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:	Kilkenny Care Centre
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Newpark Crescent, Newpark, Kilkenny
Type of inspection:	Unannounced
Date of inspection:	19 February 2025
Centre ID:	OSV-0008695
Fieldwork ID:	MON-0045699

About the designated centre

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

Kilkenny Care Centre is a purpose-built facility which can accommodate a maximum of 90 residents. It is a mixed gender facility catering for dependent persons aged 18 years and over, providing long-term residential care, respite, convalescence, dementia and palliative care. Each resident has a pre-admission assessment completed prior to admission and family input is actively encouraged. Our staff work closely with residents and family members to complete Life Stories and develop a person-centred activities programme based on the residents' individual choices and preferences.

Care is provided for people with a range of needs: low, medium, high and maximum dependency. We provide nursing care for a variety of residents, including those suffering from multifunctional illness, and conditions that affect memory and differing levels of dependency. Respite care is provided to facilitate temporary relief for primary caregivers. This service may be provided for varied periods of time, agreed upon by the HSE (where applicable), the caregiver, the person requiring care, and Kilkenny Care Centre. We provide convalescent care for people who, following treatment in hospital are assessed to require a further period recovering or recuperating following surgery, major illnesses and accidents. Palliative care is given to residents who are long term in Kilkenny Care Centre as part of their ongoing care, as required.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	89

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
Wednesday 19 February 2025	09:25hrs to 18:15hrs	Mary Veale	Lead
Wednesday 19 February 2025	09:25hrs to 18:15hrs	Laura Meehan	Support

What residents told us and what inspectors observed

This was an unannounced inspection which took place over one day by two inspectors. Over the course of the inspection, the inspectors spoke with residents, staff and visitors to gain insight into what it was like to live in Kilkenny Care Centre. The inspectors spent time in the centre observing the residents daily life in order to understand the lived experiences of the residents. The inspectors also spent time observing interactions between residents and staff, and reviewed various documentation.

The overall feedback from residents living on the ground and first floor was one of satisfaction with the quality of care, staffing levels and activities available in the centre. However, a number of residents living on the second floor voiced their dissatisfaction with staffing levels, the portion size of the food served and their lived experience. Residents with whom the inspectors spoke with on the second floor all raised concerns regarding a number of residents with cognitive impairment who walked with purpose, and had previously entered into their bedrooms uninvited, had tried to take their belongings and occasionally, had been aggressive towards them. Residents said they were afraid of these residents and this was having a negative impact on their safety and well-being. This is discussed further in this report.

Kilkenny Care Centre is a modern three story designated centre registered to provided care for 90 residents in Kilkenny city. The centre was registered as a designated centre in December 2023. Over the past 13 months, the centre had increased the number of residents accommodated. The centre was almost at full occupancy, with one vacant bedroom on the day of inspection.

The design and layout of the premises met the individual and communal needs of the residents. The building was well-lit, warm and adequately ventilated throughout. Residents had unrestricted access to all floors via a passenger lift. Corridors were spaciously wide to accommodate residents using mobility aids such as wheelchairs and walking aids. There were assistive handrails in all corridor areas. Residents had access to a dining room, day room and visitors room on each floor. The environment was modern, clean and tastefully decorated.

Residents were accommodated in 90 single rooms all with en-suite wash hand basin, toilet and shower facilities. Resident's bedrooms were observed to be clean and tidy. Many bedrooms were personalised and decorated in accordance with resident's wishes. Lockable storage space was available for all residents and personal storage space comprised of a locker, set of drawers and double wardrobes. There was a call-bell in all bedrooms and en-suite bathrooms. Inspectors observed a call-bell out of reach for a resident living on the second floor. This was brought to the attention of a staff member and the call-bell was placed in an accessible location for the resident.

Residents had access to an enclosed courtyard garden from the ground floor of the building. The courtyard had level paving and comfortable seating. The centres designated smoking area was in this courtyard.

The inspectors observed the residents' lunchtime meal. Inspectors noted that the dining experience on the ground floor and first floor differed from that found on the second floor. The dining experience on both the ground and first floors were a social and unhurried occasion for residents who were observed sitting in small groups chatting and interacting with one another. In comparison to the second floor, where 19 residents were seen to be facilitated in the dining room for their lunch time meal. Nine residents ate their lunch in their bedrooms, some residents said it was their preference but some stated that they did not wish to eat their meals in the dining room as they were nervous of the behaviour of one resident. The meal time experience was quiet and the residents were not rushed. Staff were observed to be respectful and discreetly assisted the residents during the meal times. There was a choice of two options available for all meals. The dinner time meal appeared wholesome and appetising. Further improvements were required to the dining experience and the times meals were served on the second floor. This is discussed further under Regulation 9: residents rights and Regulation 18: food and nutrition.

