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:	Kilfane House
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:	01 May 2025
Centre ID:	OSV-0007863
Fieldwork ID:	MON-0046940

About the designated centre

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

Kilfane House is a large purpose built bungalow located in a rural town in Co. Kilkenny, within easy access to local amenities. Kilfane House provides community based living, in a home from home environment for four female adults with severe and profound intellectual disability and complex needs. The house consists of a large open plan kitchen/dining/living room, utility room, visitor's room, four bedrooms, a bathroom, accessible WC/shower room, two equipment store rooms and two small store rooms. Some of the residents use wheelchairs when accessing the community. This is a high support centre, with a requirement for two staff during the day with a third to assist in accessing the community. There is one staff on night duty. The core staffing consists of a combination of a qualified person in charge and team leader/nurse, nurses, social care workers and health care assistants. The centre is a seven day residence open all year with no closure.

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
Thursday 1 May 2025	09:30hrs to 17:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out in response to unsolicited information received by the Chief Inspector of Social Services. The unsolicited information outlined concerns, including concerns regarding the residents' safety and wellbeing in the centre, and the resources available to meet their needs, such as staffing.

Prior to the inspection, by request of the Chief Inspector, the registered provider submitted a provider assurance report outlining the measures in place to meet residents' specific assessed needs. The information provided in this report formed some of the lines of inquiry used during the inspection process.

Overall, the inspector found that the registered provider, person in charge and staff team were striving to meet the residents' individual needs. However, the cohort of residents in the centre had rapidly changing needs in areas such as health and mobility which meant the current resources in place were stretched. Improvements were required in the level of staffing present on a day- to day basis to ensure residents' needs were sufficiently met. . In addition, significant improvement was required in the submission of statutory notifications. Other areas that required development and improvement included the recording of complaints and risk management.

The inspector used observations, conversations with staff, interaction with residents, 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 four residents. On the day of inspection four residents were present and the inspector met with all residents across the inspection day. Family members of all residents were informed that the inspection was taking place and were given the opportunity to speak with the inspector. One family member choose to speak with the inspector by phone call.

The centre comprises a detached bungalow building in a town in Co. Kilkenny. The home is in waking distance of the local amenities associated with the town such as shops and cafes. The home was very well presented, bright, warm and clean. As part of the inspection process the inspector completed a walk around of all areas of the home. Each resident had their own individual bedroom, access to to accessible bathrooms, and an open plan sitting, dining and kitchen area. There was one room allocated as a staff office. There were over-head hoists fitted in some areas of the home and wide corridors to ensure aspects of the homes were accessible. Pictures of residents and a resident's art work were on display throughout the home.

In the morning, on arrival at the centre the inspector was welcomed in by two members of the staff team. The members of the staff team were busy at this time, getting all the residents up and ready for the day. They explained to the inspector

that they were short staffed on this day due to a staff absence.

The inspector met with a resident in the kitchen. They were finishing their breakfast and being supported to have a hot drink. The resident did not use verbal means to communicate and seemed content to sit in the company of the inspector. The staff member was kind and caring in their interactions and were seen to ensure the hot drink was prepared appropriately. The staff member did have to leave the kitchen area for short periods of time which meant the resident was not always in sight. The resident was a high risk of falls and recent guidelines had been drawn up to state that the resident needed constant supervision. Due to the staffing levels on the day of inspection this was not possible for the staff team.

Later in the morning a second resident came to the kitchen area and was supported to eat their breakfast. The resident used some vocalisations to indicate their immediate needs but they did not interact with the inspector. They were seen to enjoy their breakfast and the staff supporting them was very knowledgeable around their individual preferences and needs.

The inspector entered the kitchen area later in the day and met with the other two residents. Again non-verbal means were used by these residents to communicated their immediate needs. One resident used a walking aid and staff were seen to support the resident use this. The other resident sat in their preferred chair and smiled when the inspector spoke with them.

