



Report of an inspection of a Designated Centre for Older People.

Issued by the Chief Inspector

Name of designated centre:	Kilcoole Lodge Nursing Home
Name of provider:	Mowlam Healthcare Services Unlimited Company
Address of centre:	Lott Lane, Kilcoole, Wicklow
Type of inspection:	Unannounced
Date of inspection:	19 March 2026
Centre ID:	OSV-0007714
Fieldwork ID:	MON-0049249

About the designated centre

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

Kilcoole Lodge Nursing Home is situated in the village of Kilcoole and is in walking distance of the sea. It is a purpose-built facility which can accommodate a maximum of 89 residents over two floors in 81 single en-suite rooms and 4 twin en-suite rooms. 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. Care for persons with learning, physical and psychological needs can also be met within the unit. Care is provided for people with a range of needs: low, medium, high and maximum dependency. The registered provider is Mowlam Healthcare Services Unlimited. The person in charge of the centre works full time and is supported by a senior management team and a team of healthcare professionals and care and support staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	80
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This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended), and the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 19 March 2026	08:00hrs to 18:00hrs	Sarah Armstrong	Lead
Thursday 19 March 2026	08:00hrs to 18:00hrs	Laurena Guinan	Support

What residents told us and what inspectors observed

Upon arrival, the inspectors commenced a walk around the centre. This afforded inspectors with an opportunity to meet with staff as they were preparing for the day, with the majority of residents still in their beds when inspectors arrived to the centre at 8:00am. An introductory meeting was held after the walk around. The person in charge (PIC) and clinical nurse manager (CNM) attended this meeting where the purpose of the inspection was set out.

Kilcoole Lodge Nursing Home is located in the village of Kilcoole in Co. Wicklow. It is a two-storey purpose built building with residents' bedroom accommodation arranged on both floors of the building. Inspectors found that the centre was appropriately furnished, warm and well-lit throughout.

This was an unannounced inspection carried out by two inspectors of social services over the course of one day, to monitor compliance with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013 (as amended). Inspectors also followed up on the compliance plan received from the previous inspection which was held in July 2025, unsolicited information and statutory notifications submitted by the provider since the last inspection.

During the morning walk around, and throughout the day, call bells were heard to be ringing continuously and were often not being addressed by staff for long periods of time. This created an unrelaxed atmosphere for residents in the centre. Staff and residents told the inspectors that this was an every day occurrence. One resident told inspectors "its always like that. All day, every day. Its very distracting and annoying". Another resident told inspectors "the bells are always going. It's enough to give you a headache".

Inspectors observed all healthcare assistants were allocated the task of delivering breakfast to residents, the vast majority of which were receiving breakfast in their bedrooms. Staff spoken with, told inspectors that care assistants were busy with breakfast duties, and as a result there was nobody assigned to assist with other tasks or deliver personal care to residents during this time. From observations and speaking with staff and residents in the centre, it was evident that a task focused approach was taken when assigning staff duties, rather than a person-centred approach to care. This was contributing to a reduced sense of urgency observed in staff responding to residents call bells throughout the day, despite there being sufficient staff on duty. For example, during the breakfast period, the focus was on distributing the breakfast trays, and this task was prioritised over responding to residents' call bells. Inspectors were required to prompt staff on two occasions to attend to residents who required assistance. For example, one resident's call bell was observed to be ringing for over 5 minutes. During this time, inspectors observed a staff member standing on the corridor adjacent to the residents' room, waiting for other staff to return with breakfast items for another resident. In another example,

during the walk around, inspectors discovered a resident who had experienced a fall from their bed. Despite inspectors sounding the alarm, staff did not respond until the inspectors sought them directly to assist the resident.

Staff told inspectors that they felt there was sufficient staffing levels available to meet the needs of residents in the centre and there appeared to be sufficient staff on duty on the day of inspection. However, inspectors observed that the allocation of staff duties was not sufficient. Additionally, there were gaps in the supervision of staff to ensure that staff were responsive and attentive to residents' needs, and that more focus was applied to a person-centred approach to care in the centre.

From speaking with residents, inspectors learnt that residents were making allowances for the delays in staff responding to their requests. The inspectors spoke with one resident whose call bell was ringing for an extended period of time in the late morning. This resident told the inspector they wanted assistance to get dressed and added, "It's getting a bit late in the day for me to be getting dressed, but I know that whenever they get a chance they'll come to me". Staff spoken with told inspectors how the current breakfast service arrangements were resulting in delays in residents' personal care needs being met.