Activities were observed taking place in the large dining and sitting rooms on the ground floor on the day of inspection, facilitated by activities staff. Activities observed by inspectors include bingo and card games. The inspectors spoke with some residents on the second floor who reported that they felt the activities on offer didn't always meet their cognitive ability and that they found them lacking in stimulation. These residents reported feeling the days sometimes long living in the centre as a result of this. The inspectors observed residents reading newspapers, watching television, listening to the radio, and engaging in conversation. Books, games and magazines were available to residents. Residents confirmed that they had access to internet services in the centre. Improvements were required to residents rights, this is discussed further under Regulation 9.

Visitors were observed attending the centre throughout the day of inspection. The inspectors spoke with four family members who were visiting. Visitors told the inspectors that they had safety concerns for their relative, and spent most days with their loved one in their bedroom, up to late in the evening, to protect their loved ones from other residents who would enter their rooms uninvited.

The inspectors observed residents interacting with staff, and attending activities. Residents were observed engaging in a positive manner with staff and fellow residents throughout the day and it was evident that residents had good relationships with staff. Many residents had build up friendships with each other and were observed sitting together and engaging in conversations with each other. There were many occasions throughout the day in which the inspectors observed laughter and exchanges between staff and residents. The inspectors observed staff treating residents with dignity during interactions. Residents' said that staff were kind to them and that they trusted staff.

The registered provider had contracted the laundry service for residents clothing to a private service. All residents' whom the inspectors spoke with on the day of inspection were happy with the laundry service. However, one resident told the inspectors that their bed sheets felt very rough on their skin.

The next two sections of this report will present findings in relation to governance and management in the centre, and how this impacts on the quality and safety of the service being delivered.

Capacity and capability

There were governance and management systems in place to oversee the operation of the centre. However, not all residents living on the second floor were protected from abuse at all times. While most residents told the inspectors that they were content living in the centre, inspectors identified areas which were not fully compliant with the regulations in areas such as; staffing, training, the maintenance of records as well as the effective governance and management of the centre.

This was an unannounced inspection carried out to monitor compliance with the regulations and standards and to follow up all statutory notifications received by the Chief Inspector of Social Services since the previous inspection.

Mowlam Healthcare Services Unlimited Company is the registered provider for Kilkenny Care Centre. The company is part of the Mowlam Healthcare group, which has a number of nursing homes nationally. The company had three directors, two of whom are engaged in the day-to-day oversight of the service. The person in charge who was the director of nursing, was on leave at the time of inspection. In the absence of the person in charge, the assistant director of nursing was overseeing the day-to-day management of the centre. The assistant director of nursing was supported by a clinical nurse manager, a catering manager, a team of nurses and healthcare assistants, activities co-ordinators, housekeeping, catering, administration and maintenance staff. The centre was supported by a healthcare manager, and had access to facilities available within the Mowlam Healthcare group, for example, human resources. There had been a high turnover of staff in the centre in 2024, with ongoing recruitment efforts in place. However, the staffing deficits were observed by inspectors to have a negative impact on the ability of the provider to ensure the needs of the residents were being met particularly those living on the second floor. This is discussed further in this report under Regulation 15: staffing.

There was an ongoing schedule of training in the centre. An extensive suite of mandatory training was available to all staff in areas such as safeguarding, fire safety, manual handling, and infection prevention and control. Staff with whom the inspectors spoke with, were knowledgeable regarding safeguarding procedures. The inspectors were informed that restrictive practice training was scheduled to take place in the weeks following the inspection. However; inspectors observed that not all staff were up to date with their training and that some staff were not

appropriately supervised. This is discussed further in this report under Regulation16: training and staff development.

Management systems in place to monitor the centre's quality and safety, in particular relating to the management of safeguarding residents, staffing, audit processes, the clarity of staff roles and records of staff meetings were insufficient to assure the registered provider that the service provided was in line with the regulations. This is discussed further in this report under Regulation 23: Governance and management. The inspectors viewed records of clinical governance meetings and staff meetings which had taken place since the previous inspection. Audits of infection prevention and control, care planning, falls management, restrictive practice, medication management and call bell response time audits had been under taken since the previous inspection. The person in charge compiled regular reports on key clinical data such as falls, incidents, complaints and antimicrobial usage, which were reviewed with the management team monthly. The annual review for 2023 was available during the inspection. It set out the improvements completed in 2023 and improvement plans for 2024. The annual review of the quality and safety of care to residents in 2024 was under review.

