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:	Comeragh Residential Services Kilmacow
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	22 May 2025
Centre ID:	OSV-0005089
Fieldwork ID:	MON-0046739

About the designated centre

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

Comeragh Residential Services Kilmacow is a designated centre operated by Brothers of Charity Services Ireland CLG. It provides a high support residential service for up to seven adults, of both genders with intellectual disabilities. The designated centre is located in a village in Co. Kilkenny located close to local amenities such as post office and shop. The designated centre is a large bungalow which consists of seven individual resident bedrooms, a kitchen, a dining room, a sitting room, a lounge, a sensory room and a laundry room. Staff support is provided by nurses, social care workers and care assistants. The staff team are supported by the person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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
Thursday 22 May 2025	09:00hrs to 17:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was carried out with a specific focus on safeguarding, to ensure that residents felt safe in the centre they were living in and they were empowered to make decisions about their care and support.

Overall, it was found that the centre had made improvements in ensuring residents' safety was considered at all times. It had been well identified by both the provider, and in previous inspections, that the incompatibility of the resident group in the centre resulted in a number of safeguarding incidents. In recent months a number of measures had been taken by the provider to help support residents in line with their specific assessed needs. This was directly reducing the level of safeguarding concerns within the centre. However, ongoing improvement was required in provider-level oversight of care and support, establishing continuity of care and developing care plans that promoted residents' communication skills.

At the time of inspection the centre had capacity to accommodate seven residents. Five residents were living in the centre on the day of inspection. The inspector met with four residents, one resident was in hospital and was not present in the centre.

The centre is a large purpose built bungalow located in a small village in Co. Kilkenny. The centre is located on the grounds of a separate nursing home and community hall. The inspector completed a walk around of the premises with the staff nurse and person in charge. Each resident had their own individual en-suite bedroom. Residents had their own personal items on display such as photographs or personal items that were important to them. In recent months some residents had relocated their bedrooms within the centre. The inspector saw that residents new bedrooms had been decorated to each residents' specific taste. The staff team told the inspector that the change in bedrooms was having a significant positive impact on residents' lived experience within the centre and this had mitigated a number of the risks in relation to safeguarding. Residents also had ample communal spaces including two sitting rooms, a parlour room, a dining room, a kitchen and sensory room. There was a nicely kept garden to the rear of the property. All parts of the home were overall well maintained and very clean.

On arrival the inspector met one resident who had finished their breakfast. The resident had a one-to-one staff available to them who was assisting them to get ready for the day. They had a hospital appointment and the staff member helped the resident change their clothes and do their hair. This resident primarily used non-verbal cues to communicate. They tolerated the inspector speaking with their staff member for a short period of time. The resident did not directly interact with the inspector. The appeared comfortable and content at this time.

Two residents were watching a football match in the sitting room with staff present to help support the residents. One resident reached out their hand to greet the

inspector and the second resident was relaxing on a chair.

Later in the morning the fourth resident got up. It was their will and preference to stay in bed for a lie in each morning. Some recent changing needs in relation to this resident had meant that rest was a very important factor in maintaining their quality of life. The inspector heard the resident chatting with staff and staff offering choices around breakfast options. The staff member was caring and patient in their interactions and sat with the resident having a hot drink with them during this time. The inspector met with the resident and the resident had a brief conversation around a specific interest.

Later in the afternoon all residents took part in a music session. A music therapist came into the centre to facilitate this activity. As it was a very warm sunny day the residents enjoyed this session out in the garden. All four residents took part in this activity. Initially when this activity was introduced to the centre each resident had individual sessions as the group session was not possible due to compatibility of residents. However, over recent weeks this had changed with the supports put in place which enabled all residents to sit together in a group and enjoy the activity. The inspector heard residents laugh and take part in the session with their specific preferred music being played.

All residents in this home required full support with all their care needs. In addition, there were significant changing needs within the group due it aging and relevant health needs. The residents had a number of regular medical appointments across each week. However, residents, if able, were brought out and about in the community to enjoy activities out of the centre. A number of in house activities also occurred such as the aforementioned music therapy and reflexology.

Residents meetings were held every week where issues to do with safety and how to stay safe in the centre formed part of the standing agenda at residents meetings. For example, residents were reminded of the importance of fire safety, how to respond in the event of a fire. Safeguarding was also part of the agenda of this meeting.

The next two sections of the report presents the findings of this inspection in relation to governance and management of this centre and, how the governance and management arrangements impacted on the quality and safety of the service being provided.

