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:	Tigh na Bhfear
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:	27 November 2025
Centre ID:	OSV-0008957
Fieldwork ID:	MON-0046624

About the designated centre

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

Tigh na Bhfear is a designated centre operated by Aurora-Enriching Lives, Enriching Communities. The designated centre provides a community residential service for up to five adults with a disability. The designated centre consists of two units located within a close proximity to each other in an estate in County Kilkenny. The first unit is a semi-detached bungalow comprised of a kitchen/dining room, living room, four individual bedrooms, shared bathroom and staff sleepover room. There is a garden to the rear of the premises for the residents to avail of as they please. The second unit is a two bedroom apartment which comprised of a open plan kitchen, dining and living room, office and one individual bedroom. The centre is staffed by team leader, social care workers and health care assistants. The staff team are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 27 November 2025	10:00hrs to 17:15hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This was an unannounced inspection conducted to monitor on-going compliance with the regulations. This inspection was carried out by one inspector over one day.

The designated centre comprises two separate units which provide a home to five individuals. The centre was registered in March 2025 and supported a long planned move of four residents from another centre operated by the provider which has since closed. In August 2025, the provider submitted an application to vary to include an apartment for one resident under the remit of this centre. This was the first inspection of the centre.

The inspector had the opportunity to meet four of the five residents across the two units over the course of this inspection. In addition, the inspector spoke with the person in charge and three staff members. Overall, the inspector found that the centre was striving to provide a safe and quality service, however significant improvement was required in implemention of the provider's systems.

On the morning the inspector visited the first unit of the designated centre which was home to four adults. The four residents did not attend a formal day service and were supported with activation from the centre by the residential staff team.

On arrival, the inspector was welcomed by the person in charge and staff while the residents prepared for the day. Two residents were having a lie in. The inspector was informed that one resident choose to have a lie in following a recent hospital admission. The inspector met one resident in the open plan kitchen, dining and sitting room as they watched TV. The fourth resident was supported to go for a drive in the morning. During the morning, the residents General Practitioner (GP) visited the centre to see the four residents.

In the afternoon, two of the residents were supported to access the community and two of the residents were supported in the house. In the evening, the four residents were home while a member of the staff team prepared dinner. Overall, the four residents appeared content and comfortable in their home. The inspector observed the staff team supporting the residents in an appropriate and caring manner.

The inspector completed a walk through of the house. The semi-detached bungalow comprised of a kitchen/dining room, living room, four individual bedrooms, shared bathroom and staff sleepover room. There is a garden to the rear of the premises for the residents to avail of as they please. The premises presented in a homely manner and was found to be well maintained.

In the afternoon, the inspector visited the second unit of the designated centre which were located a short distance away. On arrival, the resident was not present in the house as they were accessing the community. The apartment was decorated

in a homely manner and comprised of an open plan kitchen, dining and living room, office and one individual bedroom. At the tine of the inspection, the inspector was informed that the provider was exploring options for additional storage for the apartment.

Overall, the inspector found that the centre was visibly clean, homely and kept in a good state of repair. However, improvement was required in the staffing arrangements, governance and management, personal plans and fire safety.

The next two sections of the report present the findings of this inspection in relation to the the overall management of the centre and how the arrangements in place impacted on the quality and safety of the service being delivered.

Capacity and capability

The management systems in place to ensure the service provided was safe, consistent and appropriate to residents' needs required improvement.

There was a defined management structure in place. The centre was managed by a suitably qualified and experienced person in charge who started in their role in October 2025. The inspector found that the governance and management systems did not always ensure that the provider systems were effectively implemented.

On the day of the inspection, the inspector found that the staffing arrangements required review to ensure continuity of care and support for residents. Training records demonstrated that for the most part the staff team had up-to-date training.

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and was suitable qualified and experienced for the role. The person in charge demonstrated a good knowledge of the residents and their assessed needs.

Judgment: Compliant

Regulation 15: Staffing

Overall, the inspector found that the staffing arrangements required improvement to ensure the number, qualifications, skill mix and experience of staff was appropriate

to the assessed needs of the residents. The five residents did not attend a day service and were reliant on the staff team to support them in activation.

The person in charge maintained a planned and actual roster. At the time of the inspection the centre was operating with two staff on long term leave which was managed by the staff team, relief staff and agency staff covering shifts as required. The four residents in the bungalow were supported by three staff throughout the day and by two waking night staff at night. In the apartment, the resident was supported by one staff during the day and by one waking night staff at night.

While, a review of the rosters for September and October 2025, demonstrated additional staffing support was in place while a resident was admitted in hospital, the inspector found the overall staffing arrangements required improvement. For example, approximately 40% of shifts in one of the units were covered by agency and relief staff. This was impacting on continuity of care within the designated centre.

For the same period, there were four occasions where the staffing complement was below the planned staffing. A number of the staff team spoken with highlighted the need for improvement in maintaining the staffing complement.