The inspectors observed the meal time experience for residents for both the breakfast and lunch time meals. There was a practice in the centre where the majority of residents had their breakfasts delivered to their bedrooms, with a small number of residents observed to be eating breakfast in the sitting room. During the breakfast time, the dining room was not available to residents as cleaning was in progress in this area. Some residents expressed that their breakfast was cold and not appetising by the time the breakfast trolley reached them. Staff also expressed concern about the quality of the food at breakfast, particularly hot food items such as toast, which staff said they often refused to give as it would be cold and hard by the time it reached residents. Inspectors observed that residents in their bedrooms were not always assisted to sit in an upright and safe position to allow them to eat their meal. The lunch time experience was a more social occasion where the majority of residents took their meals in the dining rooms. The lunch menu was available to residents. On the day of inspection, residents had the option of soup, followed by a choice of chicken or corn beef with vegetables and potatoes, and for dessert there was a choice of fresh fruit salad, strawberry jelly or profiteroles. Tables in the dining room were nicely set with cutlery, condiments and napkins. There was sufficient staff to assist residents at lunch time, including assisting and supervising residents who wished to take their meals in their bedrooms. Inspectors observed that residents who required modified texture diets received meals in line with their assessed needs.

Inspectors observed that there was a reliance on agency staff in the centre, due to a number of staff vacancies. As a result, staff knowledge of the residents was found to be mixed. This issue was also communicated to inspectors by visitors. One visitor told inspectors that inconsistent staffing was a source of distress for their relative, as they did not understand their needs to the same extent as other staff.

Residents had access to a schedule of activities in the centre. The weekly activity schedule was displayed in prominent locations throughout the centre and residents who spoke with the inspectors were aware of it. On the day of inspection, residents were observed doing jigsaws and puzzles, arts and crafts and enjoying music. One resident told the inspectors that they enjoyed being part of the 'Men's Shed' adding "we'll be busy. We have to rebuild the bar for the garden because it got damaged in the storm". However, inspectors observed times where staff members who were supervising communal spaces were not communicating or engaging with residents, meaning residents were left for periods with no interaction. On these occasions, staff were observed sitting silently, and were only engaging when residents attempted to stand or mobilise independently to encourage them to remain in their seats. This did not demonstrate a rights-based approach to care and did not promote the independence of residents.

Residents had access to religious services. On the day of inspection, there was a Church of Ireland service taking place in the ground floor dining room after lunch. Whilst there was an oratory in the centre, inspectors found that it was not available to residents as it was not appropriately set up to be used for its registered function as it was being used by staff. This is a repeat finding from the previous inspection.

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

Capacity and capability

Kilcoole Lodge Nursing Home had undergone significant changes in management and staffing within the last year, and the inspectors saw evidence that this impacted negatively on the supervision, training and allocation of staff, staff practices, provision of adequate resources for the delivery of care, and the management systems in place to identify and respond to areas for improvement in the centre.

Mowlam Healthcare Services Unlimited was the registered provider of Kilcoole Lodge Nursing Home. There was a person in charge who worked full-time in the centre and they met the criteria as specified in the regulations, however, this was the second appointment to this position since July 2025. The person in charge was supported by the Health Care Manager and the Quality and Control Manager for Mowlam Healthcare Services Unlimited, who were both present on the day of inspection and are onsite a minimum of one day per week each. The Quality and Control Manager is also new to the role since February 2026. An assistant director of nursing and a team of clinical nurse managers also supported with the management of the centre. Staff nurses, healthcare assistants, activities coordinators, household and maintenance staff made up the remainder of the staff team in the centre. Staff spoken with told inspectors that while the person in charge was newly appointed,

they were very present on the floor of the centre and staff said they felt that they could approach the person in charge with any concerns they may have. Considering the short space of time the person in charge was in their role, inspectors found them to have a good knowledge of the individual residents in the centre, and a good awareness of risks and current issues presenting in the service.

On the previous inspection in July 2025, the purpose of some rooms had been changed without correct notification to the Chief Inspector, and the Chief Inspector had not been informed of the change in the person in charge. A cautionary meeting was held with the provider and the correct notification to appoint a new person in charge was received, along with an application to change the use of some rooms in the centre. Assurances were given that the oratory, which had been used as a staff meeting area, would no longer be used as such. However, on the day of the inspection, the room was not suitable for use as an oratory. Two laptops and communication books were on the table, and items belonging to a deceased resident were stored here. A staff training session was also conducted in the oratory during the afternoon. A file storage room was also being used as an office, and was used to store clinical supplies. This was brought to the attention of the person in charge and the management present on the day.

The inspectors reviewed audits in the areas of medication management, infection prevention and control, and call bells which showed poor compliance in these areas, and reflected what was seen on the day by inspectors. Examples of this included the medication room being unlocked, inappropriate use of the clean tagging system for shared equipment, and call bells not being responded to by staff who were in the vicinity. The person in charge was aware of the audit findings and displayed an insight into areas that required attention. Although some of the findings were issues that had been identified prior to the person in charge commencing in their role, some of the audits had been conducted in recent days, and the person in charge committed to addressing these over the course of their management.

