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:	Renua
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:	29 May 2025
Centre ID:	OSV-0003500
Fieldwork ID:	MON-0046529

About the designated centre

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

Renua is a residential home located in Co. Kilkenny. The service has the capacity to provide supports to three adults over the age of eighteen with an intellectual disability. The centre currently caters for three residents. The service operated on a full-time basis with no closures, ensuring residents are supported by staff on a 24 hour 7 day a week basis. Residents were facilitated and supported to participate in range of meaningful activities within the home and in the local and wider community. The property presents as a bungalow on the outskirts of a large town. Each resident has a private bedroom, with a shared living area space. The centre also incorporated a spacious kitchen dining area and a large garden area.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 29 May 2025	09:15hrs to 17:30hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This was an unannounced inspection completed to monitor the designated centre's ongoing compliance with the relevant regulations and standards. An inspection had previously occurred in this centre in February 2025, whereby poor levels of compliance were noted in all regulations reviewed. In response to the inspection the provider was required to submit a a detailed compliance plan. The purpose of the current inspection was to follow up on the actions taken by the provider and ensure the centre was meeting the minimum requirements as set by the regulations.

Overall, it was noted that levels of compliance had improved with marked positive outcomes noted for the residents within the home. However, continued focus was required on the governance and management of the centre, submitting notifications in line with the requirements of regulation and risk management.

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

The centre has capacity to accommodate three residents. All three residents were present during the inspection and the inspector had the opportunity to meet the residents and observe care and support being provided across the day. In addition, the inspector met with three family representatives who shared their views on the service being provided to their family members.

On arrival at the centre, the inspector was welcomed in by a staff member. There was also an agency staff member present at this time. The inspector met with the agency staff member on the previous inspection, they completed regular shifts within the designated centre and were very familiar with the residents' needs.

As part of the inspection process the inspector completed a walk around of the premises with the staff present. All parts of the home were clean and very well presented. A number of minor premises works had been completed in the preceding weeks, such as painting, sealing of gaps on floors, garden works and replacement of some furniture which had resulted in the home being appearing well kept and enabled effective cleaning across all areas of the home. Each resident had access to their own bedroom, two bedrooms had en-suite facilities. There was also a main bathroom, a kitchen and a sitting room.

Residents in this home had varying methods of communication from utilising single words or using body language, gestures and other vocalisations to indicate their immediate needs. Staff were seen to understand residents individual communication style. For example, the inspector observed the staff interpret when residents were hungry, thirsty or required attention.

Residents were observed to freely move around their home. Although they did not always interact with their peers they were comfortable in their presence.

All residents had plans for the day. Some residents had family visits, others went out shopping and a resident had a graduation party planned for later in the evening following completion of a course. The inspector observed the staff team help residents with their personal care routines, help the residents get meals drinks and snacks and spend time or engage them in activities in the home. Staff were caring and kind while interacting with the residents.

Three family representatives spent time speaking with the inspector. For the most part, they expressed they were happy with the care provided. Some family members expressed their concern around some aspects of care and support provided. The provider was aware of these concerns and were working with family representatives accordingly.

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

A number of improvements were noted in the level of oversight both at provider and local level, which was resulting in safer and better quality of care being delivered within the centre. Improvements were noted in a number of key regulations such as healthcare, the condition of the premises, staff training and supervision, positive behaviour support and communication. However, ongoing improvements were required in oversight of residents finances, notification of incidents and risk.

Since the last inspection, the provider had developed a comprehensive action plan to ensure the centre met the requirements of the regulations. This action plan was overseen by senior and local management and actions as stated were found to be completed or in the process of being completed on the inspection day. As part of this action plan regular visits by senior management occurred to the centre with audit tools being effectively used to ensure areas of improvements were identified.

At the time of the inspection, there was a team leader appointed to the centre for two days a week. They had been redeployed as an additional resource. A person in charge had been recruited and was due to start within the centre in the coming weeks.

Ongoing improvements were required in relation to the provider's oversight of residents' finances within the centre. This had been previously identified in the inspection in February 2025. Although some actions had been taken, the provider

required further time to implement the required actions.

