was not in line with the provider's policy.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The registered provider had appointed a full-time, suitably qualified and experienced person in charge to the centre. On the day of the inspection, the person in charge was on leave and suitable cover arrangements were in place. The centre was being managed by a team leader with support from senior management.

The designated centre was being audited as required by the regulations and an annual review of the service had been completed for 2024. There was some evidence of consultation with residents and/or their representatives. The provider had completed six-monthly unannounced provider visits to the centre in August 2024 and December 2024.

The quality assurance audits identified areas of good practice and areas for improvement. Action plans were developed to address the areas identified.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the centre provided person-centred care to the residents. However, the inspector found that improvements were required in areas of risk management and the systems of oversight for one restrictive practice.

The inspector reviewed a sample of the six residents' personal files which contained a comprehensive assessment of the residents' personal, social and health needs. The personal support plans reviewed were found to be up to date and to suitably guide the staff team. The were effective systems in place to ensure residents were safeguarded. However, the risk assessments regarding aspects of care and support for residents required review.

For the most part, restrictive practices were identified, reviewed and plans were in place to reduce or remove restrictive practices as appropriate. However, restricted access to sharps was in place for one resident and had not been identified or reviewed as a restrictive practice. This required review.

Regulation 10: Communication

Residents in this centre used verbal communication while others used alternative methods of communication, such as vocalisations, facial expressions, behaviours and gestures to communicate their needs. Each residents' communication needs were outlined in their personal plans which guided the staff team in communicating with the resident. The staff team spoken with demonstrated an clear understanding of the residents communication methods and were observed communicating appropriately with residents throughout the inspection.

Judgment: Compliant

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs of the residents. The centre comprises of three houses within a close proximity to each other in an urban area in County Kilkenny. The designated centre was decorated in

a homely manner and generally
well-maintained. There was evidence of energy upgrades being completed in one house including new windows, doors and insulation. Also the inspector was informed that new flooring and painting had been completed in two houses. All residents had their own bedrooms which were decorated to reflect their individual tastes.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had systems in place for the assessment, management and ongoing review of risk. The inspector reviewed the risk register and found, for the most part, general and individual risk assessments were in place. The risk assessments reviewed were up-to-date and reflected the control measures in place.

However, some improvement was required in risk management. Some risks present in the centre were not managed in line with the provider's risk management policy. For example, residents that managed their own finances did not have a corresponding risk assessment in place. In addition, an identified concern regarding the use of technology for one resident did not have a risk assessment and required review, to ensure all risks were adequately managed.

On the walk around of the premises the inspector observed three fire doors wedged open which posed a risk in the event of fire and required review. The wedges were removed on the day of inspection.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of the six residents' personal files. Each resident had a comprehensive assessment which identified the residents' health, social and personal needs. This assessment informed the residents' personal plans to guide the staff team in supporting residents' with identified needs and supports. The inspector reviewed a sample of personal care plans in areas including intimate care, communication and behaviour and found that they were up-to-date and reflected the care and support arrangements in place.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and positive behaviour support guidelines were in place as required. Staff had up-to-date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

There were systems in place to identify, manage and review the use of restrictive practices. There were a some restrictive practices in use in the designated centre which had been reviewed appropriately. However, in one house there was restricted access to sharps due to health and safety. This had not been identified as restrictive and required review.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. The inspector reviewed a sample of incidents which demonstrated that incidents were appropriately reviewed, managed and responded to. The residents were observed to appear content and comfortable in their home. The staff team had up to date training in safeguarding vulnerable persons and demonstrated good knowledge of how to identify a concern and the steps to take in the event of a concern.

In addition, there were appropriate systems and protocols in place to manage identified safeguarding concerns. For example, while there was a significant safeguarding concern active in the designated centre, the provider demonstrated that they had taken a number of appropriate actions to manage this concern and to protect the resident.

Judgment: Compliant

Regulation 9: Residents' rights

The residents living in the centre were supported to exercise choice and control over their daily lives. Staff were observed to speak to and interact respectfully with residents. Weekly meetings were held with residents which discussed plans and activities for the upcoming week. The staff team were supported to complete training in human rights.

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 Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (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	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Court - Kingsriver OSV-0007915

Inspection ID: MON-0048287

Date of inspection: 17/09/2025

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 Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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: A training schedule is in place for the remainder of 2025 to ensure all required mandatory training is completed, including for new employees. The 2026 training schedule has also been finalised to ensure all staff, including new starters, complete the required mandatory training. In accordance with the supervision schedule, all staff will receive supervision in 2025 as outlined in the policy.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Financial risk assessments are in place for all residents to ensure financial risks are effectively minimised and managed. All door wedges have been removed from all areas, and management will conduct regular checks to ensure doors are not wedged open in the future.	

Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: Restrictive practice paperwork has been completed for the area identified in the report and will be reviewed in accordance with our policies and procedures.	

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	31/12/2025
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	21/10/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and	Substantially Compliant	Yellow	21/10/2025

	evidence based practice.			