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

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| Name of designated centre: | Ohana |
| Name of provider: | Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities |
| Address of centre: | Kilkenny |
| Type of inspection: | Announced |
| Date of inspection: | 07 October 2025 |
| Centre ID: | OSV-0007781 |
| Fieldwork ID: | MON-0040065 |

## About the designated centre

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

Ohana is a designated centre operated by Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities. The designated centre provides community residential services to two adults with a disability. The designated centre comprises of two single occupancy apartments located next to each other in a town in County Kilkenny. Each apartment consists of a kitchen, sitting room/dining room, individual resident bedroom, sensory room and a bathroom. There are gardens to the rear of the apartments for the residents to use if they wish. The centre is staffed by the person in charge and healthcare assistants. Local amenities include shops, parks, café's and clubs.

**The following information outlines some additional data on this centre.**

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| 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 |
|---|---|---|---|
| Tuesday 7 October 2025 | 09:15hrs to 17:45hrs | Sinead Whitely | Lead |

## What residents told us and what inspectors observed

This announced inspection was completed to inform a decision regarding the renewal of registration for this designated centre. The inspection took place over one day. Three other inspections were also carried out at this time in other centres operated by the registered provider. Some overarching findings in relation to the provider's oversight and governance and management arrangements were identified in all four centres inspected. In addition, improvements were required in ensuring residents' contracts of care were reflective of relevant charges. This report will outline the findings against this centre. Further findings were found in this specific designated centre in relation to the premises and risks associated with the premises.

There were two residents living in the centre on the day of inspection and the inspector had the opportunity to meet with both residents. Residents used non-verbal methods to communicate and the inspector endeavoured to determine the residents experience living in the centre through meeting with them, observing non verbal communication cues, reviewing documentation relating to their care and support, and observing care practices and interactions between staff and residents throughout the course of the inspection day. In general, the inspector found that both residents appeared happy in their home and were supported by a staff team that knew their needs and preferences very well.

The inspector met with one resident on the morning of the inspection, they were finishing their cup of tea and were heading out with staff for a long walk. The inspector met with them briefly again in the afternoon and as they returned home for lunch. The inspector observed the second resident enjoying their sensory room in the morning and then going out to their vehicle to go swimming with staff. They appeared happy and content in their home with the staff supporting them and staff were joking and laughing with the resident.

The designated centre comprises of two single occupancy apartments located next to each other in a town in County Kilkenny. Each apartment consists of a kitchen, sitting room/dining room, individual resident bedroom, sensory room and a bathroom. There are gardens to the rear of the apartments. The premises posed an ongoing risk to one resident living in the designated centre. This residents garden was not suitable to meet their needs. This was due to the garden regularly flooding. The flooding caused pooling of water and uneven surfaces in the garden. The resident liked to use their garden regularly. In addition to this, the resident's sensory room needed refurbishments. The gardens flooding and uneven surfaces meant that water and dirt were regularly brought into the room when the resident used both their garden and sensory room. The step leading from the centres sensory room into the garden also presented as a falls risk and the resident had experienced falls on this.

The staff team comprised of healthcare assistants and a person in charge who divided their time equally between two designated centres. The centre had three

staff vacancies on the day of inspection. These shifts were being covered by consistent relief staff. The inspector had the opportunity to meet with four staff on the day of inspection, including the person-in-charge. Staff spoken with appeared very familiar with both residents individual preferences and were responsive to their care and behavioural needs. Both residents had regular input from multi-disciplinary supports such as physiotherapy, speech and language therapy and occupational therapy.

Activation and daily schedules were determined by the residents. Both residents enjoyed individualised daily activities facilitated by the staff supporting them such as walks, hikes, drives, visits to the beach, swimming, family visits, meals out, shopping, appointments, and visiting local community grounds and events. Residents both experienced annual personal planning reviews where goals and were set for the year ahead. Some of these included horse riding, exploring new sensory experiences, enhancing community links and personal skills development. Both residents had recently gone on holidays to Co.Clare with support from staff and they appeared to enjoy this. Both residents had their own service vehicles which were used daily.

The inspector noted some restrictive practices were in use around the centre, including modifications to one resident's kitchen. Rationale for these were clear in supporting risk management documentation and behavioural support plans. Restrictive practices were regularly reviewed and the service had established a Human Rights committee where any use of restrictive practices were considered prior to use.