The systems to notify the Office of the Chief Inspector of relevant incidents in the centre was not effective. This required improvement.

Regulation 16: Training and staff development

The inspector reviewed the training records in place for seven staff members. On review of this document it was found overall, that the majority of staff had training in areas such as safeguarding, fire safety, safe administration of medicines and first aid. Additionally the staff team had received training to support residents in line with their assessed needs such as epilepsy and feeding, eating, drinking and swallowing needs. Two staff required refresher training in two separate areas and were booked on to complete training in the coming weeks. This ensured the staff team had the necessary skills to provide care in line with residents' specific assessed needs.

The inspector reviewed the actions in relation to ensuring staff received supervision in line with the provider's policy. A supervision schedule was in place for 2025, indicating all staff had received a supervision in the first quarter of 2025. The inspector reviewed three supervision records that had been completed for three separate staff members. The records indicated that staff training, delegated duties, and action plans had been discussed during supervision. In addition a number of staff had received on the job mentoring in areas such as maintaining documentation.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector was assured that the provider had put in place the necessary systems to ensure that the oversight of the centre was effective in driving quality improvement and identifying issues as required.

Since the previous inspection the provider had taken a number of actions to ensure that the systems of oversight were implemented effectively. This included a completion of an additional six monthly provider audit, audit of the risk register, and completion of local audits around personal plans and finances. In addition, a weekly work plan was completed by the team lead was submitted to senior management on a weekly basis. In this plan the team leader outlined what actions were completed in the centre each week. This ensured that relevant duties were completed in a timely manner.

The inspector reviewed the additional six monthly audit which had occurred in March 2025, the personal plan audits and finance audits and found they were overall

comprehensive and identifying areas of improvement. For example, the finance audit completed identified the need of the updating of personal asset lists. This was in process on the day of inspection.

However, aspects of oversight of residents' finance still required improvement. As identified in the previous inspection there were limited oversight systems in relation to one resident's finances. The provider was taking actions in relation to this however, it remained unresolved on the day of inspection. The provider required additional time on this matter.

Oversight of aspects of residents' expenditure required further oversight and review. For example, charges in relation to medication were allowed accumulate and were not always paid in a consistent or timely manner. Receipts for these charges were not always available and therefore expenditure in this area was not cross referenced with relevant receipts. Although the provider was aware of this issue no effective action had been taken. The systems in place to ensure oversight of these payments required further review.

Judgment: Substantially 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. For example in Quarter 1 of 2025 the provider failed to notify minor injuries that occurred within the centre. There were documented instances whereby minor injuries were noted on the provider's daily note system. The system for recording and monitoring minor injuries required review to ensure that they were suitably monitored and notified to the Office of the Chief Inspector accordingly.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and the provider and the staff team strived to provide care in line with residents' specific assessed needs. 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 within 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 systems for the identification, recording, and learning from incidents. However, not all incidents were subject to the same robust approach. This included the reporting of minor injuries. Documentation in relation to risk management also required improvement to ensure that staff had up-to-date guidance.

Regulation 10: Communication

A number of improvements had been made in this area since the previous inspection. Each resident had a communication passport in place. Staff spoken with on the day of inspection described how they had contributed to this document. For example, the staff team had been consulted on the residents' preferences around routines to ensure this information was accurate in the communication plans. A speech and language therapist was also involved in the development of the documentation around residents' communication.

The inspector reviewed two residents' documentation around communication and found the plans were detailed. For example, the document detailed how the residents' communicated 'yes' and 'no' answers, there preferences, likes and dislikes and their routines.

In addition, a communication assessment in relation to how residents communicate pain and discomfort had been completed. Again suitably qualified health care professional had been involved in this process to ensure the information was accurate. The information in these assessments were reflected in residents' communication passports.

Judgment: Compliant

Regulation 17: Premises

The residents lived in a three bedroom bungalow building in a residential area. All residents had their own individual bedroom, two residents' bedrooms had en-suite facilities and there was also access to a main accessible bathroom. The residents

also had access to a sitting room and a kitchen come dining room. One room in the home was allocated as a staff office. To the rear of the home there was a large back garden and there was ample parking to the front of the home.