The person in charge had identified falls as a significant risk in the centre and had implemented safety pause checklists to be completed at a specified time each day on both floors. The clinical nurse manager on duty took responsibility for this checklist, and it was used to ensure residents whose needs had changed were assessed and reviewed promptly. This had resulted in a significant reduction in falls in the centre within the last month.

Minutes of residents meetings showed that items such as a blind for the ground floor day room and a TV for the ground floor dining room had been requested and approved by the previous person in charge in November 2025. They were again requested in January 2026, but neither had been sourced. The person in charge and management present on the day of inspection were not aware of these requests. Records of governance, staff, and health and safety meetings were reviewed. The most recent staff meeting had been held in August 2025 and was attended by five staff members. The records of other meetings did not show that actions required from the meetings had been addressed. This was brought to the attention of the person in charge who acknowledged that these meetings had not facilitated efficient

two way communication within the centre, and did not show that requests and requirements for efficient delivery of care were attended to in a responsive manner.

The inspectors were told by both staff and residents that there was often a lack of hygiene supplies such as continence wear and gloves. A resident told inspectors that on one occasion, they had been left undressed while staff left to look for correct-sized continence wear, and on the day of the inspection, there was only one continence pad of that size available for the resident in the centre. The inspectors reviewed the store rooms in the centre, and observed that of the small selection of pads in stock, not all sizes used by the residents were available and there was also a shortage of wipes and personal protective equipment including disposable gloves for staff. This was brought to the attention of the management present, and the inspectors were told that additional supplies had not been ordered due to budgeting constraints. An immediate action was required and an order was placed on the day of the inspection for an emergency delivery of hygiene supplies.

The centre had experienced a significant turnover of staff since the last inspection in July 2025. On the day of inspection, there were five staff nurse vacancies and four healthcare assistant vacancies. There was active recruitment to fill the vacancies, with one nurse and three healthcare assistant positions offered to successful applicants. Vacancies were currently being filled by agency staff and there was an effort to book the same agency staff when possible. However, the inspector saw that on the two rosters which covered March 2nd to March 29th, there were thirteen different nurses and thirteen different healthcare assistants booked in the four week period. Five of the nurses and six of the healthcare assistants were booked on each roster. A family member spoken with told the inspector that their relative found it distressing to have different staff caring for them regularly, as they felt the staff did not know their needs and preferences well enough. This was brought to the attention of the person in charge who explained that the previous two weeks had been a particularly challenging period for staffing. They were implementing a rostering system to ensure a minimum level of regular staff were on duty at each shift, and had implemented a daily allocation system to address the number of new or inexperienced members on the staff team. The system aimed to ensure that there was an adequate skill-mix on each floor, and within staff teams. On the allocation list, four agency staff were identified, however the person in charge was only aware of two on duty, and none of these staff were on the agency roster for that day. Additionally, one clinical nurse manager, one nurse and two care staff who were rostered and allocated to work on the units on the day of inspection were rostered to attend training for two and a half hours that afternoon. There were no additional staff rostered to cover their absence on the units. Two staff who were rostered for duty were not on the allocation list, and sick leave was not identified on the current roster.

The inspectors reviewed the training matrix and saw that a number of staff required updated training in areas that included mandatory training and areas identified as requiring improvement through audits, notifications and observations on inspection. This will be discussed under Regulation 16: Training and staff development.

Inspectors spoke with agency staff on the day who said that they had completed an induction to ensure they were familiar with the centre and the residents. However, they were unaware of essential information regarding the needs of the residents under their care, for example, the residents who were at risk of falls or required enhanced supervision. One staff had missed handover and had not received an update, and one staff did not understand some of the abbreviations on their handover sheet which related to residents' mobility needs.

Over the course of the day, the inspectors saw staff practices that did not promote a high standard of care. Call bells were alarming for much of the day, and the inspectors saw instances where staff were standing or working in the vicinity of an alarming bell, but did not respond to it. On one occasion, four staff were serving breakfast outside a room where a call bell had been alarming for ten minutes. When the inspectors enquired if there was a staff assigned to attend to residents during breakfast service, they were told there was not. The staff was then alerted to the alarming call bell by the inspectors and they responded to it.

Staff were seen to stock supplies of toiletries, continence wear and personal protective equipment on a radiator unit on a first floor corridor for quick access during morning care, and staff also reported that because gloves were not readily available on the corridors, they often carried gloves in their pockets which did not promote good infection prevention. When this was reported to management staff, they clarified that there were smaller stock cupboards on each floor, but staff spoken with only appeared to be familiar with the main stock room on the ground floor.