The routines in the home were busy as residents required full support with all their personal care needs, including mobilising safely. Three of the four residents had complex needs associated with their health. Recently, two residents' needs had changed requiring two staff to support transfers. On the day of inspection a physiotherapist was visiting a resident due to their rapidly changing needs.

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

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided in the centre.

Overall, the inspector found that that provider was striving to keep the residents safe and support their changing needs. The provider had self-identified that staffing levels in the centre required review to ensure the number and skill-mix of staff were in line with the emerging assessed needs of residents. Although this had been identified, the plans on how this would look like in the centre were in the early

stages of development.

In addition, the systems in place to ensure statutory notifications were submitted in line with the requirement of regulations required significant improvements. At times, notifications were not submitted, or submitted outside the required time lines. This had been identified in a previous inspection that had occurred in the centre in 2023 and had not been resolved to an effective degree.

Regulation 15: Staffing

Due to emerging changing needs of the residents living in the designated centre, the number of staff was not always adequate to meet all of the residents' needs.

The skill-mix of staff comprised the person in charge, staff nurse and health care assistants. There were staff vacancies in the centre with approximately 2.5 whole-time equivalent staffing vacancy at the time of inspection. Agency staff and a regular relief staff were being utilised to cover vacant posts and planned and unplanned leave of the staff team.

On the day of inspection, from a review of assessments of needs and other documentation, it was noted that one resident required two staff to mobilise independently and all other residents required one-to-one support to mobilise independently. For example, one resident had supervision guidelines in place which outlined the level of supervision from staff required to keep the resident safe. These guidelines were dated 10th April 2025 and indicated that the resident requires full supervision and to be in view of staff at all times. However, the staffing levels had not been increased or risk assessed following these changing needs. All residents within the home were assessed as falls risks with a number falls recently occurring within the centre.

The inspector reviewed the planned and actual staff rotas from March to May 2025 with the person in charge. The inspector found that improvements were required to maintenance of the rotas. For example, the rotas did not always show that the required number of staff were on duty at all times, or clearly show the full names of all staff working in the centre during those months. However, the person in charge provided assurances to the inspector that the centre had been staffed at all times.

Judgment: Not compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix that was in place which provided a summary of the training requirements within the centre. There were eight staff members represented on this matrix. The majority of staff had completed training

and refresher training in line with the provider's policy and the residents' assessed needs. For example, staff had completed training in relation to fire safety, safeguarding, manual handling, feeding, eating, drinking and swallowing needs, epilepsy and safe administration of medicines. Where refresher training was required this had been identified and the staff members were booked on accordingly.

All staff, including the person in charge, were in receipt of regular supervision. The inspector reviewed supervision notes in place for three staff. All staff received an action plan of delegated duties following their supervision. In addition, staff were also in receipt of on the job mentoring to ensure they could complete their role effectively. The inspector reviewed documentation which indicated that staff were directly supervised performing specific health checks and safety checks relevant to their roles.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure which identified the lines of authority and accountability. The centre was managed by a person in charge who was familiar with the care and support needs of the residents. The person in charge was supported by the Wellness and Cultural Integration Manager who was the person participating in management (PPIM) of the centre. The PPIM was present in the centre on a frequent basis and was also very familiar with the residents' specific needs.

The provider completed audits of the quality of care and support provided to residents as required by the Regulation. For example, the provider had completed an Annual review in March 2025 and previous to this they had completed the six monthly unannounced audit in November 2024. The person in charge had completed the 103 identified actions in the six monthly unannounced audits and was in the process of completing the actions identified in the annual review.

As part of the assurances provided to the Chief Inspector, the provider had submitted a provider assurance report. This was used to form the lines of enquiry of the current inspection. It was found that the provider has completed or was in the process of completing all relevant actions. For example, there was good oversight of all health related appointments and any outstanding appointments had been followed up accordingly. This formed a significant action in the provider assurance report and the written assurances were in line with the findings of the inspection.

