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:	Ceol
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	07 October 2025
Centre ID:	OSV-0007747
Fieldwork ID:	MON-0039396

About the designated centre

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

Ceol is a designated centre operated by Aurora. The designated centre provides a community residential service for up to four adults with a disability. The designated centre is a large purpose-built bungalow located in County Kilkenny which comprises of four individual resident bedrooms, shared bathrooms, an open plan living, dining and kitchen area, visitors room and utility room. There is a private garden to the rear of the premises for residents to avail of as they please. The centre is staffed by the person in charge, staff nurse, social care workers and care assistants.

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
Tuesday 7 October 2025	09:20hrs to 16:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision regarding the renewal of registration for this designated centre. The inspection took place over one day. Three other inspections were also carried out over at this time in other centres operated by the registered provider. Some overarching findings in relation to the provider's oversight and governance and management arrangements were identified in all four centres inspected. In addition, improvements were required in financial oversight to ensure a comprehensive approach to managing residents' finances was in place. This report will outline the findings against this centre.

The inspector had the opportunity to met with the four residents in their home as they went about their day. Overall, the inspector found that the residents received good quality person centred care and support in this designated centre. However, some improvement was required in areas of the governance and management, general welfare and development and fire safety.

Since the last inspection, two of the residents had been supported to move another designated centre operated by the provider. In turn, there had been two new residents that recently moved into this centre from other centres operated by the service provider.

On arrival the inspector, the inspector was welcomed by two of the residents in the kitchen/dining room while two other residents enjoyed a lie in. The residents were observed watching TV and having breakfast. The inspector was informed and shown framed photos of a recent family event one resident attended. Later in the morning, the two other residents were supported to prepare for the day. The residents appeared comfortable and relaxed in their home. The four residents did not attend a day service and were supported by the staff team with activation. The inspector observed the residents spending time in the centre and leaving the centre to go for walks, attend appointments and access the community.

In the afternoon, the inspector observed one resident who was supported to engage in art in the centre. A second resident was enjoying nail care and listening to music with staff. Another resident was observed in the kitchen, hallway and car spending time with staff and items important to them. The fourth resident decided to return to bed as they were feeling unwell and this was respected.

The inspector carried out a walk through of the house accompanied by the person in charge. As noted, the house was a large purpose built bungalow which comprised of four individual resident bedrooms, shared bathrooms, an open plan living, dining and kitchen area, visitors room and utility room. There is a private garden with patio area to the rear of the premises for residents to avail of as they please. Overall, it was decorated in a homely manner and one of the residents artworks were on display throughout the house. There were areas of internal painting which required some attention due to wear and tear. The inspector was informed that painters were

scheduled to paint the house the week following the inspection. For the most part, the resident bedrooms were personalised to the residents' preferences. The two residents who recently moved into the service were in the process of individualising their rooms.

The inspector also reviewed four questionnaires completed by residents with the support of staff and one questionnaire completed by a resident and their representative. The questionnaires described their views of the care and support provided in the centre. Overall, the questionnaire contained positive views with many aspects of service in the centre such as activities, bedrooms, meals and the staff team. However, one questionnaire noted that at times residents involvement in the decisions that are made about their home could be better.

Overall, based on what the residents communicated with the inspector and what was observed, the residents received good quality of care and support. The staff team were observed supporting the residents in an appropriate and caring manner. However, as noted, some improvement was required in the governance and management, general welfare and development 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

Overall, the inspector found that there were management systems in place to ensure the provision of a good standard of care to the residents. The provider had ensured suitable staffing was in place to meet the needs of residents. However, some improvement was required in the provider's annual review.

There was a clear management structure in place. The centre was managed by a full-time, suitably qualified and experienced person in charge. The person in charge was also responsible for one other designated centre operated by the provider. There was evidence of quality assurance audits taking place including the annual review in 2024 and the six-monthly provider visits. However, some improvement was required in capturing residents and representatives views in the annual review.

On the day of the inspection, the inspector observed that there was an appropriate number of staff to support the residents' assessed needs. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner. There were appropriate systems in place for staff training and development. This meant that the staff team had up-to-date knowledge and skills to support the residents.