The inspectors reviewed the files of staff members who were undergoing disciplinary procedures and saw that they did not contain the information as set out under Schedule 2 of the regulations. Where disciplinary records were available, there was no evidence to show that the disciplinary procedure had been followed and completed satisfactorily. The inspectors saw areas where residents' information was not kept in a safe and secure manner which impacted on the residents' rights and privacy. Bank statements, residents' contracts and residents' care plans and medical information were seen in different, unlocked areas of the centre, including in the oratory and at nurses stations. Information on residents' nutritional status and preferences, and daily care needs were displayed on bedroom doors. This was brought to the attention of the clinical nurse manager who said that one resident's family had requested that they could have access to a record of the care delivered to the resident, and that dietary needs and preferences were on display so that staff unfamiliar with the residents would not make a mistake.

Regulation 15: Staffing

Although there appeared to be an appropriate number of staff on duty on the day of inspection, the skill mix of staff was not always seen to be appropriate to the needs

of the residents as evidenced by a high number of different staff who were not always familiar with the centre or the residents.

The roster was not in line with the staff on duty on the day of the inspection.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The training matrix available to inspectors showed gaps in training in a number of areas. This was seen in training required by the regulations. For example, 23% of staff were out of date for fire training and 15% of staff were out of date for safeguarding training. In addition, 12% of staff were out of date for manual handling training.

Gaps in training were also observed in areas that required improvement through the centre's own auditing process, notifications received by the Chief Inspector, and observations made on the day by the inspectors. For example:

- 25% of staff were out of date for restrictive practice training.
- 24% of staff were out of date for falls prevention training.
- 12% of staff were out of date for infection prevention and control training.

Staff were not adequately supervised which resulted in practices that did not promote best care. For example:

- Some staff spoken with were not familiar with residents who required enhanced supervision, or were at a high risk of falls.
- One staff spoken with had not received a handover of the residents in their care.
- Restrictive practice procedures were not implemented in line with the centre's own policy.
- Call-bells alarmed for much of the day and often went unanswered for long periods, despite staff being in the vicinity and engaged in non-essential tasks.
- Staff practices which were unsafe and undignified. For example;
 - Staff were seen on a number of occasions not to communicate with residents when assisting them with meals or supervising communal rooms.
 - Residents had meals served on tables which were unsuitable and inaccessible to the resident.
 - Residents having meals in a reclined position.
 - Staff sitting or standing over residents when assisting them with meals, rather than sitting at their level.
 - Staff practices with accessing supplies did not promote a high quality of care or effective infection prevention.

- Residents' personal information was displayed inappropriately and not kept secure.
- Disciplinary procedures were not seen to have been implemented and completed.

Judgment: Not compliant

Regulation 21: Records

The inspectors reviewed four staff files and found that records as required under Schedule 2 of the regulations were incomplete. For example:

- There was no evidence of current professional registration for a member of the nursing staff.
- The records of three staff undergoing disciplinary procedures were not available, and the disciplinary records of a fourth staff member were incomplete.
- Unexplained gaps in employment history were seen in three staff files.
- Two staff members had only one written reference.
- One file had no documentary evidence of the staff members' qualifications.

Residents' records were not seen to be kept in such a manner as to be safe. This was evidenced by:

- Residents' personal information was found in the files rooms, the comms rooms and in an open box in the oratory. All the rooms were unlocked.
- Personal information on residents' dietary needs and care needs were displayed on bedroom doors.
- Residents' files were stored in an unlocked press at a nurses' station.
- A computer at an unmanned nurses' station was unlocked, with residents' care plans and personal information visible and easily accessible.

Judgment: Not compliant

Regulation 23: Governance and management

The designated centre did not have sufficient resources to ensure the effective delivery of care as evidenced by the lack of adequate hygiene supplies.

The registered provider had not ensured that the commitments provided to the Chief Inspector following the last inspection had been implemented in full. For example, the oratory remained unavailable for use by residents and as a result, the registered provider was in breach of condition 1 of their certificate of registration.

This was seen to impact residents on the day of inspection when they were required to use the dining room for religious service.

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

- Actions required following residents' meetings were not seen to have been addressed as of the day of inspection.
- The system to ensure adequate and timely supply of hygiene supplies was ineffective.
- Audits identified areas of improvement that had not been addressed such as staff not responding promptly to call bells, unlocked medication room and staff administering medication to wear a red apron.
- The system to ensure staff were supervised appropriately and supported to adhere to best practice was ineffective. This resulted in staff practices that did not promote safe, person-centred care.
- The systems of communication with staff were not seen to be effective as evidenced by:
 - There was no evidence to show that staff had been informed of the low compliance in audits and areas identified for improvement, with the result being that staff continued with practices that did not promote the delivery high-quality care.
 - There was no schedule of staff meetings which meant that actions from previous meetings were not addressed, and two-way communication was not ensured. The most recent staff meeting had been held in August 2025 and was attended by five staff.
 - Large notices on bedroom doors were used to communicate residents' dietary needs and preferences.