The provider had also identified the need for additional staffing within the designated centre. Although identified, the plans in place to complete this action were not formalised on the day of inspection. This has been addressed under Regulation 15.

Judgment: Compliant

Regulation 31: Notification of incidents

Documentation in relation to notifications which the provider must submit to the Chief Inspector under the regulations were reviewed during this inspection. Such notifications are important in order to provide information around the running of a designated centre and matters which could impact residents. While a number of the required notifications had been submitted in a timely manner, some notifications were submitted outside the required time frame. In addition, not all notifications were submitted as required. From a review of incidents it was noted that a resident received medical treatment following a fall. This was not notified to the Chief Inspector as required. This was a repeated non-compliance. The previous inspection in 2023 also identified the need for improved systems around the notification of incidents.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a complaints policy and procedure in place that was effective and available in an accessible format for residents and for their representatives to use. There was a nominated complaints officer and systems to log and show follow ups on complaints made.

The inspector reviewed the complaints register for the centre. There were three complaints logged in from June 2023 to November 2024 and it was noted all complaints had been resolved. However, the inspector reviewed meeting notes with a family representative that indicated they were not satisfied with all areas of care and support being delivered to a resident. Although the provider was addressing this with the family, this had not been logged as a complaint. It was unclear if the the provider was utilising their own complaints process to deal with this effectively.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and strived to provide person centred care to the residents. A number of key areas were

reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review of personal healthcare plans, risk documentation, and safeguarding documentation. The inspector found some evidence of residents being well supported in some areas; such as their healthcare needs. However, improvements were required in relation to relation to risk management.

The provider had also implemented risk management procedures. The management team and person in charge maintained a risk register, which outlined the main risks and hazards in the centre. The inspector reviewed a sample of the associated risk assessments, and found that appropriate control measures were in place. The inspector also found that there were effective systems for the identification, recording, and learning from incidents. However, not all identified risks were being managed in line with the provider's risk management systems and there were gaps in the documentation process which meant that not all risks were comprehensively accounted for.

Regulation 17: Premises

The design and layout of the premises was in line with the centre statement of purpose. The house had been laid out to meet residents' needs, with spacious communal areas, wide corridors and individual bedrooms.

All parts of the home were bright, well kept and very clean. There were residents' photographs and paintings residents completed framed and on display throughout the home.

The residents bedrooms were personalised and decorated in line with their taste and preferences. The inspector observed comfortable seating, ornaments, medals and photographs that were important to residents on display. There were two large accessible bathrooms available to the four individuals who lived in the centre. In addition to a large open-plan kitchen, dining and sitting room there was a smaller living room that could be used for visitors and was also in use as a staff office.

Overhead hoist were in place in some areas of the home. This equipment had been serviced on a regular basis to ensure it worked effectively. The provider was in the process of increasing the number of overhead hoists in place in the designated centre in order to future proof the home for potential accessibility needs.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider's risk management policy contained all information as required by the

Regulation. The provider and person in charge were overall, identifying safety issues and putting risk assessments and appropriate control measures in place. Risk assessments considered each individuals needs and the need to promote their safety.

The inspector reviewed two residents' individual risk assessments in place. A number of risks had been identified which included healthcare risks, falls risks, fire risks, choking, admission to hospital, and epilepsy risks. However, not all risk assessments were being updating following a change in circumstances. Although the provider had identified a Falls Screening Pathway which outlined the measures to be taken if a fall occurred in the centre. This pathway failed to identify the need for updating the falls risk assessment or mobility support plan if a fall occurred. This meant that the most up-to-date control measures were not always represented on the risk assessment. For example, a resident was prescribed new medication to potentially decrease the occurrence of falls. this control measure was not accounted for on the residents' relevant risk assessment.