Staff records, as set out in Schedule 2 of the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), were available to the inspectors. Not all staff files contained full employment histories. This will be addressed under Regulation 21: Records.

A sample of resident's contract for the provision of services were viewed. However, not all contracts contained the required information set out in the regulations, this is discussed further under Regulation 24: Contract of service provision.

Incidents and reports as set out in schedule 4 of the regulations were notified to the Chief Inspector of Social Services within the required timeframes. The inspectors followed up on incidents that were notified since the previous inspection and found these were managed in accordance with the centre's policies.

The inspectors reviewed the records of complaints raised by residents and relatives and found they were appropriately managed. Residents who spoke with the inspectors were aware of how to make a complaint and to whom a complaint could be made. Nonetheless, inspectors observed this information to be incorrect and is discussed under Regulation 34: complaints procedure.

Regulation 15: Staffing

The provider did not ensure that there were sufficient staffing levels in the centre to meet the needs of the residents, for the size and layout of the centre. For example;

- A review of the staffing rosters against the staffing resources outlined in the statement of purpose found that there was a vacant clinical nurse manger

post, a vacant chef post, a vacant housekeeping supervisor and half an activities coordinator post.
- The number of staff allocated to the second floor was not appropriate to meet the residents safety needs. From discussion and conversations with residents and relatives current staffing and supervision was inadequate to ensure staff could respond to incidents in a timely and safely manner.

Judgment: Substantially compliant

Regulation 16: Training and staff development

A review of the staff training records found that some staff had not received training required for their role. For example:

- 9 staff had not completed training in managing behaviour that is challenging.
- 8 staff had not completed training in infection prevention and control.
- Following a safeguarding incident a commitment had been given by the provider that all staff would have completed communication training on the 22 January 2025. From the records observed on inspection 9 staff had attended communication training in January 2025 and 5 staff had attended communication training in June 2024.
- Following a safeguarding incident a commitment had been given by the provider that arrangements had been made for all centre staff to attend restrictive practice training for two dates in January 2025. From a review of the records all staff had not attended restrictive practice training. This is discussed further under Regulation 7: Managing behaviour that is challenging.

The inspectors did not see any evidence to assure the registered provider that appropriate staff supervision arrangements were in place on the second floor. For example:

- Residents on the second floor told the inspectors that there were three staff allocated from 8pm to 8am daily, and that when two health care staff are assisting residents at the same time as the nurse administering medication, the response time to respond to threats of abuse is too slow. Residents on the second floor had experienced instances of physical and verbal abuse by other residents, at these times. Visitors who spoke with the inspectors confirmed that they were required to stay with their loved ones till late at night, to protect their loved ones from such abuse.
- Some residents living on the second floor highlighted dissatisfaction with the management of their continence wear which was as a result of the frequent use of agency staff who were not familiar with their needs.
- There was no appropriate supervision of the provision of meals to residents in the dining room on the second floor.

Inadequate supervision of staffs ability to respond appropriately to and manage behaviour that is challenging was reported to the inspectors as having a negative impact on the lived experience for some residents on the second floor.

Judgment: Not compliant

Regulation 21: Records

The record management system in place did not always ensure that records were maintained in line with the requirements set out in Schedule 2 of the regulations. For example:

- Two staff records did not contain the required up-to-date employment history.

Judgment: Substantially compliant

Regulation 23: Governance and management

The overall governance and management of the centre was not fully effective.

The registered provider did not ensure there was a clearly defined management structure that identified the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision. For example:

- The full-time positions of housekeeping supervisor, clinical nurse manager and chef position and part-time activities position were vacant. The lack of such managerial oversight was seen to impact the dining experience, and the safety and well-being of residents living on the second floor.
- There was a clearly displayed complaints procedure with a named nominated officer to investigate. However, inspectors observed posters in the visitors room on the ground floor and on the door of the dining room on the first floor referring residents and families to contact persons who were not involved in the complaints procedure.