Judgment: Not compliant

Quality and safety

Overall, areas for improvement were identified to ensure that the residents living in Kilcoole Lodge Nursing Home received an equal and consistent high standard of care. For example, in the areas of food and nutrition, access to necessary care supplies and meaningful engagement with staff.

Residents' assessed needs were supported through good access to medical and health care services, including speech and language therapists, dietitians, tissue viability nurses and physiotherapists. Residents' privacy was respected and staff were observed to be knocking on residents' doors and seeking permission before entering their rooms. When staff were observed communicating with residents, these interactions were respectful and polite. However, inspectors observed

occasions where staff supervising residents did not provide any meaningful interaction which did not promote the rights of residents.

A selection of care plans were reviewed by inspectors. Care plans were found to be person centred and contained sufficient, current and accurate information to guide staff in caring for the residents. Residents' needs were assessed using validated assessment tools and the outcome of these assessments informed the care provided to residents. However, as discussed under Regulation 23: Governance and management, the systems in place to ensure stock control of essential supplies were ineffective. This was found to impact on the quality of care received by some residents, and restricted staff in providing care aligned to what was set out in residents' care plans. For example, inspectors found that there was limited availability of the appropriate continence wear for one resident, based on their assessed needs. This resident told inspectors "this is always happening to me" and "when the stock supply runs out, staff have no choice but to use a smaller size" adding "its cuts into me and hurts". Residents also referenced a lack of other personal care supplies including wipes, telling inspectors that staff had sometimes used pillow cases to clean and wash them which residents stated "it happens quite often and it is not good enough".

The centre had outsourced the laundry of clothes, and residents spoken with said that they were happy with the service. There had been delays in receiving clothes back from the laundry provider, and some items had gone missing. The registered provider had liaised with the company to resolve these issues and the service was now regular and reliable. Residents' bedrooms were seen to be furnished with their own belongings, and residents said that their rooms were comfortable and spacious. There was lockable storage available in the bedrooms should residents want to secure valuables.

Residents had access to foods and drinks throughout the day. Meals were served at suitable times and snacks were available and offered to residents outside of the set meal times. Menus were available to residents which outlined the different choices available at each meal. Staff spoken with were familiar with residents nutritional and dietary requirements. There had previously been some gaps identified in meeting residents' assessed dietary needs, to ensure the correct texture of food and fluids was provided. Inspectors found that improvements had been made and a clear system had been established to ensure that recommendations made by healthcare professionals resulting in changes to residents' dietary needs were promptly incorporated into residents' care plans and communicated with staff. All staff, including catering staff, staff nurses and healthcare assistants who spoke with inspectors were familiar with residents' current dietary needs. Catering staff received a daily update from the nursing team advising of all residents' dietary information and residents were observed to receive meals aligned to their assessed needs. However, despite these good practices, the overall mealtime experience for residents was found to be inconsistent. For example, the lunch time meal was a positive and social occasion, with most residents receiving meals in the dining rooms in the presence of sufficient numbers of staff to supervise and assist. However, the breakfast meal was not served to residents in the communal dining spaces and on the first floor, during the breakfast time there was cleaning in progress including

washing of the floor. This meant this space was unavailable to residents at this meal time. A small number of residents were observed eating in sitting rooms, with inappropriate tables and limited encouragement and assistance from staff. The majority of residents were receiving meals from a trolley service to their bedrooms, with meals being delivered cold and of poor standard to some residents. In addition, not all residents who received breakfast in their bedrooms were supported to establish a safe and suitable position to allow them to take their meal, which resulted in unsafe eating practices and in some cases, meals not being eaten.

There was a risk management policy in place in the centre which inspectors reviewed, alongside the register displaying current risks. All identified risks were appropriately documented and control measures had been established and implemented to mitigate the risks.

Where an allegation of abuse had been made, the person in charge had carried out a comprehensive investigation into the incident and identified key learnings which could inform future practice and help mitigate the risk of incidents recurring in future. However, despite this good practice, inspectors found that not all staff were up to date with training in the detection and prevention of, and responses to abuse. This finding is discussed in more detail under Regulation 8: Protection.

Regulation 12: Personal possessions

Residents' clothes were laundered regularly and returned to them. Residents had adequate space for their clothes and personal possessions.

Judgment: Compliant

Regulation 18: Food and nutrition

All residents had access to fresh drinking water, refreshments and snacks throughout the day. Residents had a choice of menu at meal times and adequate quantities of nutritious food. Residents' dietary needs were met. However, residents were not found to be appropriately assisted at all meal times, particularly at breakfast. This was due to a practice in the centre where most residents were delivered breakfast in their rooms. Inspectors observed that residents were not always assisted by staff to be seated in a safe position in order to eat their meal. Some residents told inspectors that the food was often cold when they received it.

Judgment: Substantially compliant

Regulation 26: Risk management

There was a risk management policy in place that included all requirements as set out in the regulations.