In addition, one resident had a personal assistant service in place for 14 hours a week. At times, the personal assistant hours could not be facilitated due to the staffing needs of the overall house. On the day of inspection, there was uncertainty on how the personal assistant hours were tracked and this required review.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. From a review of a sample of training records, the majority of the staff team had up-to-date training in areas including fire safety, safe administration of medication, safeguarding, manual handling and de-escalation and intervention techniques. Where training was required, there was evidence that this training had been identified and scheduled.

Judgment: Compliant

Regulation 23: Governance and management

The provider's systems for governance and management were not proving effective on the day of inspection. Also the allocation of some resources was not in line with residents' assessed needs.

As a requirement of the regulations the provider is required to complete audits such as the six-monthly provider and annual review. As the residents had only transitioned to the centre in June 2025 the provider had scheduled these as required. Notwithstanding this, the provider had not completed any review of the service since the residents had transitioned in and therefore were not addressing areas required for improvement in a timely manner.

For example, this inspection found improvements were required in personal plans including timely reviews, completion of monthly reviews and addressing gaps in documentation regarding personal supports. In addition fire safety measures were not been implemented in line with the provider's policy and had not been identified as an areas that that required improvement.

In addition, the staffing allocation in terms of personal assistant hours was not been allocated as required. This is discussed in further detail under Regulation 15: Staffing.

Overall, the inspector found a lack of oversight in key areas of care and support, limited audits being completed and gaps in oversight which were impacting on areas of care and support.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of adverse accidents and incidents occurring in the centre in the period June 2025 to November 2025. The inspector found that the Office of the Chief Inspector was notified as required by Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the registered provider was striving to provide care in line with residents' specific needs. However, improvement was required in personal planning and fire safety.

The centre was registered in March 2025 and the provider had supported the five residents to transition into this service. The premises was decorated in a homely manner, clean and well maintained.

The inspector reviewed a sample of residents' personal files and found that annual reviews were not occurring as required meaning that residents did not have up- to -date meaningful goals in place. As residents did not attend a day service it was essential that their personal plans were kept current and in line with their preferences and assessed needs.

Overall, there were appropriate systems in place to keep the residents safe. For example, a review incidents and accidents demonstrated that the were appropriately managed. However, some improvement was required fire drills to demonstrate that all persons could evacuate the centre to a safe location in a timely manner.

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner and laid out to meet the needs of residents. As noted, the centre consists of two houses which are located within close proximity to one another in Co. Kilkenny. The first unit is a semi-detached bungalow comprised of a kitchen/dining room, living room, four individual bedrooms, shared bathroom and staff sleepover room. There is a garden to the rear of the premises for the residents to avail of as they please. The second unit is a two bedroom apartment which comprised of a open plan kitchen, dining and living room, office and one individual bedroom. The inspector completed a walk around the premises and found that that it was well maintained, clean and homely. The centre was decorated to reflect residents' needs, preferences and interests.

Judgment: Compliant

Regulation 28: Fire precautions

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. A personal emergency evacuation plan (PEEP) had been developed for each resident to guide staff in the effective evacuation of the centre, if needed. There was evidence of regular fire evacuation drills taking place in the centre.

However, improvement was required in fire drills. The residents had transitioned into the centre in June and August of this year. To date there had been no drill completed that represented the staffing or conditions that would occur at night.

Therefore the provider could not be assured that the residents could be safely and effectively evacuated at this time.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Each resident had an assessment of needs in place which identified the residents' health, social and personal needs. The assessment informed the residents' personal plans. However, a number of the plans were in need of review. For example, one file reviewed had a number of notes identifying the need for review which had yet to be completed. In addition, one resident was referred for a psychology review in 2023 and it was unclear if this had been carried out or was still outstanding.

There were were gaps in documentation regarding personal supports which required attention. For example, one resident used a continuous positive airway pressure (CPAP) machine at night and was assessed as requiring hourly checks. From a review of documentation, there were some gaps in recording that the checks were completed as required.

In order to identify residents' goals for the upcoming year and review residents' personal plans from the previous year the registered provider scheduled annual visioning meetings with residents, key members of staff and family members. On review of two residents' files it was found that these reviews were not occurring. For example, on review of one resident's file it was noted that their last visioning meeting was completed in August 2024 and yet to be reviewed. Another resident had a visioning meeting to identify personal goals completed in March 2024 and the next scheduled meeting occurred in November 2025, which was 20 months later. Also, in line with the provider's processes, monthly reviews of all residents goals should be completed for each resident. On review of the files, this was not being consistently completed for some residents.

Judgment: Not compliant

Regulation 8: Protection

The registered provider and person in charge had systems to keep the residents in the centre safe. There was evidence that incidents were appropriately managed and responded to. Staff were found to be knowledgeable in relation to keeping the residents safe and reporting allegations of abuse. All staff had received training in safeguarding vulnerable adults. The residents were observed to appear relaxed and content in their home.