Capacity and capability

Overall, the inspector found that there was a clearly defined management structure in the centre which included reporting safeguarding concerns when they arose in the centre. However, some continued improvement was needed in provider level oversight and ensuring continuity of care was promoted at all times.

The centre's management structure had recently been re-configured. This meant that the designated centre now came under a different management structure. Although some members of the management team were new to this designated centre, they were a well established team under the provider's overarching management structure supports. Overall, the staff team expressed they felt well supported in their roles and there was a regular management presence in the centre.

There was a large staff team employed in the centre. However, due to vacancies and staff leave, there was a reliance on the use of agency staff at times which was not in line with best practice around continuity of care. This was self-identified by the provider and plans to recruit staff were ongoing at the time of inspection.

Regulation 15: Staffing

Due to the assessed needs of residents and the level of care and support required there was a large staff team employed in the centre. On the day of inspection there were five staff allocated to work during the day and three waking night staff at night. The provider had committed to providing support to the resident in the hospital setting and a staff member was allocated to support the resident.

The skill mix of the staff comprises of Clinical Nurse Managers (CNM), staff nurses, social care workers and health care assistants. On the day of inspection, information in relation to staff deficits within the centre was unavailable. The day following inspection an email was submitted to the inspector to state that there was a deficit of approximately six whole time equivalent posts. In order to ensure there was sufficient staff a reliance on agency was required in centre.

The inspector reviewed a six week period of rosters that spanned between April and May 2025. Although agency use was variable from week-to-week there was reliance on an agency staff on a daily basis. For example, in two separate weeks in April, 13 agency staff were utilised to cover 26 shifts and on another week eight agency staff covered 20 shifts.

Although some measures had been put in place to minimise the impact of the reliance of agency such as ensuring agency staff completed three shadow shifts and ensuring a permanent employee was rostered with an agency. Further recruitment and stabilisation of the staff team was required to ensure continuity of care was available at all times.

Overall, the rosters were well maintained with the full name of staff and their relevant role represented on the roster. In addition, the provider now identified a shift lead on each shift to ensure the smooth day-to-day management of the centre. This person was clearly highlighted on the roster.

Judgment: Substantially compliant

Regulation 16: Training and staff development

There was a very good level of compliance with mandatory and refresher training maintained in the centre. This was an area of sustained improvement within the centre and was having a positive impact on the care and support being delivered to residents. The Clinical Nurse Manager (CNM1) was delegated the duty of ensuring staff were trained in all relevant areas.

The inspector reviewed the training records for all staff and saw that all staff were up-to-date in training in key areas including safeguarding, hand hygiene and managing behaviour that is challenging.

Additionally, staff were up-to-date in trainings required by residents' specific needs. For example, the majority of staff had received training in dysphagia and catheter care.

Where staff were due refresher training this was highlighted on the training matrix and staff were booked on this training in advance of their existing training expiring.

Staff were in receipt of support and supervision through individual staff supervisions. The provider's policy stated that all staff required one formal supervision per calendar year. For the current centre, the person in charge was striving to complete a minimum of two supervisions per year. The inspector reviewed the records from the most recent individual supervision sessions for three staff. These were found to cover key areas relating to staff member's roles and responsibilities including, for example, staff training and residents' needs. Overall, the records indicated that all staff felt well supported in their role. Staff on the day of inspection, also directly reported this to the inspector.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in the designated centre. All staff reported to the person in charge. The person in charge was supported in their role by the Service Manager and Regional Service Manager. Although some improvements were required across aspects of oversight, overall improvements were noted in this area. This included regular visits by senior management, an improvement in documentation maintenance resulting in more detailed care plans and risk assessments and good oversight of safeguarding processes.

Although there was evidence of oversight at both provider and local level.

Improvements were required in aspects of the provider-level oversight. For example, the six-monthly unannounced audit completed by the provider was not available in the centre on the day of inspection. The inspector was informed that this was completed in January 2025, however a copy of this document had not been furnished to the staff team within the centre. The person in charge was emailed a copy of this on the inspection day. On this document actions were to be completed by February 2025. As the person in charge or staff team did not have access to this, not all actions had been completed as required.

Overall, there were good systems of oversight at local level which included regular Infection Protection and Control (IPC) audits, person in charge audits and trending reports on accidents and incidents. There was regular reviews of safeguarding plans to ensure they were accurate and reflected the current needs of the centre. Regular communication was occurring within the staff team which encompassed staff meetings. Staff meeting occurred across the whole staff team and additionally a staff meeting occurred with the nursing staff to ensure clinical matters were addressed accordingly. The inspector reviewed staff meeting notes that occurred in April 2025 and found that a recent safeguarding incident had been discussed.