Judgment: Compliant

Regulation 5: Individual assessment and care plan

Residents' health and social care needs were assessed on admission to the centre and personalised care plans were developed within 48 hours of admission. All care plans reviewed had been updated within the last four months and there was evidence that residents, and their families where appropriate, were involved in the care planning process. However, despite these good practices, the registered provider had not arranged to meet the assessed needs of each resident. For example, based on one residents' continence assessment and elimination care plan, there was insufficient stock of continence wear available to meet the assessed needs of that resident.

Judgment: Substantially compliant

Regulation 6: Health care

Residents had good access to medical practitioners and other allied healthcare professionals. There was evidence that referrals to these professionals was made in a timely manner for residents and recommendations made by those professionals were accurately incorporated into residents' care plans.

Judgment: Compliant

Regulation 8: Protection

Where allegations of abuse had been made, the person in charge had conducted an investigation into the incident. However, the registered provider had not taken all reasonable measures to protect residents from abuse, as inspectors found that 15% of staff were not up to date with safeguarding training.

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	Not compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 18: Food and nutrition	Substantially compliant
Regulation 26: Risk management	Compliant
Regulation 5: Individual assessment and care plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Kilcoole Lodge Nursing Home OSV-0007714

Inspection ID: MON-0049249

Date of inspection: 19/03/2026

Introduction and instruction

This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2015 and the National Standards for Residential Care Settings for Older People in Ireland.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non-compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant** - A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.
- **Not compliant** - A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 15: Staffing	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <ul style="list-style-type: none"> • The Person in Charge (PIC) will ensure that there are always appropriate staffing levels available to ensure the safe and effective operation of the centre and to ensure that residents' care needs are met. • There is an active recruitment programme under way to fill vacant posts with suitably qualified staff, supported by the Human Resources (HR) Department. The PIC meets with HR each month to review the status of recruitment. • The PIC will complete a risk assessment and add it to the center's Risk Register in relation to the contingency planning for the management of agency staff and the recruitment of staff to fill vacant posts. This contingency plan will focus on the need to always prioritise resident care. • The PIC and Assistant Director of Nursing (ADON) will review any staff shortages to ensure that they identify risks and allocate staff appropriately throughout the centre. • The ADON/Clinical Nurse Manager (CNM) will ensure that duties are delegated appropriately, that staff are appropriately deployed throughout the centre, and will provide support to staff and residents and ensure the skill mix of staff facilitates the provision of person-centred care. • The PIC, supported by the Healthcare Manager will continuously monitor the roster to ensure it is updated to reflect any changes to personnel. • The PIC will liaise with the approved agencies to ensure that wherever possible the same agency staff return regularly as required which will ensure consistency so that agency staff become familiar with the environment, residents and their families and the staff in the centre; and they will understand the workflow. • The PIC will ensure that the ADON and CNMs are available, visible and accessible to staff, residents and families, and that they are closely supervising staff and providing guidance and direction as required to ensure that the standards of care are maintained at a high level 	

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Regulation 16: Training and staff development	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 16: Training and staff development:</p> <ul style="list-style-type: none"> • The Person in Charge (PIC) has completed a comprehensive review of mandatory training requirements. Staff requiring training or refresher updates have been scheduled to attend training programmes. The PIC will ensure that as training is completed the training matrix will be updated accordingly. • The mandatory training of all staff has been further enhanced with the introduction of an online learning platform. This will allow staff to complete some mandatory online training courses, many of which are further supplemented by the provision of on-site tutor-led training. • The PIC will maintain oversight of the training matrix; it will be discussed as part of the monthly management meeting in the Centre. The PIC, ADON and CNM will monitor attendance at training to ensure all staff are compliant with requirements. • The PIC has reviewed the supervision arrangements and roles and responsibilities have been clarified; the ADON and CNM provide supervision hours over seven days each week. The role will include the appropriate delegation of duties, providing support to staff and residents, having oversight of the provision of safe, dignified daily care to residents. The Person in Charge will maintain oversight of the supervision within the Centre. The PIC and management team will ensure that all staff understand the care requirements of the residents in their care. • The ISBAR handover document is used at daily shift hand over and also at mid shift safety pause. In addition to handovers this document includes information on all resident risks including, falls and safety awareness. The information is updated as changes occur, and all clinical staff are provided with a copy. • Agency staff on duty are supported by Centre Staff to complete an induction to the Centre and to the residents. • A restrictive practice Link nurse has been identified and will be supported to drive the initiative within the Centre with guidance from the management team. • The PIC will ensure that call bell audits are regularly conducted, taking into account response time. A Quality Improvement Plan (QIP) will be developed and shared with all staff at daily handover and safety pause meetings. The PIC will monitor the effectiveness of the QIP as part of daily walkabout. • The PIC will ensure that dining rooms are supervised at all meals and that staff have appropriate seating to ensure they can engage meaningfully with residents as they assist them with meals. • The PIC will ensure that all staff are familiar with the Food and Nutrition QIP developed by the Quality team. This QIP includes direction on assisting residents with meals and dining room ambiance. • The PIC will ensure that there are sufficient supplies available so that staff can safely and effectively deliver care to residents while minimizing risk of infection. • The PIC will ensure that all resident records are maintained securely within the centre in line with our policies. As part of the Manager daily walkabout the PIC will monitor 	

compliance with data protection and any breach will be rectified immediately.