A number of maintenance and repair works had been completed to the home over the previous months. This included

- Repairing of peeling laminate on kitchen doors.
- Replacement of kick boards in the kitchen.
- Sealing of gaps in floors to ensure that dirt and debris could not accumulate.
- Removal of mould from a bathroom ceiling.
- Painting of areas of the home.
- Clean up of garden area and replacement of garden shed.

All parts of the home presented as well kept and clean. Staff were observed to completed cleaning duties across the day of inspection.Overall, the premises presented as a homely environment.

Judgment: Compliant

Regulation 26: Risk management procedures

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. A number of improvements had been made to the systems in place to manage risk. However, ongoing focus and improvement was required in this area.

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 and minor 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.

In addition, the provider used an online system to record incidents. On the day of inspection and for approximately one month previously this system was not available in the centre. There was no alternative system in place to record incidents during this period of time.

The inspector reviewed three residents individual risk assessments. Overall all risks were accounted for. The inspector reviewed risk assessments in relation to risks on transport, choking, skin integrity, self-harm, restrictive practices and medical procedures. All risk assessments had been recently updated and or reviewed.

Control measures in place were found to be in place and utilised by staff to mitigate risks. However, there were duplicate risk assessments in place for certain risks. On review of these documents they had differing control measures and risk ratings. Further review of the documentation was required to ensure it was reflective of relevant practices in place.

The provider was in process of reviewing the risk in relation to using a restrictive practice on an emergency exit. Since the previous inspection, a risk assessment was now in place. The provider had committed to reviewing this practice with a suitably qualified fire person and this was due to occur the day after the inspection.

Judgment: Substantially compliant

Regulation 6: Health care

The inspector found that the provider was recognising residents' current and changing needs in relation to healthcare. 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, wound care and feeding eating drinking and swallowing needs.

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 team leader was very familiar with the ongoing needs of the residents and discussed in detail the level of input from health and social care professionals. For example, the team leader discussed that one resident had refused a medical test. This was discussed with the relevant healthcare professional and this was documented accordingly.

Residents accessed a range of healthcare professionals including General Practitioners, Chiropody, Psychiatry, Dental and Optical care to name a few. Appointment records were kept for each year. The inspector reviewed the appointment record for 2025 and found that it accounted for all appointments that the residents had attended.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector reviewed the measures in place to ensure appropriate supports were in place to manage incidents where residents engaged in behaviour that challenges.

In recent months an updated positive behaviour support was developed for one resident. The staff team present discussed that there had been a number of updates to this document and was overall reflective on how to support the resident.

The inspector reviewed the positive behaviour support plan which had been developed in March 2025. This was readily available in the resident's file and the majority of staff, including agency staff had signed off that they had read this document. The inspector found that there were clear proactive and reactive strategies detailed in the plan which aligned with relevant healthcare plans and risk assessments.

All staff had completed up-to-date training in relation to managing behaviour that is challenging and de-escalation techniques.

Judgment: Compliant

Regulation 8: Protection

The previous inspection had identified that aspects of ensuring controls were in place to safeguard residents from financial abuse were not robust or comprehensive for all residents that lived in the centre. As previously mentioned, under Regulation 23, this was in the process of being addressed by the provider and has been accounted for under this Regulation. Overall, the provider had gained assurances that the residents monies were safe and were in the process of developing oversight mechanisms in relation to this aspect of care and support at the time of inspection.

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

Regulation 9: Residents' rights

Overall, the provider had taken a number of steps in relation to addressing the issues identified previously in relation to a right's based approach to care and support.

Residents had correspondence in place which indicated that they had now been informed in the change in Residential Support Services Maintenance and Accommodation (RSSMACs) charges. This included an easy read version of the

document to help explain to the residents what was happening.

One resident's bedroom was facing a residential footpath and the designated centre's car park. A privacy cover had been installed on this window which allowed the resident look out but blocked the view from the other side.