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 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Compliant

Compliance Plan for Tigh na Bhfear OSV-0008957

Inspection ID: MON-0046624

Date of inspection: 27/11/2025

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: WCI manager and PIC met to review staffing compliment on 1.12.2025, full review of rosters was completed and review of staffing skill mix in the designated centre. WCI manager identified two new on boarders to be allocated to Tigh na BhFear, - adding 2 permanent WTE to the staffing compliment, one staff commenced on the 8.12.2025 and one staff to commence in January 2026. 1 WTE staff has returned from long term sick reducing the need for agency usage. Ongoing oversight by PIC of agency usage in both centres to ensure consistency and correct skill mix are being used. Further review of staffing compliment by WCI and PIC on 22.12.2025 to review skill mix of staff team, roster patterns reviewed and discussed. Further review scheduled with PIC in January 2026. Review of personal assistant hours for person supported and allocation of hours. PA hours are to be identified on the following documents going forward, clearly noted on rosters, shift planners, weekly planner for person supported and to be discussed at weekly focus on future meetings. Person supported calendar available in working file to reflect completed personal assistant hours for person support, PIC has oversight of this document and reviews weekly- evidence added to PIC weekly report which is submitted to WCI for review. This is to ensure clear accuracy of received hours by person supported. Nursing supports allocated to the centre in the form of community liaison nurse and hours allocated for support to staff team for on-the-job mentoring/training and medical supports for people supported. This is will continue on an ongoing basis for the designated centre.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management:	

The six-monthly provider audit scheduled for completion in Dec 2025. This was completed on 31.12.2025, action plan received and is under review by PIC and WCI. Actions to be discussed and progress recorded at weekly governance meetings. Medication management audit to be completed by medication management officer by 16.1.2026 and Finance audit to be completed by finance dept by 16.1.2026. - The providers review of annual and six-monthly provider audit system on Viclarity has commenced in October 2025; this will be further developed with input from Quality in 2026. An update on the Viclarity system is required for same.

As part of review of governance and oversight of the centre, weekly support meetings for PIC scheduled by WCI as part of PIC induction for Jan and Feb 2026 to ensure adequate support for PIC in the role.
Ongoing support by community liaison nurse in the centre to ensure reviews of personal plans, support/medical plans, risk assessments and guidelines for people supported are reviewed and updated in a timely manner, in conjunction with this, on the job mentoring being provided by community liaison nurse for the staff team on developing and reviewing personal plans and support plans & other documentation.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:

Full review of PEEPs for all people supported in Tigh na BhFear completed and CEEP updated by PIC on 29.12.2025. Review & update of PEEP and CEEP for An Tobar completed on 30.12.2025 by PIC.
Night time fire drills completed in Tigh na BhFear on 31.08.2025 and 21.10.2025, ongoing reviews by PIC of actions and evacuation times to ensure same are completed correctly. Day time fire drills 20.6.2025, 2.10.2025, 16.10.2025, 30.12.2025. Noted gaps on day time fire drills, on the job mentoring in place since inspection for staff team on completing fire drills and monitoring in place by PIC. Fire Drills to be added to shift planner to ensure completion monthly as required.
Night time fire drill completed in An Tobar since inspection on 11.12.2025. Ongoing supports in place from night manager CNM2, at present night manager CNM2 monitors and supervises night time fire drills in Aurora. Day time Fire drills for An Tobar 6.9.2025, 4.10.2025,3.11.2025 & 2.12.2025- PIC reviewing day time fire drills.
Actions identified include lock box installed in Tigh na BhFear for additional storage of rescue medications, storage box for additional keys installed also inside the front door. WCI and PIC attended additional fire safety training "Focus on Fire Safety Awareness" provided by Kilkenny Fire Station to Aurora on 10.12.2025.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

Community Liaison nurse allocated to Tigh na BhFear and An Tobar, ongoing reviews of all medical support plans for people supported, in conjunction with on the job mentoring and training for staff team on completion of same. All personal plans to be reviewed and updated by 31.01.2026. PIC to have oversight of same.

File cleanse completed for all people supported on 15.12.2025, 16.12.2025, 22.12.2025 and all non-relevant/out of date documentation archived in house.

All annual visioning meetings completed for people supported completed on the following dates 3.10.2025, 30.10.2025, 5.12.2025, 18.12.2025, 19.12.2025- minutes available in the designated centre for three people supported and two are currently being typed and finalised.
Ongoing on the job mentoring for monthly reviews for November 2025 and December 2026 are currently in progress and being reviewed by PIC.

Updated Psychology notes added to person supported file, as email received on 28.11.2025 from psychologist. Input for person supported on 22.5.2025 as per email. PIC liaising with psychologist for further review for person supported post transition and is awaiting an appointment for same.

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	08/12/2025
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 safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	02/01/2026
Regulation 28(3)(d)	The registered provider shall make adequate	Not Compliant	Orange	11/12/2025

	arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.			
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Orange	22/12/2025
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	22/12/2025