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:	JULA
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	03 September 2025
Centre ID:	OSV-0005694
Fieldwork ID:	MON-0047392

About the designated centre

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

Jula is a residential home located in Co.Kilkenny, catering for four adults with an intellectual disability over the age of 18 years. The service operates 24 hours, seven days a week. The property is a large bungalow which provides a homely environment for the residents. Each resident's private bedroom is decorated to their unique tastes. The person in charge works in a full time capacity with the support of the management team and the staff team.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Wednesday 3 September 2025	09:20hrs to 17:10hrs	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 and that safeguarding measures were in line with the requirements of the relevant Regulations.

Overall, it was found that residents' care needs were being well met and residents were receiving care in line with their specific assessed needs. Safeguarding incidents were overall well managed within the centre. However, further improvements were needed in ensuring residents' finances were adequately accounted for and kept safe at all times. In addition, improvements were needed on notifying the Office of the Chief Inspector of incidents and ensuring residents views were accounted for in the annual review process.

The centre is registered to provide full-time residential care to four individuals. At the time of inspection four residents were living in the centre. The inspector had the opportunity to meet with the four residents and observe some care and support practices. All residents within the home used non-verbal means to communicate. In addition, the inspector met with a family representative, met with staff and the person in charge and reviewed documentation in relation to the care and support provided to the residents. All residents appeared calm and content on the day of inspection. The family representative indicated they were happy with the care and support being provided and knew how to raise a concern if they needed too.

This centre is a large bungalow in a rural area in Co Kilkenny which has ample space for parking and has a large well-kept garden and patio area. Residents all have their own bedrooms and there is a kitchen-dining room with access to a sun room and large living room. The provider has ensured that the premises is well maintained and laid out to meet the needs of the individuals who live here. There was large spacious hallways and all of the home was bright, clean and homely in presentation.

There was sufficient equipment and adaptations to the premises to ensure it was accessible. This included an accessible garden with hard surfacing, overhead hoists in the bedrooms to assist with moving from one position to another, adapted bathing and personal care equipment and wide hallways. Equipment was stored in an appropriate manner.

In the morning the inspector met with two residents that were up and ready for the day. They were relaxing in the kitchen and sun room. Staff were seen to prepare breakfast and assist the residents with this meal. The staff prepared the meals in line with specific needs around feeding, eating, drinking and swallowing. They staff took time and effort to ensure the meals were presented in a nice way, such arranging trays with nice glass ware and utensils. They were patient and caring during this care need and were aware of residents' non-verbal cues. For example,

one staff identified that the resident had enough of one type of food and offered an alternative.

One resident was in bed and was assisted to get up later in the morning in line with their preferences. They again were seen to be supported in a kind manner. The final resident was out at this time. They had an appointment to get their hair done and returned before lunch.

Across the day of inspection, the inspector observed staff interact with residents, put on music for them, meet all their specific assessed needs and bring them out and about in the community to do shopping and attend appointments.

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. Some improvement was needed in the systems for reporting statutory notifications to the Chief Inspector which is captured under Regulation 23: Governance and management.

There was a core staff team employed and the numbers and skills mix of staff were appropriate to meet the needs of residents. Staff had been provided with appropriate training, in respect of safeguarding. The staff were knowledgeable about the care and support needs of each resident, and of the reporting procedures in place should a safeguarding concern arise in the centre.

Regulation 15: Staffing

The registered provider had ensured that the staff complement and skill mix was appropriate to the number and assessed needs of the residents. For example, nursing care was available to the residents within the designated centre. Residents were also supported by a team of health care assistants and social care workers.

There was 1.5 whole time equivalent vacancies at the time of inspection. To manage this, regular relief staff and some agency staff were utilised to ensure there was sufficient staffing available. In recent weeks there had been a recruitment campaign to ensure a stable relief panel was in place. Two new relief staff had joined the relief staff team and had completed the on-boarding piece with the organisation and were

available to cover shifts as required. This meant the reliance on agency had reduced.

The inspector reviewed six weeks of recent rosters and found that they were well maintained with staff members' full name and role represented on the document.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix in place which detailed the training completed by the staff team within the centre. On the matrix review, the inspector saw that the nine staff members had completed mandatory training in relation to safeguarding, fire safety, safe administration of medicines and managing eating, drinking, feeding and swallowing. This ensured that the staff team had the necessary skills to deliver safe care.