- The Person in Charge will review any active Disciplinary procedures and will ensure actions are implemented and completed in a timely manner with support and guidance from HR. The PIC will be supported by the HCM.

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Regulation 21: Records

Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:

- The PIC has completed a comprehensive review of staff files supported by the administration team. Evidence of professional registration is now available for all nursing staff, and all staff files are compliant with Schedule 2 of the regulations.
- The PIC will ensure that a monthly audit of staff files is conducted by the Administration staff, this audit will be verified by the PIC.
- The PIC will ensure that any/all documentation in relation to disciplinary procedures will be fully complete and uploaded to electronic record.
- The PIC will ensure that a current record of all staff nurse pins is available in the centre and certificates verifying qualifications are uploaded to electronic record.
- The PIC will conduct a risk-based assessment and ensure that records are stored safely, appropriately and retained in line with legislative requirements.
- Resident files have been removed from the communications room and the oratory and are now stored in a locked cabinet in a locked room.
- The PIC as part of Manager daily walkabout will monitor use of papers containing resident information and will discuss as part of handover / safety pause meeting.
- Where learning deficits are identified the PIC will schedule training for staff as necessary.
- The PIC / CNM will ensure that all staff are aware that the nurses station must be kept clutter free and computers shut down when not in use.

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Regulation 23: Governance and management

Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

- The PIC has completed a comprehensive review of continence product requirements and hygiene supplies, and we will ensure that appropriate quantities are ordered in a timelier manner and that stocks and supplies are monitored to ensure that there is always plenty of continence products and required clinical equipment available.

- The CNM will monitor use of products to ensure staff are using equipment appropriately and correctly. Where necessary an additional continence assessment will be undertaken to ensure that each resident is assigned the correct number of agreed products, but we will maintain a supply of all sizes in stock in any case.
- Immediately following inspection, the Oratory was reorganised and all inappropriate items were removed. It was deep cleaned and made available for resident use. All staff have been advised that this room is not to be used for any purpose other than residents' quiet space for spiritual reflection and prayer.
- The PIC will monitor compliance as part of Manager daily walkabout.
- The PIC will ensure that all comments, suggestions and feedback from residents' meetings are responded to and the notes of meetings will include responses and updates.
- The PIC will implement a schedule of meetings to be held in the centre and will ensure staff are aware of these and the agendas to be discussed; staff will be encouraged to attend and notes from meetings will be available for all staff as appropriate.
- There is a monthly management team meeting in the centre which reviews all operational aspects of the home, including key performance indicators, risk management, incidents, and complaints. Improvements are discussed and agreed with timebound implementation plans at this meeting.
- In addition, a monthly Governance meeting has commenced and this is chaired by the Healthcare Manager (HCM), Quality & Compliance, and is attended by PIC, ADON, CNMs, HCM, Director of Care Services, Quality and Compliance Co-ordinator (Q&CC), Facilities representative and HR. This meeting covers all areas of compliance as identified through audits, inspections and management meetings, to ensure that there is a on risk identification, assessment and compliance.
- There is a schedule of audits in place, and on completion of audits, timebound corrective action plans are developed to address any deficits identified. The PIC will ensure that action plans are discussed with all staff at staff meetings and daily handover / safety pause meetings.
- There is a CNM rostered in a supernumerary capacity 7 days per week and the ADON is also fully supernumerary. The CNM is supported by the PIC / ADON to ensure that staff supervision is effective, practices are monitored and any deficits to practice will be identified and rectified either with reflective practice meetings or further training, as required.
- The role of the CNM has been clarified and additional oversight and guidance will be provided by the Q&CC assigned to the centre.
- The PIC will ensure that audit results and associated corrective action plans are readily available for all staff at daily handover and monthly management meetings. A copy of the Audit and Quality improvement plan will be available for staff reference.
- The PIC will ensure that regular staff meetings take place and that minutes are maintained and made available to all staff.
- The PIC will ensure that all resident information is maintained in the electronic record system. All notices have been removed from communal areas and bedroom doors. The PIC will continue to monitor compliance as part of daily walkabout.
- The PIC and management team will ensure that staff understand the importance of responding to call bells in a timely manner and regular call bell audits will be conducted to monitor compliance.

