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:	Tús Nua
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:	15 September 2025
Centre ID:	OSV-0005698
Fieldwork ID:	MON-0047829

About the designated centre

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

In this centre a full-time residential service is provided to a maximum of three adults. In its stated objectives the provider strives to enable people to live a good life, with supports and opportunities to become active, valued and inclusive members of their local community.
Residents present with a broad range of needs and the service aims to meet these physical, mobility and sensory requirements. The premises comprises of two houses. Houses are two storey and semi-detached. Both houses are equipped with all facilities that a comfortable modern home would have. Each resident has their own bedroom and two residents share communal, dining and bathroom facilities. The houses are located in a populated suburb of the city and a short commute from all services and amenities.
The centre is operated on a social model of care. The staff team is comprised of social care staff and care assistants. The team work under the guidance and direction of the person in charge. Ordinarily there are four staff on duty each day, three in one house and one in the other house. There are two waking night staff except on occasions when there are only two residents in the house at night, when one waking night staff suffices.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Monday 15 September 2025	09:30hrs to 16:30hrs	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 supported to make decisions about their care and support.

Overall, the inspector found that residents were in receipt of safe and good quality care and support. The residents had the benefit of individualised services which allowed them to have a good level choice and control over their care and support. Some minor improvements were required ensuring the systems in relation to financial safeguards were applied on a consistent basis.

The inspector used observations, conversations with staff , observations of residents care and support, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre.

The centre had capacity to accommodate three residents and there were one vacancy on the day of inspection. The two residents received full-time residential care and support.

On arrival at the centre the inspector was welcomed in by a staff member and brought into the kitchen area. A resident was present eating their breakfast. The resident choose not to engage directly with the inspector but greeted them and continued with their routine. They were seen to tidy away their dishes after breakfast and go into the sitting room to relax and watch their preferred television program. The resident had a busy day planned as they were getting organised to go on a hiking holiday the following day. They had plans to shop for some items for this trip.

The inspector completed a walk around of this part of the centre with the staff member present. The designated centre comprises of two semi-detached adjoining homes. One resident lived in each side of the home. In the first home the resident had access to a kitchen come dining room, a sitting room, a downstairs bathroom, and laundry room. Upstairs there was a main bathroom, the residents bedroom, a staff office and a second sitting room and spare bedroom. The resident also had access to their back garden which had a swing. The home was clean and well presented. The resident in this home preferred a more minimalist approach to decor and this was respected.

In the second home, the resident soley utilised the downstairs area of their home due to their mobility needs. They had their bedroom, bathroom, living and dining room and small kitchen area. Again there was a garden to the rear of the property. Upstairs there was a staff office, two empty rooms and a main bathroom. Again all parts of the home were clean and well kept. The inspector saw family pictures

throughout this part of the home and other items that were important to the resident.

Later in the morning the inspector met with the second resident. They were relaxing in their chair. The resident would smile when spoken with but did not overly engage with the inspector. They were watching a preferred program on television. The staff explained that the resident was leaving later in the day to go out for a coffee.

During the inspection day the inspector saw and heard both residents leave their homes at different times. Meals and snacks were prepared in the home and residents were offered choice in terms of what was available. Residents appeared comfortable and content in their home and were observed to move freely around their homes or request assistance from staff when needed. Staff were patient and caring in their interactions with the residents.

The two residents in the designated centre had very differing needs and routines. Each resident had their own staff team who were very familiar with the residents and planned their days in line with their interests and needs. One resident required a very active schedule. They enjoyed hiking, cycling, going to the gym, meeting family, attending matches and volunteering at local sports clubs, and going on holidays. They were out and about every day and had access to their own vehicle. The second resident in the home, required a slower pace of activities. They liked drives, going out for coffee, going to mass and shopping. Due to the individualised aspect of the centre both residents' needs were well accommodated.

The inspector spoke with both staff members that were on duty. One staff member had over 25 years experience in the centre and was very familiar with the resident they supported. The staff were able to identify the most pertinent risks in the centre. For example, a staff member spoke about the falls risks in relation to one resident. The staff team stated they were well supported in their roles and knew who to contact if there were any types of concerns including safeguarding concerns.

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

Capacity and capability

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.

There was a consistent and committed staff team in place which ensured residents were safe and care was delivered to a very good standard. The staff team were up-to-date across the training requirements which meant they could deliver care in line

with best practice. Staff spoken with on the day of inspection were very knowledgeable around the residents' needs.

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.

The staff team consisted of a dedicated team of a social care workers and care assistants.