Management systems were not sufficiently robust to ensure the service was safe, appropriate, consistent and effectively monitored. For example:

- There were inadequate systems of oversight in place to monitor and respond to issues of concern found by the inspectors, particularly in relation to safeguarding residents living on the second floor.This is discussed further under Regulations 8: protection.
- The centres audit system and processes required review. For example: Call-bell response waiting times were recorded in an audit completed in December

2024, as almost two minutes for residents living on the second floor. There was no evidence of a call-bell audit review or action plan to reduce call-bell response times.
- There was no record of staff appraisals completed in the centre for 2025. This was a missed opportunity as a staff appraisal could provide feedback to the employee on their performance, identify any areas of improvement, and ensure that the service provided is sufficiently resourced to ensure the effective delivery of care.
- The inspectors observed that 25 staff were on their probationary period of employment. Four of the 25 staff had not completed their probationary period meeting which was over due.
- On the morning of the inspection, a product used to thicken fluids was observed stored in an unsafe manner, this was highlighted to the management team who informed inspectors this would be addressed immediately. However, the same product was observed on a trolley in the dining room in the afternoon.

Systems of communication required review. For example;

- Minutes of staff meetings viewed contained information which were documented in an unprofessional and unclear manner.

Judgment: Not compliant

Regulation 24: Contract for the provision of services

The contract for provision of services did not include details required as set out in the regulations. For example:

- There were three different versions of the contract for the provision of services. This did not ensure that there was a consistent approach to the contract for provision of services.
- One residents contract for provision viewed did not relate to the services provided for that resident. The contract of provision was for respite care but the resident was receiving long term care.
- Some contracts for provision did not contain clear details of additional fees to be charged for services including opt in and opt out charges.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

Incidents and reports as set out in schedule 4 of the regulations were notified to the office of the Chief Inspector within the required time frames. The inspectors followed up on incidents that were notified and found these were managed in accordance with the centre's policies.

Judgment: Compliant

Regulation 34: Complaints procedure

The correct nominated officers information details was not provided to residents in line with the centres complaints procedure and policy. For example:

- Inspectors observed posters in the visitors room on the ground floor and on the door of the dining room on the first floor referring residents and families who had complaints or concerns to persons who were not involved in the complaints procedure.

Judgment: Substantially compliant

Quality and safety

The inspectors found that the provider was, in general, delivering a good standard of nursing care. However, gaps in the oversight of governance and management were impacting on the quality of life and the safety of the residents, particularly those living on the second floor. On this inspection actions were required to comply with managing behaviour that is challenging and protection, as well as areas of care planning, residents rights and food and nutrition.

The inspectors viewed a sample of residents' electronic nursing notes and care plans. There was evidence that residents were comprehensively assessed prior to admission, to ensure the centre could meet their needs. Care plans viewed by inspectors were generally person- centred. However, a review of a sample of care plans found that there were inconsistencies and insufficient details of information recorded to effectively guide and direct the care of these residents. Details of issues identified are set out under Regulation 5.

Since the centre opened bed rail usage had been steadily increasing, with 17 of the 89 residents using restrictive bed rails on the day of inspection. There was a policy in place to inform management of responsive behaviours (how people with dementia or other conditions may communicate or express their physical discomfort with their social or physical environment) and restrictive practices in the centre. Residents' had access to psychiatry of later life. For resident's with identified responsive behaviours, nursing staff had identified the trigger causing the responsive behaviour using a

validated antecedent- behaviour- consequence (ABC) tool. A restrictive practice committee had been established. Risk assessments were completed, a restrictive practice register was maintained, and the use of restrictive practice was reviewed regularly. Less restrictive alternatives to bed rails were in use such as sensor mats and low beds. The front door to the centre was secured with a keypad lock. The intention was to provide a secure environment, and not to restrict movement. However; the management and response to behaviours that are challenging was not always appropriate, this is discussed further under Regulation 7.

A safeguarding policy provided guidance to staff with regard to protecting residents from the risk of abuse. Staff demonstrated an appropriate awareness of the centres' safeguarding policy and procedures, and demonstrated awareness of their responsibility in recognising and responding to allegations of abuse. All interactions by staff with residents were observed to be respectful throughout the inspection. The centre did not act as a pension agent for any of the residents. Notwithstanding these good practices not all residents felt safe or that they were protected from abuse atall times. This is discussed further under Regulation 8: Protection.

The centre was clean and tidy. The overall premises were designed and laid out to meet the needs of the residents. A schedule of maintenance works was ongoing and parts of the centre had been prepared for painting. Alcohol hand gel was available in all communal and bedroom corridors. Most bedrooms were personalised and residents had sufficient space for their belongings. Residents had access to call-bells in their bedrooms, en-suite bathrooms and all communal rooms. Grab rails were available in all corridor areas, toilets and en-suite bathrooms. The premises mostly supported the privacy and comfort of residents.