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Regulation 18: Food and nutrition	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 18: Food and nutrition:</p> <ul style="list-style-type: none"> • The PIC will ensure that resident wishes are respected with regard to dining preferences. These preferences will be clearly documented in the resident plan of care. • Residents will be encouraged to attend dining room for meals, in particular breakfast where necessary assistance can be provided in a timelier manner so that food is still hot when resident receives it. • A Quality Improvement Plan (QIP) Food & Nutrition will be developed, including the dining experience and the role of nurses and carers in providing assistance and supervision in a respectful manner to residents; the PIC will ensure that all staff are familiar with the Food and Nutrition QIP, this will be discussed at daily handover / safety pause meetings. • The PIC/CNM will monitor the dining experience at all mealtimes; inappropriate practices will be highlighted to staff and corrected as they occur, and this will be discussed at the monthly management meeting. • The PIC/CNM and catering manager will be available at mealtimes to discuss any issues the residents may have with food. All complaints will be logged on the electronic complaints system and actioned in accordance with the centre's complaints procedure. • Food and Nutrition is a standing item at the residents' meetings where residents are encouraged to discuss any changes they would like and any issues they encounter. <p>]</p>	
Regulation 5: Individual assessment and care plan	Substantially Compliant
<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and care plan:</p> <ul style="list-style-type: none"> • The PIC / CNM will ensure that residents' care plans are updated to reflect the assessed care needs of the residents. • The PIC will ensure that the care plan is developed only after a series of assessments are completed, the care plan will then be developed in consultation with the resident / representative. A continence assessment is completed for all residents on admission to the centre. This will guide staff in the completion of an appropriate Elimination Care Plan. • The PIC will ensure that residents' assessments are completed accurately and reviewed / updated as necessary to ensure they reflect the current status of the resident, this information will be shared at handover and safety pause. This will include the accurate and timely assessment of residents' continence needs. 	

- The care plan will focus on what matters to the resident and will incorporate the Age Friendly Health Systems framework, including the 4 Ms (What Matters to Me, Medication, Mentation and Mobility).
- The PIC/CNM will complete a care plan audit monthly and develop a QIP as necessary, the results of which will be shared with nurses and used as an opportunity for learning. The PIC will conduct reflective practice meetings with nursing staff to discuss their performance and identify any development needs.
- The CNM will maintain daily oversight to ensure sufficient continence supplies are available and will monitor ordering to ensure orders are processed in a timely manner to prevent shortages.

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

- The PIC has completed a comprehensive review of the training matrix and all deficits have been rectified. All staff will have received training or refresher updates by 31/05/2026.
- The PIC will review training matrix weekly with support from HCM and it will be discussed as part of the monthly management meeting in the centre.
- As well as the training available on the Online platform, on-site training workshops have been scheduled to deliver further training on safeguarding vulnerable adults from abuse. In addition, a Safeguarding workshop will be facilitated for all staff to attend, hosted by the HCM, Quality & Safety.
- The PIC will review all incidents weekly with the HCM and will ensure that those requiring further investigation are prioritize The HCM, Quality & Safety will conduct staff workshops for Incident Managements and Complaints Awareness. and escalated. Any education developments will be addressed through reflective practice meetings and/or further education as required.

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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	31/07/2026
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training.	Substantially Compliant	Yellow	31/07/2026
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	31/05/2026
Regulation 18(1)(c)(i)	The person in charge shall ensure that each resident is provided with adequate quantities of food	Substantially Compliant	Yellow	31/05/2026

	and drink which are properly and safely prepared, cooked and served.			
Regulation 18(3)	A person in charge shall ensure that an adequate number of staff are available to assist residents at meals and when other refreshments are served.	Substantially Compliant	Yellow	31/05/2026
Regulation 21(1)	The registered provider shall ensure that the records set out in Schedules 2, 3 and 4 are kept in a designated centre and are available for inspection by the Chief Inspector.	Not Compliant	Orange	30/06/2026
Regulation 21(6)	Records specified in paragraph (1) shall be kept in such manner as to be safe and accessible.	Not Compliant	Orange	31/05/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre has sufficient resources to ensure the effective delivery of care in accordance with the statement of purpose.	Not Compliant	Orange	31/05/2026
Regulation 23(1)(d)	The registered provider shall ensure that management systems are in place to ensure	Not Compliant	Orange	30/06/2026

	that the service provided is safe, appropriate, consistent and effectively monitored.			
Regulation 5(1)	The registered provider shall, in so far as is reasonably practical, arrange to meet the needs of each resident when these have been assessed in accordance with paragraph (2).	Substantially Compliant	Yellow	31/05/2026
Regulation 8(2)	The measures referred to in paragraph (1) shall include staff training in relation to the detection and prevention of and responses to abuse.	Substantially Compliant	Yellow	31/07/2026