The audits and reviews were driving quality improvement within the centre. However, one local level audit required improvements to ensure it were accurately capturing areas of improvement. For example, the health and safety audit did not capture the requirement to check fire containment within the centre. On the day of inspection an issue with fire containment was identified and subsequently addressed. However, the audits and checks in place fail to identify this.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that residents lived in a comfortable home, were their needs were being met. Clear care plans were in place that guided staff to provide care in line with residents' assessed needs. A number of measures had been put in place to address the ongoing incompatibility of residents within the home. This included the reconfiguration of aspects of the centre to ensure sufficient communal spaces were available and assessing residents needs in a comprehensive manner. This was having a positive aspect on the lived experience of the residents.

Although good practices were observed on the day of inspection in relation to supporting residents' communication, there was a lack of written guidance in place to guide staff practice. This documentation was essential to guide staff practice ensure that residents' specific communication needs were met.

Safeguarding practices were in line with best practice and concerns were investigated and reported accordingly. Safeguarding plans were in place and were

proving successful in ensuring that residents were kept as safe as possible.

Regulation 10: Communication

Some good practices around encouraging residents' communication were noted on the day of inspection. For example, during resident meetings, pictures were utilised with resident to help them to contribute to menu planning. Daily activity schedules were in place in the residents' bedrooms. Staff were seen to understand residents' non-verbal cues and respond accordingly. Staff interactions were patient and kind and time and space were afforded to residents to respond to questions.

Although a number of tools were used to assess residents' communication, no care plans or other documentation were developed on foot of these assessments to guide staff practice. For example, on review of two residents' personal plans there was a specific reference in the assessment of need around their communication requirements. Both these residents primarily communicated by using non-verbal means. However, there was no associated care plan or other type of document to guide staff practice in this area. Although this had been identified by the provider, no effective action had been taken to rectify this on the day of inspection. Documentation around residents' communication needs required improvement to ensure staff practice was effectively guided.

Judgment: Substantially compliant

Regulation 17: Premises

The premises were laid out to meet the assessed needs of the residents and were generally kept in a good state of repair, so as to ensure a comfortable and safe living environment for the residents.

Each resident had their own bedroom which were decorated to their individual style and preference. Their rooms provided a safe and private space for them to relax in and spend some time by themselves, when they so wished. The inspector reviewed each residents' bedroom. The residents who had moved bedroom location had been suitably consulted and had input into how the rooms were decorated. For example, one residents bedroom and sitting room was observed to be decorated in brightly coloured tiles.

There was sufficient communal space available to the residents in the centre, which was important for their overall well-being. The majority of residents did not attend a formal day service, the centre provided adequate space for recreational activities, relaxation activities, socialising in a comfortable and safe environment and space to receive visitors in private. It also allowed residents have separate comfortable spaces if they required time and space to regulate or if they required access a low

arousal environment.

As all residents in the home required a low-arousal environment suitable soundproofing had been added to areas at the home. The addition of this measure and relocation of resident bedrooms had ensured the premises was promoting good safeguarding practices.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider's risk management policy contained the information as required by the Regulation. The provider and person in charge were identifying safety issues and putting risk assessments and appropriate control measures in place. Risk assessments considered each individuals needs and the need to promote their safety. From a review of a sample of centre specific risks and individual resident risks, the inspector found the risk assessments to be detailed with considered control measures in place and regularly reviewed.

For example, the inspector reviewed individual risk assessments around choking, behaviours of concern, use of restrictive practices, falls and the risk of insomnia. Control measures were in place to mitigate identified risks as much as possible. On review of one risk assessment around a significant choking risk, it was found that the risk control measures were reviewed and updated following any reported related incidents. Multi-disciplinary team (MDT) review of control measures took place as well as appropriate referrals to health and social care professionals to ensure control measures were in line with assessed needs. In addition, the inspector reviewed risk assessments that were directly related to safeguarding concerns and plans within the centre. The control measures in place aligned with relevant safeguarding plans.

The inspector reviewed the incident logs over the last 12 month period. It was found that suitable arrangements were also in place for identifying, recording, investigating and learning from incidents, and there were systems for responding to emergencies.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The designated centre had a previous history of not operating in a manner that was suitable to meet the assessed needs of residents. As previously mentioned the incompatibility of residents within the centre resulted in frequent safeguarding concerns occurring. However, in the last 11 months the provider had taken a number of effective actions to resolve this. This included a comprehensive

assessment of need occurring for one resident. The inspector reviewed this document and found that the assessment was completed in September 2024 and a number of recommended actions had been taken to ensure the residents needs were sufficiently met. The more robust approach to assessing the resident's specific needs had resulted in a decrease in safeguarding concerns occurring in the centre.