A choice of meals and snacks were offered to all residents. The dining experience on the ground and first floor was relaxed. A daily menu was available for residents' in the dining rooms. Residents on modified diets received the correct consistency meals and drinks. As previous outlined under Regulation 23: Governance and management the vacant chef and clinical nurse manager positions were impacting on the supervision of meals for residents living on the second floor. The residents dining experience for those living on the second floor was not the same as those on other floors. This is discussed further under Regulation 18: Food and nutrition.

Residents had the opportunity to meet together and discuss relevant issues at resident committee meetings in the centre. Residents had access to an independent advocacy service. Residents has access to daily national newspapers, weekly local newspapers, books, televisions, and radio's. Mass took place in the centre weekly which residents said they enjoyed. Further improvement were required in activities and the residents right to choice which is discussed in this report under Regulation 9: Residents rights.

Regulation 17: Premises

The premises was appropriate to the needs of the residents and promoted their privacy and comfort.

Judgment: Compliant

Regulation 18: Food and nutrition

There were an insufficient number of staff to ensure residents were served their meal appropriately on the second floor. For example;

- During the dining time experience on the second floor. The inspectors observed two residents who required assistance with their meals had their lunch time meals placed on the table in front of them. Staff were not available to assist the residents with their meals for 15 minutes after the meal was left on the table. Staff were asked by the inspectors to reheat the meals so as residents could enjoy the food served at the optimum temperature.
- Systems for the serving of food required action. For example:
    - The inspectors observed a resident sitting on their own, at a table eating their dinner with 11 deserts taking up the table top space.
    - Residents told the inspectors that the food served on the second floor was often of a small portion.
- Condiments were not available on the tables for residents in all dining rooms.

Judgment: Substantially compliant

Regulation 5: Individual assessment and care plan

Action was required in individual assessment and care plans to ensure the needs of each resident are assessed and an appropriate care plan is prepared to meet these needs. For example;

- A resident had additional elimination care needs included in the care plan, however, there was no information as to how those needs could be supported to enable best outcomes for the resident.
- A resident who was a known risk of wandering did not have a care plan in place outlining the interventions in place to manage or prevent their wandering tendencies.
- Disparities were noted in residents care plans for wound management. Inaccurate documentation could lead to the incorrect management of a wound leading to a slower healing process.
- A resident's care plan was found to provide differing guidance for staff with respect to their eating and drinking support needs. There was a risk that the residents could receive the wrong consistency of diet.

- Within care plan documentation there was noted gaps in information completed by staff e.g skin integrity recordings, daily recording sheets.
- A resident's physiotherapy programme had been updated, the corresponding care plan had not been updated to reflect this change, to ensure the programme was completed as required.

Judgment: Not compliant

Regulation 6: Health care

Residents had access to a doctor of their choice. Residents who required specialist medical treatment or other healthcare services, such as mental health services, dietetics and physiotherapy, were supported to access these services. The records reviewed showed evidence of ongoing referral and review by these healthcare services for the residents' benefit.

Some improvements were required to ensure care plans in place reflects the current support needs of resident healthcare support needs as discussed under Regulation 5: Individual assessment and care plan

Judgment: Compliant

Regulation 7: Managing behaviour that is challenging

The person in charge had not ensured that staff had up-to-date knowledge and skills appropriate to their role in responding to and managing challenging behaviour. A review of mandatory training records found that 50 % of staff had not completed training in restrictive practices.

There were poor systems in place for checking the safety and effectiveness of use of restrictive practices such as bed rails. For example: gaps were identified in the safety checks for two residents who had bed rails in place. This was a repeated finding on the previous inspection and is a requirement as per national guidelines.

Judgment: Substantially compliant

Regulation 8: Protection

Based on observations of practice over the inspection and from what the residents told the inspectors. The inspectors were not assured that the registered provider

had taken all reasonable measures to protect residents living on the second floor from abuse, for example:

- Residents who walked with purpose on the second floor, who were a known safeguarding risk to other residents, and had measures documented to mitigate this risk, had not had a review of the safety measures to ensure all residents were safeguarded from abuse. For example: a sensor beam was placed in a residents' room to reduce the residents' risk of abuse, this intervention was not effective and the residents' family said they had to stay with the resident to ensure their safety was maintained.
- Where safeguarding plans had been developed and agreed, measures had not been implemented to ensure all actions were completed within the allocated timeframe, including staff training and awareness.
- The daily handover sheet did not incorporate known safeguarding concerns, to ensure staff were provided with accurate and current information to ensure residents were protected from abuse.
- Conflicting information was provided to inspectors with respect to safeguarding plans. For example, within a resident's care plan it stated the resident was to receive one-to-one supervision, however, the inspectors were informed this was not accurate or implemented.