Observations on the day of inspection, indicated that staff were trying to ensure a person-centered approach to care and support. Residents' were treated kindly. The language used to describe the residents was professional and in line with their specific needs. Residents were afforded privacy and dignity when their personal care needs were being met.

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 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Renua OSV-0003500

Inspection ID: MON-0046529

Date of inspection: 29/05/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Positive development has commenced in relation to further developing a plan in gaining transparency over finances. The Human Rights and Equality Lead, Social Worker and Person in Charge met with stakeholders on 10.03.2025 to develop the agreement for transparency in relation to managing finances. A follow-up meeting took place on 28.03.2025 with support from the Director of Finances, after which an agreement was reached between the stakeholders and the provider on 07.05.2025 on one aspect of management of finances. The provider is aiming to close this action fully by 30.09.2025. The person in charge will then have oversight of the finances. Further meetings are planned with stakeholders to agree on the management of the second aspect of finances. This meeting is planned for November 2025 and will be led by Human Rights and Equality Lead, Social Worker and PIC. The provider is further reviewing options to increase oversight on people's expenditures, relating to medication charges. This issue arises due to different pharmacies using various systems to invoice. Wellness, Culture and Integration Managers will meet with the Director of Finance on 14.07.2025 to review options to increase this oversight on pharmacy charges. Complaints in relation to RSMACC charges have been addressed satisfactory by the provider.	
Regulation 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents:	

Person in Charge will ensure that all notifications are submitted within time frame and report on it through her PIC weekly Status report to WCI Manager.
Risk Management Policy remains under review by DOS and SMT. Finalising of the policy requires further time, due to including a full review of Board and provider risk oversight and ensure the reporting system for local level is fully clarified. The policy will be updated by 30.7.2025.

The provider is currently parallel developing the new system for daily notes, potential injuries, and other events for daily reporting on a person supported, which will align an oversight system for local and provider level to ensure notes are accurate and data can be requested from entries. The process of reporting minor injuries will be clearly outlined in the new policy and as part of the new Viclarity daily notes system.

The Risk Management Policy will be sent out across service as Practice Development and discussed at all team meeting, then all staff with sign off on reading and understanding the policy. This will provide the staff with knowledge and direction to correctly report any reportable incidents, ensuring all reportable incidents are reported within time frame. Person in Charge will review incidents on ongoing basis report to through PIC weekly report to WCI Manager and will ensure that quarterly notifications are submitted accordingly.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

Aurora is completing a full review of Risk Management Policy to include Board, Provider and local responsibility and oversight on risk management. The policy will clearly outline the process of reporting, reviewing and oversight of potential injuries and minor injuries. There will be a clear process on actions following potential injuries that developed into injuries. This process will align with safeguarding policy.

Parallel to the development of this policy, Aurora is currently developing a new system for daily notes, general notes and notes in relation to e.g. potential injuries and injuries to a person supported. This system will support data driven reporting and facilitate better oversight for PICs and provider on events in a person's life.

The risk management policy will be discussed at PIC Governance Meeting and Quality Assurance Meeting whereby Wellness, Culture and Integration Managers will clearly communicate updated processes within the policy to Persons in Charge.

Updated policy and process within the policy will be discussed at the Team Meeting in House in August 2025.

All risk assessment have been reviewed by Quality Auditors and action plan was developed on 18.03.2025. Action Plans have been completed and all risk assessments have been reviewed. Further review by new appointed Person in Charge is scheduled to commence 20.06.2025 she will review all risk assessments to ensure they are reflective

of relevant practices in place.

Fire Chief Officer visited the center on 30.05.2025. No recommendations have been made.

Restrictive practices committee met on 10.06.2025 to review the plan for reduction of restrictive practices on an emergency exit has been implemented with the aim of eliminating this restrictive practice. The plan has been discussed at the team meeting on 25.06.2025. Behavior Support Specialist will review the data of reduction plan on 17.07.2025 and bring report to the Restricitve Practice Committee meeting on 10.09.2025 for review.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/10/2025
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	30/07/2025
Regulation 31(3)(d)	The person in charge shall ensure that a written report is	Not Compliant	Orange	30/07/2025

	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).			