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 the centre provided a comfortable home and person centred care to the residents. Residents appeared to enjoy living in their homes and had a consistent staff team supporting them. The management systems in place ensured the service, for the most part, provided appropriate care and support to the residents. However, there were some improvements required in relation to the premises and risk management as discussed further under the relevant regulations.

## Registration Regulation 5: Application for registration or renewal of registration

The inspector reviewed information submitted by the provider to the Chief Inspector of Social Services with their application to renew the registration of the centre. They had submitted all of the required information in line with the required timeframes.

Judgment: Compliant

## Regulation 15: Staffing

The staff team comprised of healthcare assistants and a person in charge who divided their time equally between two designated centres. The centre had three staff vacancies on the day of inspection and these shifts were being covered by consistent internal relief staff who knew the residents and their individual needs. The inspector reviewed a sample of staff rotas for three months and found that these were well maintained and reflective of the Whole Time Equivalant (WTE) detailed in the centres Statement of Purpose. Staff personnel files were not reviewed as part of this inspection.

Judgment: Compliant

## Regulation 16: Training and staff development

All staff had completed training and refresher training in a number of mandatory areas. Training was provided in areas including:

- Fire Safety
- Manual Handling
- Safeguarding
- Infection Control
- Food Safety
- Childrens First
- Behaviour Support

Training needs were regularly reviewed by management and further refresher training was scheduled when required. Outstanding training needs identified during the centres most previous inspection had been appropriately addressed.All staff received regular one to one formal supervision with their line manager. This occurred on a quarterly basis.

Judgment: Compliant

## Regulation 23: Governance and management

There was was a clear management structure in place. There was a full-time person in charge in place who shared their role with one other designated centres and divided their time equally between the two centres. The person in charge was regularly present in the centre and was knowledgeable regarding the residents care and support needs. The person in charge was supported by a senior area manager and liaised with them regularly. A weekly report was sent to the senior manager which detailed any issues of concern in the service.

The service provided was regularly audited and reviewed by the provider. Six monthly unannounced audits were completed in the centre by other persons in charge working within the service. An annual review of the quality and safety of care and support had also been completed by the service quality team. In general, these had appropriately identified areas in need of improvements in the centre. However the provider was not reflecting residents and their representatives views on the quality and safety of care and support in this annual review.

Audits and reviews were identifying the issues regarding premises and risk, as highlighted under Regulations 17: Premises and Regulation:26 Risk Management. However to date, the provider had failed to appropriately address these findings. This was also an outstanding action from the centre's inspection in March 2024 and the provider had not adhered to the compliance plan response submitted to the Office of the Chief inspector following the inspection.

Judgment: Substantially compliant

## Regulation 24: Admissions and contract for the provision of services

There had been no recent admissions to the designated centre. Both residents had contracts of care in place. Residents had experienced a review of travel and support requirements in December 2024 and this had resulted in some changes to service charges for both residents. While this had been communicated with the residents, the provider had not yet ensured that the residents contract of care was updated and fully reflective of these changes.

Judgment: Substantially compliant

## Regulation 3: Statement of purpose

The statement of purpose was submitted with the provider's application to renew the registration of the centre and was available and reviewed in the centre. The inspector found that this was reflective of the service provided and contained the required information set out in Schedule 1 such as the registration details, the

profile of residents and their support needs in the centre and staffing arrangements.

Judgment: Compliant

## Quality and safety

The inspector reviewed a number of areas to determine the quality and safety of care provided, including a review of premises, risk management, individual assessments and personal plans, protection and fire safety. While it was found that all residents were in receipt of a good quality service, improvements were required in the area of premises and risk management to ensure that one resident was always safe and that the premises was suitable to meet their assessed needs.

### Regulation 17: Premises

The designated centre comprised of two single occupancy apartments located next to each other. Each apartment consisted of a kitchen, sitting room/dining room, individual resident bedrooms, sensory rooms and a bathroom. There were gardens to the rear of both of the apartments.

The premises was not suitable to meet the needs of one resident living in the designated centre due to ongoing issues with flooding in the resident's garden. This resident liked to use their garden daily and enjoyed very regular movement and physical activity. The flooding caused pooling of water and uneven surfaces in the garden. As the resident had a risk in relation to falls, the condition of this area of the designated centre was not meeting their assessed needs.