In addition, although there were arrangements were also in place for identifying, recording, investigating and learning from incidents, and there were systems for responding to emergencies. The recording of potential injuries was not subject to the same level of review or oversight. There was incomplete records on how potential injuries were effectively monitored. For example, the potential injury would be logged on the provider's system however, no other data was taken to ascertain if the injury emerged or required medical treatment. There was a risk that potential injuries were not been monitored in an effective manner. This system required review.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that the provider was recognising residents' current and changing needs and responding appropriately by completing the required assessments and supporting residents to access health and social care professionals in line with their assessed needs. Residents had their healthcare needs assessed and were supported to attend medical appointments and to follow up appropriately. Records were maintained of residents' appointments with medical and other health and social care professionals, as were any follow ups required. The inspector read care plans in relation to medications, epilepsy, admission to hospital

Health related care plans were developed and reviewed as required. The inspector reviewed a number of health related care plans and found them to be detailed and to guide staff practice. The person in charge was very familiar with the ongoing needs of the residents and discussed in detail the level of input from health and social care professionals. On the day of inspection there was a health and social care

professional on site to review a residents' needs in terms of mobility.

Residents had access to national health screening programs and were facilitated to attend appointments as required.

Judgment: Compliant

Regulation 8: Protection

The registered provider had implemented systems to safeguard residents, which included an up- to-date policy to guide staff practice.

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 concerns on the day of inspection.

Intimate care plans had also been prepared to support staff in delivering care to residents in a manner that respected their dignity and bodily integrity. The inspector reviewed two residents' plans and found them detailed to ensure staff were aware on how to respect the residents' privacy and dignity during the care practices.

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	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Kilfane House OSV-0007863

Inspection ID: MON-0046940

Date of inspection: 01/05/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Full review of roster by WCI manager and PIC, current vacancies reduced to 1.7 WTEs. Additional relief staff allocated to the designated centre to cover vacancies, unplanned/planned leave of the staff team. Additional review to include staffing levels at different times of the day, staffing levels increased to ensure sufficient staffing to support supervision guidelines and changing needs of people supported within the centre. This is reflected by an additional 0.6 WTE per day (three staff on shift at all times during day shift), this is an ongoing HSE Business Case and is currently being funded by Aurora at present. Risk assessments updated to reflect supervision requirements in the centre. On the job mentoring provided by WCI manager to PIC on the management of rosters for the centre to include day to day reviews, correct use of hours and correct documentation of same.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: Ongoing on the job mentoring being provided by WCI manager to PIC regarding the guidance for providers on notification of incidents. Training by WCI included review of HIQA portal and review of incidents. PIC and WCI to ensure correct notification of incidents going forward.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Review of complaints received in the centre by WCI and PIC. Discussions at team	

meetings regarding completion of a complaint with staff members on 10.6.2025. Training regarding complaints procedure and processes scheduled for team, this is to be completed by the end of June 2025. WCI manager and PIC reviewing documentation and ViClarity system.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Completed review of center's risk register by PIC, ongoing OTJ mentoring for the staff team by PIC and WCI on the updating of risk assessments to ensure a clear reflection of recent events and how to clearly document a potential risk. WCI to review falls pathway documentation with community liaison nurse to ensure that there is a direction to update risk assessments post fall- to be completed by the end of June. Pathway currently includes reference to mobility support plans. Ongoing review of potential injuries system, all potential injuries are to be documented on the person supported DMS notes and escalated to emergency governance report at night to ensure that management personnel are aware and to continuing monitoring- this has been discussed at Governance meeting held monthly for PICs. Documentation of potential injuries also discussed with staff team at team meeting on 23.5.2025 and 10.6.2025- this will be continually added to the agenda for team meetings. On the job mentoring are being completed also for the staff team- team to be fully completed by end of June. Ongoing use of body charts to document injuries.	

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, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	12/06/2025
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.	Substantially Compliant	Yellow	12/06/2025
Regulation 31(1)(d)	The person in charge shall give the chief inspector	Not Compliant	Orange	30/06/2025

	notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.			
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	12/06/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	12/06/2025