Judgment: Not compliant

Regulation 9: Residents' rights

A small number of residents were observed seated in the sitting room and their bedrooms on the second floor with limited stimulation for long periods. These residents were not provided with an opportunity to participate in the programme of activities in accordance with their interests and capacities.

Improvements were required to ensure all residents were provided with the opportunity and supports to be consulted about their care. For example, upon review of one residents contract of care a decision was made with respect to the fees to be charged and use of the residents bank account without evidence of consultation with the resident.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 21: Records	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 5: Individual assessment and care plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Managing behaviour that is challenging	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Kilkenny Care Centre OSV-0008695

Inspection ID: MON-0045699

Date of inspection: 19/02/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • The vacant Clinical Nurse Manager (CNM) post has been filled and the new CNM will commence in post on 22/04/25. • There are now 3 Chefs available within the centre which is in line with the Statement of Purpose. • A Housekeeping Supervisor has commenced in post in early April. • The Person in Charge (PIC) has reviewed staffing on the second floor, and this along with the increased level of supervision provided by the appointment of the second CNM will ensure that staff are appropriately deployed and available to respond to incidents in a timely and safe manner.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff have received training on managing responsive behaviours and the management team will observe practice to ensure that there is a consistent approach by staff to all individuals who display responsive behaviours in line with what has been documented in their individualised care plan. • Infection Prevention and Control training programmes have taken place and further training has been scheduled so that all staff will have completed this training by the end of April. • All staff have completed communications training. • All staff will have completed Restrictive Practice training by the end of April. • The appointment of a second CNM will enhance the supervision on the second floor	

and will ensure that staff are deployed appropriately to enable hem to respond to incidents in a timely and safe manner. Staff will ensure that residents who display responsive behaviours are closely monitored and in the event of an escalation in behaviours staff will intervene quickly, in line with the individual resident's care plan to ensure the safety of all residents.
• The use of agency staff has been significantly reduced and all nursing and care staff are aware of the appropriate continence care needs for all residents. The management team will ensure that all staff involved in direct care are aware of any change in the continence care needs and the appropriate incontinence wear for each resident.
• The PIC and management team will closely monitor the care delivery and management of responsive behaviours on the second floor and will remain in regular contact with residents and their family members to ensure that they feel safe and content.
• There will be s Staff Nurse supervising the dining rooms at mealtimes.

Regulation 21: Records	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
• We will ensure that all staff records are maintained in line with Schedule 2 requirements and available for inspection at all times.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
• The PIC is supported by a management team that includes an Assistant Director of Nursing (ADON) and 2 CNMs. There is also a regional Healthcare Manager (HCM) who visits the centre regularly and provides guidance, advice and support to the PIC in the daily operation of the centre. The Director of Care Services is available for advice, guidance and support.
• A Housekeeping Supervisor has commenced in post in early April.
• The vacant CNM position has been filled. This, along with a review of the staffing on the second floor, will enhance supervision and staff will be deployed appropriately to allow them to ensure that care will be delivered effectively so that all residents feel safe and content.
• There are 3 Chefs working in the centre which is in line with the Statement of Purpose.
• The vacant Activities Coordinator position has been filled.
• The Complaints Procedure and easy-read posters displayed around the centre have been updated and include the name of the nominated officer who will address

complaints.
• The management team will provide enhanced supervision and will ensure that all residents are well cared for and that they feel safe and protected. Staff will be appropriately deployed so that they can respond in a timely and safe manner to any incidents and ensure the wellbeing of all residents.
• Monthly call bell audits will be carried out. Where there are delays in responding to call bells identified, these will be investigated, and a quality improvement plan (QIP) will be developed and implemented. These will be reviewed by the management team.
• Staff performance appraisals will be competed by 31/05/2025. There will be an opportunity for staff to discuss how they feel they are performing and for the line manager to provide constructive feedback on overall performance, identify development areas, agree objectives for improvement where required and agree support systems if needed that will assist the staff member to succeed in their role. This will enhance communication between staff and as a consequence the residents will receive a consistently better standard of care.
• All staff probationary meetings have been completed.
• Fluid thickener agent is stored appropriately and safely in the clinical treatment room, and staff are aware that this needs to be stored there when not in use.
• All written communications will be documented clearly, accurately and professionally.