In addition to this, the resident's sensory room needed refurbishments. The flooding and uneven surfaces in the garden meant that water and dirt were regularly brought into the room when the resident used both their garden and sensory room.

Following the centres most recent inspection in March 2025, the provider had committed to comply with Regulation 17 before 31 July 2025. This date had passed and appropriate actions had not yet been taken to ensure that the premises was suitable to meet the resident's needs.

Judgment: Not compliant

### Regulation 26: Risk management procedures

Overall, it was found that the systems in place for risk management were not proving effective for all identified risks.

The premises posed a number of ongoing risks to one resident living in the designated centre, as discussed under Regulation 17. The garden was susceptible to flooding, uneven surfaces and step leading into the garden posed significant falls risks. The resident was identified as having an unsteady gait. The flooding also caused further hazards to the resident due to an identified swallowing risk and the presence of free flowing fluids in the garden at times of flooding. Minor rainfall caused pooling of water in the garden and managing this risk presented significant challenges to the staff working with the resident.

There were risk assessments in place which identified the risks associated with the garden flooding, however control measures in place were not appropriately mitigating these risks and were not proportionate to the level of risks identified. This was seen in the centres accident and incident log where it was noted that despite control measures in place, the resident had experienced a fall in July 2025 in their own garden. This issue had been self identified by the provider for over three years and had also been noted during the centre's most previous inspection. However, the provider had failed to appropriately mitigate the identified risks to date.

Judgment: Not compliant

## Regulation 28: Fire precautions

The inspector found that the provider had ensured there were appropriate fire safety systems in the centre. A walk around the centre found that there were appropriate detection systems, emergency lighting, containment and fire fighting equipment. These were all serviced and checked regularly with a qualified fire safety specialist. Daily and weekly fire safety checks were being completed by staff.

Staff and residents were completing regular fire drill evacuations. These simulated both day and night time conditions and demonstrated that the centre could be evacuated in an efficient manner in the event of a fire. All residents had personal emergency evacuation plans which detailed individual support levels required in the event of an emergency evacuation. All staff had up-to-date fire safety training.

Judgment: Compliant

## Regulation 5: Individual assessment and personal plan

Both residents had regular input from multi-disciplinary supports such as physiotherapy, speech and language therapy, behavioural support and occupational

therapy. Recommendations made by health and social care professionals were integrated into the residents' plans of care. Residents had personalised assessments of needs and plans of care in place which were subject to regular review and guided staff practice.

Activation and daily schedules were determined by the residents. Both residents enjoyed individualised daily activities facilitated by the staff supporting them such as walks, hikes, drives, visits to the beach, swimming, family visits, meals out, shopping, appointments, and visiting local community grounds and events. Residents both experienced annual personal planning reviews where goals and were set for the year ahead. Some of these included horse riding, exploring new sensory experiences, enhancing community links and personal skills development.

Judgment: Compliant

## Regulation 9: Residents' rights

The inspector noted that both residents appeared to have choice and control in their daily lives. The service provided was lead by both residents and staff were supportive of their individual daily choices. This was seen through daily activation records, daily menus and interactions between staff and residents. Activation and daily schedules were determined by the residents on a daily basis. The service had developed a human rights committee.

Judgment: Compliant

## Appendix 1 - Full list of regulations considered under each dimension

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

| Regulation Title | Judgment |
|---|---|
| **Capacity and capability** | |
| Registration Regulation 5: Application for registration or renewal of registration | Compliant |
| Regulation 15: Staffing | Compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 23: Governance and management | Substantially compliant |
| Regulation 24: Admissions and contract for the provision of services | Substantially compliant |
| Regulation 3: Statement of purpose | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Not compliant |
| Regulation 28: Fire precautions | Compliant |
| Regulation 5: Individual assessment and personal plan | Compliant |
| Regulation 9: Residents' rights | Compliant |