Registration Regulation 5: Application for registration or renewal of registration

The application for the renewal of registration of this centre was received and contained all of the information as required by the Regulations.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was employed on a full-time basis and was suitably qualified and experienced for the role. The person in charge was also responsible for one other designated centre operated by the provider. 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 provider had ensured that the number, qualifications, skill mix and experience of staff was appropriate to the assessed needs of the residents. The rosters for September and October 2025 demonstrated that the provider had reviewed and amended the staffing levels and arrangements in line with the addition of two new residents to this designated centre. The inspector was informed that plans were in place to monitor and review the establishing staffing arrangements. Throughout the inspection, staff were observed treating and speaking with the residents in a dignified and caring manner.

The four residents were supported by four staff members during the day which reduced to three staff members in the evening. At night the four residents were supported by two staff on waking night shifts. The four residents did not attend a day service and were reliant on the staff team to support them in activation. At the time of the inspection, the centre was operating with three whole time equivalent vacancies. The vacancies were managed through the staff team and regular relief staff. This ensured continuity of care and support to the residents.

Judgment: 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 the training matrix and a sample of training certificates, it was demonstrable that the majority of the staff team had up-to-date training in fire safety, manual handling and safeguarding. A small number of staff were due refresher training in safe administration medication and de-escalation and intervention techniques. The refresher training had been identified by the provider and scheduled for the weeks following the inspection. This ensured the staff team had up-to-date knowledge and skills to support residents.

The staff team engaged in supervision in the centre. From a review of records for three of the staff team, supervision was provided to staff team in line with the provider's policy.

Judgment: Compliant

Regulation 22: Insurance

The provider ensured that there was appropriate insurance in place in the centre. This policy ensured that the injury to residents, building, contents and property was insured.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The registered provider had appointed a full-time, suitably qualified and experienced person in charge. The person in charge reported to the Wellness, Cultural and Integration Manager, who in turn reported to the Assistant Director of Service. The provider had on-call arrangements in place to support staff at evenings and weekends and in the event of an urgent situation.

There was evidence of quality assurance audits taking place to ensure the service provided was appropriate to the residents needs. The quality assurance audits included the six-monthly provider visits and the annual review in 2024. In addition, local audits were being completed in medication management and infection prevention and control. The audits identified areas for improvement and action plans were developed in response. However, while there was evidence that the provider consulted with residents and representatives for the views on the care and support provided in the service, this consultation was not clearly included and captured in the annual report as required by the regulations.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider prepared a statement of purpose which included all the information as required in Schedule 1 of the regulations. This is an important governance document that details the service to be provided in the centre and details any charges that may be applied.

Judgment: Compliant

Regulation 31: Notification of incidents

The provider had a system in place for the recording, management and review of incidents in the centre. The inspector reviewed the record of incidents occurring in the centre for the period June 2025 to October 2025 and found that the person in charge had notified the Chief Inspector of all incidents as required by Regulation 31.

Judgment: Compliant

Quality and safety

Overall, the service strived to provide person centred care and support to the residents in a homely environment which ensured that each resident was supported to enjoy a good quality of life. However, some improvement was required in fire safety and general welfare and development.

The inspector reviewed a sample of the four residents personal files which comprised of an up-to-date comprehensive assessment of the residents' personal, social and health needs. Personal support plans reviewed were found to be up-to-date and to suitably guide the staff team in supporting the resident with their personal, social and health needs. However, the arrangements in place to support residents engage in opportunities to access occupation and recreation required review.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place and fire drills had been carried out. However, a recent fire drill identified some areas for improvement.

Regulation 13: General welfare and development

Although the residents were afforded opportunities to engage in activities of their choosing, the transport charges imposed on residents in relation to this required review to ensure it was fair and equitable. For example, the residents were charged transport and travel charges when using the centre's vehicle to engage in any leisure activity. The four residents did not attend a day service and were reliant on the staff team and centre's transport to engage in an activity outside of the centre. This meant that the residents were paying up to the agreed monthly cap on transport charges to engage in recreational activities.

Judgment: Substantially compliant

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner. As noted the designated centre comprises of four individual resident bedrooms, shared bathrooms, an open plan living, dining and kitchen area, visitors room and utility room. There is a private garden to the rear of the premises for residents to avail of as they please. The inspector completed a walk around the premises and found that that it was clean and homely. The centre was decorated to reflect people's needs, preferences and interests. The inspector was informed of plans to support two residents who recently moved into the service to personalise their bedrooms. While there were some minor areas of wear and tear, the inspector found that these had been identified and plans were in place to address it.