Although the person in charge had only recently commenced in the role, they had ensured they completed formal one-to-one supervision with each staff member. They had a schedule in place for the reminder of the year. The inspector reviewed the notes of four staff members recent supervisions and or probation records. Topics such as safeguarding and residents rights, featured as discussion points during this process.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the registered provider had ensured that the centre had adequate resources, was well managed and had sufficient monitoring systems in place to ensure that the care was in line with residents' care needs. Improvements were needed in the systems around the notifications of incidents within the designated centre.

There was a clearly defined management structure with corresponding lines of authority. The person in charge was in a full-time post and had responsibility of two designated centres operated by the registered provider. They were in post for approximately two months but had been in person in charge roles within the organisation for a number of years. They had very good knowledge of the centre and of the residents' specific needs. They reported directly to the Wellness and Cultural Integration Manager.

The provider had completed their relevant audits as set out by the Regulations. This included completing two six monthly unannounced provider audits and an annual

review. The inspector reviewed each of these documents. It was found that safeguarding was reviewed as part of this process. However, the annual review did not account for residents' views. This is a requirements set out in the Regulations to ensure residents' voice form part of the quality improvement initiatives with the centre. Improvements were required to ensure that this was captured in this process.

The systems in place had failed to ensure that statutory notifications were submitted in line with the requirements of the Regulations. On review of the safeguarding incidents within the centre, the inspector saw that three notifications had not been submitted the Chief Inspector. Improvements were required to ensure that notifications were submitted in a timely manner.

Judgment: Substantially compliant

Quality and safety

Overall, it was found that care was delivered in a caring and safe manner. Residents' lived in a comfortable home and were well supported to access the community and preferred activities. Residents were found to be kept safe in their home. Some improvements were needed to financial safeguards in place to ensure all expenditure was accounted for in a timely manner.

Residents had safe and good practices around risk, personal planning, communication and rights. Their premises was well maintained and had sufficient accessibility equipment available.

Regulation 10: Communication

The inspector reviewed residents' communication plans. All residents within the centre used non-verbal means to communicate. The provider used a communication tool box which highlighted how each resident communicated. Assessments such as Distress Assessment tools were also used to inform this process. This ensured that residents communicative intent around pain could be accurately captured.

The inspector reviewed two residents communication tool box. This document captured how a resident used their facial expressions, gestures, and sounds in a communicative manner.

The inspector observed how staff interacted and communicated with residents across the inspection day. Staff were mindful of residents' means to communicate and accommodated their needs. For example, while providing assistance with feeding staff were observed to take their time and speak with the resident in a kind

and caring manner. They were aware of their non-verbal cues and would offer choice to residents as needed.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises was well laid out and accessible to all residents. It presented as a bright, homely environment with pictures, soft furnishings and decor in place in all areas of the home. The residents' bedrooms were personalised to each residents taste and preference. Overhead hoists, accessible bathrooms and other equipment was in place for the residents as required.

The inspector completed a walk around of all aspects of the home which included the sitting room, kitchen area, sun room, bathrooms and bedrooms. All areas of the home were well maintained and very clean. Residents were supported to access all areas of their home.

Judgment: Compliant

Regulation 26: Risk management procedures

Systems were in place to manage and mitigate risk within the centre and keep the residents safe at all times.

There was a policy on risk management available and each resident had a number of individual risk assessment plans on file, so as to support their overall safety and well being. The inspector reviewed two residents' individual risk assessments. Risks in relation to manual handling, supporting hospital admissions, choking risks, medical risks and risks in relation to self-injurious behaviours were all assessed with control measures in place. Additionally a risk assessment was in place for both residents in relation to safeguarding. Control measures included staff training, supervision and audits, which were found to be in place on the day of inspection.

The inspector reviewed the incident log which was located on National Incident Management System (NIMS). All incidents that occurred within 2025 were reviewed and found to be managed appropriately. Learning was identified following incidents and appropriate measures put in place. For example, following a medication error, more detailed care plans were put in place to mitigate against this risk occurring again in the future.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed two residents individual files which contained their assessment of needs and associated care plans. All residents specific needs had been appropriately assessed through this process. Providing, and accessing healthcare formed an important part of residents' assessed needs. This was very well managed within the centre with detailed care plans in place. For example, the inspector reviewed an epilepsy care plan which detailed a recent hospital admission and the outcome of the same. This ensured that this care plan was detailed and up-to-date with the most accurate information.