The inspector review rosters from the 20th of July 2025 up to the inspection date of the 15th of September 2025. All rosters were well maintained with staff members full name represented on the roster. The staff members present on the day of inspection were represented on the roster. For example, in one of the homes the staff had spilt the shift across the day. This change was represented on the roster with the change over of staff and time this occurred clearly documented.

There were no staff vacancies at the time of inspection and one staff was on statutory leave. Although, there was some use of agency, this was kept to a minimum and relief or regular staff covered any required shifts if possible. This ensure continuity of staffing was in place as much as possible. For example, on the rosters reviewed seven shifts were completed by agency or relief staff.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix that was in place to track the relevant trainings completed by staff. There were seven staff represented on this matrix. From reviewing the training records the inspector found that, staff were provided with the required training to ensure they had the necessary skills to respond to the needs of the residents and to promote their safety and well being. For example all staff had completed training in relation to safeguarding, safe administration of medicines, managing behaviour that is challenging and feeding, eating, drinking and swallowing needs.

There were systems in place to ensure that staff received regular supervision to enable them to complete their role effectively. Each staff received supervision once per quarter. The Wellness and Cultural Integration Manager (WCI) had direct oversight of this process and would track the completion of this process through the person in charge weekly status report. The inspector reviewed the most recent

report which indicated all staff had received supervision in quarter one and two of 2025. Staff told the inspector they were well supported in their roles.

Judgment: Compliant

Regulation 23: Governance and management

Overall, there were effective systems in place to promote a safe environment for the residents and ensure care was delivered in line with their assessed needs. Some improvements were required in the annual review process and to aspects of oversight of residents finances. For the most part the provider was aware of the issues and were actively working to improve systems in these areas.

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by a person in charge. They were supported in their role by WCI manager. There were clear reporting structures in relation to reporting safeguarding concerns with a identified designated officer appointed to the centre.

The inspector reviewed the six monthly audit that had occurred in April 2025, this identified deficits in finance audits such as checks on balances not occurring and an absence of audits. In a recent provider audit that occurred in August 2025 similar issues were identified and the auditor stated that systems in relation to management of finances had not been adhered too. The consistent application of the finance audits was required to ensure sufficient oversight of finances was occurring within the designated centre. Although the provider had identified this further effective action was required in this area of support.

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.

Regular staff meetings were occurring. The inspector reviewed team meeting notes from April, May, June and July 2025. It was found that safeguarding was a standing agenda at these meetings. For example, a safeguarding incident that occurred in March 2025 was discussed at the next team meeting in April 2025 to ensure that staff were aware of the measures taken.

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. The individualised support in place ensured that a number of safeguarding risks were minimised. Residents were supported to have good choice and control in regards to their care and support.

Residents had safe and good practices around risk, personal planning, communication and rights. Their premises was well maintained and overall met their assessed needs.

Regulation 10: Communication

The inspector reviewed both residents' communication plans that were in place. Both residents had differing needs in relation to their communication and this was suitably reflected in their plans. For example, one resident's plan described how they need movement for emotional regulation and how this impacts their communication. The plan described the equipment they used during this process. The inspector observed that this equipment was in place, such as the swing in the garden and the rocking chair in the sitting room.

Assessments such as Distress Assessment tools were also used to inform communication and pain care plans. This ensured that residents' communicative intent around pain could be accurately captured.

Residents also had access to telephones and other such media as Internet, televisions, radios and personal computers. For example, both residents had their own phones and were facilitated to communicate with family members

Judgment: Compliant

Regulation 17: Premises

As previously described the designated centre comprises two adjoining semi-detached homes in an urban area of Co. Kilkenny. The inspector completed a walk around of all aspects of the designated centre. Overall, all parts of the centre were clean, warm and well presented.

In the first home the inspector saw that downstairs there was a kitchen come dining room with a sliding door out to a well kept garden. Additionally the resident had access to a large sitting room, small bathroom and separate laundry area. The residents bedroom was located upstairs which had been decorated to their specific taste. The main bathroom was also located on this floor with a second sitting room and staff office and empty bedroom.

In the second home the layout was different due to the needs of the resident. They had a bedroom, bathroom, living come dining area and small kitchen area downstairs. Again there was a sliding door of the dining come living room to the back garden. There was a ramp and handrail which led to the back garden. Upstairs there was a second bathroom, staff office and two empty rooms.

Out the front, there was ample parking for cars.