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:
• Resident Contracts of Care have recently been reviewed and they are now documented to facilitate a consistent approach to the contract for provision of services.
• The PIC, supported by the HCM, will review all residents Contracts of Care to ensure that the individual contract for each resident covers the services that are provided with respect to the category of care, whether that is long-term or short-term (respite).
• The PIC will ensure that contracts contain clear details of additional fees to be charged for services, including an opt-in or opt-out clause.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
• The Nominated Officer's details are correctly detailed on the Complaints Procedure in the centre in line with the centre's Complaints policy.

• The Complaints Procedure has been reviewed by the PIC and the updated, accurate version is clearly displayed on each floor of the Centre. • The PIC is available to meet with Residents and their families when requested.

Regulation 18: Food and nutrition	Substantially Compliant

Outline how you are going to come into compliance with Regulation 18: Food and nutrition:

• The PIC, with support from the HCM has reviewed staffing on the second floor, and there are now sufficient staff deployed to meet the care needs of all residents.
• A second CNM has recently been appointed and this will enhance the level of supervision on the second floor and will provide effective supervision.
• A Staff Nurse will be deployed to supervise the dining room at mealtimes. The enhanced supervision on the second floor will facilitate staff to prioritise the needs of residents who require assistance at mealtimes, and staff will ensure that the meals are served at the optimum temperature so that the residents can enjoy their meals.
• The PIC and Catering Manager will ensure that residents can enjoy mealtimes as an enjoyable social and unhurried occasion where their meals are served to them with respect in pleasant surroundings. Desserts will only be served when the residents have finished their main course.
• The Catering Manager will ensure that meals are served in appropriate portion sizes in accordance with the individual resident's preferences and choices.
• The Catering Manager will ensure that condiments are available on each table for residents in the dining rooms.
• A Residents' meeting takes place every quarter. Residents will be encouraged to highlight any concerns relating to mealtimes at these meetings, and these concerns will be brought to the attention of the Catering Manager so that a QIP can be developed and implemented.
• The PIC and management team will observe the mealtime experience and monitor the quality of food served and the residents' experience.
• A dining experience audit was undertaken on 26/03/25 and a QIP was implemented to address deficits observed at the time of the audit. The PIC will review the QIP to ensure that improvements have been sustained.

Regulation 5: Individual assessment and care plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:

• Prior to admission, the PIC will undertake a Pre-Admission Assessment to ensure that the centre is equipped to meet the assessed care needs of the prospective resident.

• Each resident will have a person-centred care plan prepared within 48 hours of admission, which will outline all their care needs, based on the outcomes of comprehensive clinical assessment, including a suite of validated, evidence-based assessment tools. Care plans will be developed in consultation with the resident and/or their designated representative.
• The PIC will ensure that the nursing staff are competent to undertake clinical assessments and develop an appropriate care plan. Where there are development needs identified in the care planning process for nurses, additional training will be provided for the nursing staff to ensure that care plans will be documented that are an accurate reflection of the specific requirements for care of each individual resident.
• At the time of the 4-monthly care plan review, the nurse will assess whether the care needs have changed and will update the care plan accordingly.
• If there are any changes in the resident's care plan, such as an update to the physiotherapy regime, this will be documented in the care plan.
• Care plans will be kept updated as required and out of date care plans will be archived in the electronic care record; this will ensure that the care plan is up to date and provides only the current care requirements to avoid confusion.
• The PIC will ensure that all nurses receive wound management education and that they are competent to classify wounds and develop appropriate wound care plans. The PIC will review the wound management care plans every week. Further advice will be sought from the Tissue Viability Nurse as required.
• A care plan audit is completed three times per annum and a QIP will be developed to address any deficits identified. The PIC will review the findings and monitor the implementation of the QIP to ensure that improvements' in the quality of care documentation are maintained.
• The management team will conduct Reflective Practice meetings individually with nursing staff, and feedback and support is given as necessary.