The residents' goals were selected during their annual visioning meeting. This meeting reviewed what the resident wanted to achieve for the upcoming year and also detailed all the important, events, incidents, goals and supports provided in the preceding year. As part of this process safeguarding was reviewed. The inspector saw that residents goals included accessing activities within the community and maintaining and continuing family relationships. Monthly tracking of goals occurred whereby the person in charge would go through daily notes and highlight were an activity occurred in line with the residents' chosen goal. This ensured that the residents were accessing meaningful activities on a regular basis.

Judgment: Compliant

Regulation 7: Positive behavioural support

Overall in the centre, residents required minimal support in the area of positive behaviour support. There were minimal restrictions in place in the designated centre. The restrictions that were in place were directly linked to relevant health and mobility needs. There was regular review of the practice to ensure it was a least restrictive approach to care and support.

There was one behaviour support plan in place. The inspector reviewed this document. This had been updated in November 2024 by the Behaviour Support Specialist. There was clear strategies in place to guide staff, including proactive, reactive and post incident strategies. The plan was formulated on a function based methodology to ensure it was in line with evidence based practices.

Although behaviour support needs were low in the centre, the inspector saw how the behaviour support specialist was consulted to ensure specific care needs were met in the best possible way. For example, when a new piece of equipment was introduced to one resident, the behaviour support specialist had created a plan to guide staff on how to introduce the equipment in a successful and positive manner.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented systems to safeguard residents, which were underpinned by a written policy. Staff had also completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. Staff spoken with were aware of the procedure for responding to and reporting safeguarding concerns.

There was one open safeguarding plan at the time of inspection. The inspector reviewed the documentation in place around safeguarding and found that all incidents had been identified, reported to the Safeguarding and Protection Team, and measures had been put in place to mitigate the identified risks. However, not all incidents had been reported to the Chief Inspector. This has been addressed under Regulation 23: Governance and management. In addition, current safeguarding plans were only available on the providers' online system. Staff did not have access to this. Although safeguarding plans had been discussed during team meetings, a robust system was required to ensure safeguarding plans were available at all times.

In addition, the systems for ensuring residents' finances were comprehensively accounted for required further review. The provider had made some improvements in this area however, gaps remained. For example, on review of one residents' finance bank statements were only in place until April 2025. Although the person in charge was able to get access to statements from April 2025 later in the day, they had not been cross referenced with expenditure which was a gap in accounting for residents' finances.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Overall, it was found that residents' rights were strived to be upheld within the centre. The residents who lived in this centre were supported to experience activities as part of the day-to-day running of their home and to be aware of their rights through residents' meetings and discussions with staff.

There was information available in an easy-to-read format on different topics that were important to the resident. For example, the inspector reviewed easy read documentation in relation to a recent safeguarding incident which explained the outcome. This had been read to the resident with the support of staff.

Staff practices were observed to be respectful of residents' privacy. For example, they were observed to knock on doors prior to entering, the staff asked for

permission before delivering care practices and were professional and caring in how they spoke about the residents.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for JULA OSV-0005694

Inspection ID: MON-0047392

Date of inspection: 03/09/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

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

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

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC submitted 3 NFO6s for two people supported retrospectively on 06.09.2025 as discussed at inspection. Safeguarding folder has been updated as of 07.09.25. PSF printed and put in place in person supported folder with signature sheet for the staff team. The PIC has ensured all team members are familiar with same. The PIC will complete On the Job Mentoring with two staff Nurse to ensure further oversight of completion of notifications in the centre, this will be completed by 10.10 2025. In absence of PIC the WCI Manager will keep oversight of notifications. This compliance plan will be discussed at Team Meeting on 06.10.2025 to provide further learning for the team on the feedback and identified areas of improvement. The Director of Services and the QA team will meet on 09.10.2025 to review the providers template for their annual review and six-monthly audits. The provider presently establishes feedback from people supported through feedback form issued to them prior to annual review, however the provider will take the comments in this report into consideration at the upcoming review meeting. An immediate action for the Auditor will be to document within the annual report the observations made while in the designated centre on how people supported and staff interact, this will commence in October 2025.	
Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: QA & Safeguarding have reviewed the daily working folder and have amended the index to include a section for all live safeguarding plans, this will ensure that all plans are available to the team members, this will be actioned across the service by 10.10.2025. Quarterly finance statements for 2025 period to be audited by PIC and cross referenced with receipts. To be completed for all people supported by 04.11.25 The Finance Department will review the Person Supported Personal Property, Finances & Possessions policy by 31.10.2025, taking into considerations the frequency statements are issued.	

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	10/10/2025
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	10/10/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/10/2025