In addition, the inspector reviewed two residents personal plans and found that they also had assessments of needs completed with associated care plans in place. The inspector reviewed care plans in relation to mobility needs, dietary needs, medical needs, night time supports and falls prevention care plans. The plans had all been updated in the latter half of 2024 or in early 2025 which meant the most up-to-date information was available to staff. Care plans in place also aligned with relevant risk assessments and associated control measures. Overall good guidance was in place to help staff deliver care an a safe manner.

There was evidence of regular mufti-disciplinary team (MDT) input into all plans. For example, both residents had a MDT review in April 2024. The inspector reviewed the notes of these meetings and found that they reviewed relevant care needs and actions were in place on to ensure that residents received the best possible care.

Judgment: Compliant

Regulation 8: Protection

The registered provider and person in charge had implemented systems to safeguard residents. For example, there was a clear policy and procedure in place, which clearly directed staff on what to do in the event of a safeguarding concern.

All staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with were knowledgeable about their safeguarding remit.

On the day of the inspection, there were a small number of open safeguarding plans in place. The inspector reviewed two open safeguarding plans and found that suitable actions had been identified to address the relevant safety concerns. Reporting to relevant agencies had occurred. The staff spoken with were familiar with the plans and knew were to locate them if they needed to reference them for information.

In order to promote a positive safeguarding environment for all residents, the provider had outlined protection plans which were detailed around the needs of each individual resident to keep them safe. This further enhanced the safeguarding measures within the centre. The inspector reviewed three protection plans. The details in the plan included the triggers to behaviours of concern, the importance of staff supervision, strategies in place to prevent safeguarding concerns and how to report safeguarding concerns.

Following a review of two residents' care plans, the inspector observed that safeguarding measures were in place to ensure that staff provided personal intimate care to residents who required such assistance in line with residents' personal plans and in a dignified manner. The plans also accounted for individual preferences such as playing soft music or having only one staff member speak if two staff were present to help with a care need.

As part of the inspection process the inspector followed up on the measures in place to safeguard residents' finances. It was found that all residents had suitable systems in place to ensure sufficient oversight and to safeguard that finances effectively. his included residents having a bank account in their own name, regular checks of bank statements against everyday expenditure and audits and reviews of expenditure.

Judgment: Compliant

Regulation 9: Residents' rights

Overall, due to the assessed needs of residents' being met this had a positive impact on residents' rights within the centre. Management and staff were very supportive of residents rights and clearly knew residents very well and cared for them. Staff were observed to be professional, caring and respectful to residents rights throughout this inspection. Staff were heard to give residents' choice around meals and drinks and were respectful around residents' choices

As part of the inspection process the inspector reviewed resident meeting notes which documented how residents were consulted on the day to day running of the designated centre. There was an improvement in this area with a new template devised to guide staff in these meeting to ensure effective communication with residents. It was evident from reviewing meeting notes in April 2025 that residents were consulted and afforded choice in their day-to-day experiences within the centre, such as choosing meals and activities.

There were easy read documentation in place. For example, if restrictive practices were in use there was a picture document in place to discuss the use of these practices with residents. All restrictive practices had been referred and reviewed by the Human Rights Committee.

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	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Comeragh Residential Services Kilmacow OSV-0005089

Inspection ID: MON-0046739

Date of inspection: 22/05/2025

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The registered provider is continuing to engage with the recruitment process for the designated center. A number of interviews have taken place, potential applicants have been identified and are currently being processed for various posts. This will continue until all vacancies are filled.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The registered provider will ensure that all 6 monthly internal audits are completed and the PIC is in receipt of a copy of the completed audit within an identified timeframe to ensure the quality and safety of the designated centre is assured at all times. The actions of the current 6 monthly audit are in the process of being completed. The Health and Safety department have completed a review of the Health and Safety audits and will have an updated version which will include fire containment checks. These will be checked at a local level quarterly until the template has been reviewed and rolled out.	

Regulation 10: Communication	Substantially Compliant
Outline how you are going to come into compliance with Regulation 10: Communication: The person in charge has engaged with the Speech and Language department to ensure there is a review of resident's individual communication passports and support plans have commenced around resident's communication to guide staff.	

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 10(2)	The person in charge shall ensure that staff are aware of any particular or individual communication supports required by each resident as outlined in his or her personal plan.	Substantially Compliant	Yellow	31/12/2025
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	31/12/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in	Substantially Compliant	Yellow	31/12/2025

	place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			