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:
• The PIC will ensure that all staff receive training on the management of responsive behaviours to enable them to recognise the Behavioural & Psychological Symptoms of Dementia (BPSD), to identify signs of escalations in behaviours, and teach them behavioural de-escalation and distraction techniques. The training will also equip nurses to document person-centred behavioural care plans as required that are individualised and sufficiently detailed to allow staff to adopt a consistent approach to management of escalations in behaviours.
• Restrictive Practice training will be completed for all staff by the end of April.
• The use of restrictive practices has been reviewed in the centre to ensure safety and effectiveness of use.
• The PIC will review residents who display responsive behaviours to determine whether

the interventions to manage their behaviours are effective. If not, it may be appropriate to consult with the resident and the family with a view to consider referring the resident to a designated Memory Care Unit in the local area which may be more suitable to meet the needs from the behavioural perspective.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• The PIC will review the care and management of residents with Behavioural & Psychological Symptoms of Dementia and will ensure that they are appropriately supervised to maintain their own safety and the safety of other residents.
• Staff training and awareness has been implemented. In addition to Safeguarding training, all staff will attend a Safeguarding Workshop with the Healthcare Manager, Quality & Safety. This is a practical session, using real-life scenarios to improve staff awareness and understanding of how to recognise, respond to, report and manage issues that are a safeguarding concern. The Safeguarding Workshop will raise the profile of Protection of Residents from Harm and maximizing safety in the centre. There is also a workshop for the management team so that they understand how to be responsible and accountable for the protection of residents in the centre and for implementing and evaluating the effectiveness of safeguarding QIPs within the appropriate timeframe.
• The ISBAR daily handover sheet now incorporates known safeguarding concerns to ensure staff are provided with accurate and current information to ensure residents are protected from abuse.
• A safety pause takes place on each floor daily and all safeguarding concerns are discussed at the safety pause.
• Nursing and care staff use the STOP and WATCH alert to create an alert for a Resident when a safeguarding concern exists.
• Safeguarding care plans are now reviewed and updated in a timely manner, ensuring all information is relevant, accurate and up to date.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
• The PIC will ensure that residents are consulted about their choices and preferences regarding activities and will make sure that the Activities Coordinator will offer residents opportunities to participate in the activities they enjoy on a regular basis. in accordance with their interests and abilities.
• The Activities Coordinator will develop a schedule of activities for all residents, including one to one, small or large group activities and music sessions. The schedule will be

displayed in the dayroom and each resident will also receive a copy of the weekly activities programme so that they can make an informed choice about which activities they wish to attend.
• Each resident has a person-centered care plan in place. Nursing staff will ensure all consultation with residents is documented appropriately and will record all details of consultation with residents in respect of bank accounts as required.

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 15(1)	The registered provider shall ensure that the number and skill mix of staff is appropriate having regard to the needs of the residents, assessed in accordance with Regulation 5, and the size and layout of the designated centre concerned.	Substantially Compliant	Yellow	30/06/2025
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Not Compliant	Orange	30/04/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	30/04/2025
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food	Substantially Compliant	Yellow	30/04/2025

	and drink which are properly and safely prepared, cooked and served.			
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Substantially Compliant	Yellow	30/04/2025
Regulation 23(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	Orange	31/05/2025
Regulation 23(b)	The registered provider shall ensure that there is a clearly defined management structure that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of care provision.	Not Compliant	Orange	31/05/2025
Regulation 23(c)	The registered provider shall ensure that management systems are in place to ensure that the service	Not Compliant	Orange	31/05/2025

	provided is safe, appropriate, consistent and effectively monitored.			
Regulation 24(2)(b)	The agreement referred to in paragraph (1) shall relate to the care and welfare of the resident in the designated centre concerned and include details of the fees, if any, to be charged for such services.	Substantially Compliant	Yellow	30/04/2025
Regulation 34(1)(a)	The registered provider shall provide an accessible and effective procedure for dealing with complaints, which includes a review process, and shall make each resident aware of the complaints procedure as soon as is practicable after the admission of the resident to the designated centre concerned.	Substantially Compliant	Yellow	30/04/2025
Regulation 5(3)	The person in charge shall prepare a care plan, based on the assessment referred to in paragraph (2), for a resident no later than 48 hours after that resident's admission to the designated centre concerned.	Not Compliant	Orange	30/04/2025

Regulation 7(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to and manage behaviour that is challenging.	Substantially Compliant	Yellow	30/04/2025
Regulation 7(3)	The registered provider shall ensure that, where restraint is used in a designated centre, it is only used in accordance with national policy as published on the website of the Department of Health from time to time.	Substantially Compliant	Yellow	30/04/2025
Regulation 8(1)	The registered provider shall take all reasonable measures to protect residents from abuse.	Not Compliant	Orange	30/04/2025
Regulation 9(2)(a)	The registered provider shall provide for residents facilities for occupation and recreation.	Substantially Compliant	Yellow	30/04/2025