Overall, the layout of the premises was meeting the current assessed needs of the residents within the 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 slips, trips and falls, supporting hospital admissions, behaviours of concern, fire and allergies 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 2024 and 2025 were reviewed and found to be managed appropriately. Overall, there was a low level of incidents within the centre with 17 incidents recorded during this time period. Learning was identified following incidents and appropriate measures put in place. For example, one resident's slips, trips and falls risk assessment was updated to reflect that they had been referred health and social care professionals to assess their current needs.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed two residents' individual files which contained their assessment of needs and care plans. All residents specific needs had been appropriately assessed through this process, including their health, social and daily living skills. Associated care plans were in place to guide staff practice. The inspector

read care plans in relation to health needs, manual handling needs, dental needs, financial needs and behaviours of concern. All plans had been updated or reviewed in 2025.

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 reviewed one resident's annual visioning notes and saw that they had chosen goals such as joining sporting activities, volunteering in local sporting clubs, attending local sporting matches and continuing family relationships. There were photographs of the resident achieving each goal as well as a monthly review to track the residents' progress.

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 reduction in the need for positive behaviour support occurred due to the individualised service being provided for each resident.

There was one behaviour support plan in place. Additionally for the second resident there was care plans in relation to behaviour support but they did not require the support of the behaviour specialist. The inspector reviewed all these documents.The behaviour support plan had been updated in 2025 by the Behaviour Support Specialist and the care plans were updated in 2025 by the person in charge.

In the behaviour support plan 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. There was very low level incidents in relation to behaviour support indicating that the strategies and model of care was in line with residents' specific needs.

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 were no open safeguarding plans at the time of inspection. The inspector reviewed the documentation in place around previous safeguarding incidents 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.

Intimate care plans had also been prepared to support staff in delivering care to residents in a manner that respected their dignity and rights. The inspector reviewed two plans and found they identified the needs of each resident. For example, the plans described each residents preferences in how these needs were best met.

Although improvements were required in relation to the auditing of finances to ensure that all expenditure was accounted for this has been addressed under Regulation 23: Governance and management.

Judgment: Compliant

Regulation 9: Residents' rights

The centre had adopted good practices in ensuring residents' rights were considered and respected. Staff spoke with residents in a kind, respectful and dignified manner.

There were easy read documentation available to residents. The inspector saw easy reads in place around, their contract of care and associated charges, complaints, introduction of new staff and advocacy. In addition, one resident had taken part in a safeguarding session in their day service hub and had the easy ready information available to refer to if needed. This ensured residents were informed of their rights around these aspects of care and support.

An independent advocate had been utilised as required to ensure that a resident was suitably consulted in relation to a specific need. The inspector read the email thread in relation to this and saw that the advocate had visited the resident.

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	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Tús Nua OSV-0005698

Inspection ID: MON-0047829

Date of inspection: 15/09/2025

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 Person in Charge has communicated Aurora's Persons Supported Personal Property Finances & Possessions Policy to the team in Tus Nua, asking them to read and sign by 17.10.2025. This policy and management of finances was also discussed at the Team Meeting on 17.10.2025. Person in Charge has outlined the processes and importance of adherence to same. The Soldo card responsibilities pathway is now on the standing agenda of team meetings for the next 6 months to ensure consistent follow up and implementation. The Wellness, Culture and Integration Manager will be in attendance at the team meeting on 19.11.2025 to support the above.

The Person in Charge has commenced On the job mentoring in relation to management of finances; this will be completed with each member of the team by 31.10.2025.
The On-the-job mentoring will cover the weekly Soldo checks to include each transaction being cross checked with the receipt. If weekly checks identify any errors, team member will complete an error form, identify actions and inform Person In Charge via email.

Person In Charge will ensure that monthly finance audits are completed each month. This audit will identify any areas that require improvement in finance management and follow up on weekly findings and error forms. Person in Charge will identify the actions and discuss them at monthly team meetings. Any further mentoring will be delivered based on the findings of the audits.

The Finance Department will review the Persons Supported Personal Property Finances & Possessions Policy by 31.10.2025

Director of Service, Director of Finance and Wellness, Culture and Integration Managers have a planned meeting on 29.11.2025 to complete a full review of the management of finances in the service at both local and provider level.
The Wellness, Culture and Integration Manager met with Auditor 25.09.2025 to review

both the six monthly and Annual audits taking into considerations feedback from HIQA.

The Quality department has met with the Director of Services on 09.10.2025 and discussed a number of actions required to update audits. The actions include each function reviewing audit questions, to avoid repetitiveness, and cut down on number of questions. The DoS also agreed on a number of changes to the providers Annual review Report and has actioned changes to QA department. The QA department will update the Viclarity system when audit questions are updated by 07.01.2025.

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	30/11/2025
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	07/01/2026