# Compliance Plan for Ohana OSV-0007781

## Inspection ID: MON-0040065

## Date of inspection: 07/10/2025

**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:<br>The Director of Services and the QA team held a meeting on 09.10.2025 to review the providers template for their annual review and six-monthly audits. At present the provider establishes feedback from people supported through feedback form issued to them prior to annual review, and collect feedback from family through direct contact from the Lead Auditor. The provider has taken the comments in this report into consideration and has agreed on a robust action plan in regards to update of all audits. The QA will meet with all functions to review and agree on updated audits by 20.12.2025. In Q 1 of 2026 the QA will work with Viclarity to amend and update audits on the Viclarity system. | |
| Regulation 24: Admissions and contract for the provision of services | Substantially Compliant |
| Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:<br>The provider takes responsibility for the people supported in Aurora to safeguard finances, as most people supported are not in a position to open their own bank account. Based on this, the provider has implemented the least restrictive finance system and maximized safeguarding over person's finances, by using SOLDO system.<br>The provider has set weekly limits, based on the person's spending patterns; those weekly limits are reviewed regularly and can be increased as required and requested to meet the person's needs. | |

Since implementing SOLDO and the Trojan system, the provider is still in the improvement phase to make adjustments, where errors have been identified. The Director of Finances has put controls in place to mitigate and reduce errors due to manual processes. As part of the improvements, a more in-depth review of the Person Supported Finance Policy is ongoing and yet to be finalized to ensure detail and transparency in processes and the policy. Director of Finances, Director of Services and both teams have met on the 29.10.25 to discuss the findings from most recent HIQA inspections and issues identified in provider audits to agree on next actions for improvements. Senior Management Team have met on the 3.11.25 to further review Aurora Service Provision for residential and Day Service to ensure equity and fairness in applying charges and contributions. This will be finalized by 15.12.25 and the policy and service provision documents will be updated accordingly and communicated to employees and people supported.

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| Regulation 17: Premises | Not Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
The provider has highlighted the issues in relation to person supported garden to Kilkenny County Council over the past year. Multiple actions have been taken to address the issues in the garden area for a person supported and ensure adequate risk management and supports can be applied.

1. To support the person's mobility to access the garden safely, a ramp has been proposed for installation. The provider has successfully secured a grant for installation of a rear ramp from the sensory room to the garden to support mobility for the person supported.

2. Due to the drainage issues in the garden, it has been established, that the installation of the ramp cannot proceed until the remedial works in the garden area in relation to ground levels, drainage and cover have been completed, to ensure level and professional implementation and finishes.

3. Costings have been sourced for remedial work in relation to the drainage issue and provider has also completed a grant application to Kilkenny County Council to support these works to be completed.

4. Aurora has also applied to Kilkenny County Council for approval of the ground works being carried out – this includes drainage work and wet pour surface finish. Aurora is waiting for the confirmation of Local authority to be able to commence this work. As soon as this is confirmed, the provider will update HIQA inspector on commencement date of works.

5. Parallel to the planning of building works in the premises to increase safety and wellbeing for the person, the provider has also highlighted the concerns to Kilkenny

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| County Council to advocate for the person and request a housing transfer. This is advocating for the person supported to highlight that the current situation in the garden is not acceptable and to put emphasis on the necessary works being carried out. |

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| Regulation 26: Risk management procedures | Not Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
Whilst the provider is addressing issues in relation to the premises and risk management for a person supported, the PIC is managing and assessing risk on local level with the team.

Since the inspection took place, the PIC has reviewed risk management in Ohana for a person supported, especially in relation to the usage of garden and sensory room.
The PIC has reviewed the person's weekly planner and activities planned to ensure the usage of the garden area is managed appropriately and the person is supported in more community-based activities, such as walks in the woods and locality, visits to the beach and walks in scenic parks – which is in line with sensory requirements also for the person supported.

Risk assessments have been reviewed and are monitored closely by the PIC until the garden works are being completed as per compliance plan.

## 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 17(1)(a) | The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents. | Not Compliant | Orange | 19/11/2025 |
| Regulation 17(1)(b) | The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally. | Substantially Compliant | Yellow | 19/11/2025 |
| 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 | Substantially Compliant | Yellow | 30/03/2026 |

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| | safe, appropriate to residents' needs, consistent and effectively monitored. | | | |
| Regulation 24(4)(a) | The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged. | Substantially Compliant | Yellow | 15/12/2025 |
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. | Not Compliant | Orange | 19/11/2025 |