Judgment: Compliant

Regulation 20: Information for residents

The provider had prepared a residents guide which contained all of the information as required by Regulation 20 including a summary of the services and facilities, the terms and conditions, the arrangements for consultation with residents, how to access inspection reports, the complaints procedure and the arrangements for visits.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there were systems for the assessment, management and ongoing review of risk. The inspector reviewed the risk register and found that general and individual risk assessments were in place. The risk assessments were up to date and reflected the control measures in place. The inspector reviewed risk assessments including behaviour, absconding and feeding, eating and drinking. In addition, the documentation reviewed demonstrated that the risk assessments had been reassessed in response to changing needs. For example, one falls risk assessment had been reviewed a number of times in the last year in response to an increase in the number of falls.

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, the fire evacuation arrangements required some improvement. For example, the last hour of darkness drill in one unit took place in September 2025 took over eight minutes and identified some areas for improvement. For example, the need to have medication boxes to ensure access to medication in the event of an emergency evacuation was identified. This action remained outstanding on the day of inspection.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents were supported to manage their behaviours and positive behaviour support guidelines were in place which appropriately guided the staff team in supporting the residents. The residents were facilitated to access appropriate health and social care professionals including psychology and psychiatry as needed.

There were a number of restrictive practices in use in the designated centre including an all-in-one outfit and bed alarms. There were appropriate systems in place to identify, assess and review restrictive practices.

Judgment: 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

Regulation 9: Residents' rights

The inspector noted that residents were supported to have choice and control in their daily lives. The service provided was lead by the residents and staff were supportive of their individual daily choices. This was seen through daily activation records, daily menus and interactions between staff and residents. The inspector reviewed a sample of minutes of focus on future meetings which are held weekly. Discussions were held around upcoming events and celebrations, menu and activity planning.The staff team had been supported to undertake additional training in human rights.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ceol OSV-0007747

Inspection ID: MON-0039396

Date of inspection: 07/10/2025

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Quality department have met with the Director of Services on 09.10.2025 and discussed a number of actions required to update audits. The actions include each function reviewing audit questions, to avoid repetitiveness, and cut down on number of questions. The DOS also agreed on a number of changes to the providers Annual Review Report that included feedback from people supported & their representatives and has actioned these changes to QA department. The QA department will update the Viclarity system in Q 1 2026 when functions audit questions are updated. An immediate action for the Auditor will be to document within the annual report the observations made while in the designated centre on how people supported and staff interact.	
Regulation 13: General welfare and development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 13: General welfare and development: The provider takes responsibility for the people supported in Aurora to safeguard finances, as most people supported are not in a position to open their own bank account. Based on this, the provider has implemented the least restrictive finance system and maximized safeguarding over person's finances, by using SOLDO system. The provider has set weekly limits, based on the person's spending patterns; those	

weekly limits are reviewed regularly and can be increased as required and requested to meet the person's needs.

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

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
PIC will request through viclarity system that a medication press will be set up in front sitting room near front door by 20.11.2025. Medication boxes have been sourced for three of the people supported for their epilepsy rescue medication. These medication boxes will be stored in this medication press in the sitting room. This will allow all team members to have access to rescue medication in two different areas of the home in the event of a fire, they can access from safest area.

PIC will communicate with Night Manager to complete a night time fire drill, this will take place by 28.11.2025. The night time fire drill completed in September was completed in line with lateral moves of two new people supported into Ceol. Additional learnings have been taken and actions completed post fire drill in September.
Staff have become more familiar with all 4 people and their potential needs during a fire/ fire drill.
PIC will ensure all night time fire drills to year end will be completed using a variety of scenarios and with different staff.

Aurora have been in communication with the senior Assistant chief fire officer and they have committed to visit Ceol. On this visit, PIC will discuss the changing needs of the people supported and the recent fire drills and response times.

All PEEP's will be reviewed by 14.11.2025

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	15/12/2025
Regulation 23(1)(e)	The registered provider shall ensure that the review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.	Substantially Compliant	Yellow	27/03/2026
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	28/11/2025