



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Blossom Hill
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:	14 August 2025
Centre ID:	OSV-0007921
Fieldwork ID:	MON-0047088

About the designated centre

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

Blossom Hill is a designated centre operated by Saint Patrick's Centre (Kilkenny) trading as Aurora-Enriching Lives, Enriching Communities. It provides a residential service to a maximum of four adults with a disability. The designated centre is located near Kilkenny City and close to all local amenities. The designated centre comprises of a single detached bungalow located on its own grounds. The house consisted of four individual resident bedrooms, kitchen/dining room, sitting room, bathroom, office and utility room. There was a large garden to the rear of the house which contained an activity room for residents to use if they wish. The designated centre is staffed by staff nurse, social care worker 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:	4
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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 14 August 2025	10:20hrs to 18:00hrs	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 with a specific focus on safeguarding. This inspection was carried out by one inspector over one day.

The inspector had the opportunity to meet with the four residents over the course of the inspection. The residents used alternative methods of communication, such as vocalisations, facial expressions, behaviours and gestures to communicate their needs. The inspector also met with the team leader and two staff members.

On arrival to the house, the inspector observed three residents in the kitchen/dining room being supported to prepare for the day. One resident was being supported to have breakfast. The two other residents were listening to music and engaging with the staff team. One resident was being supported in their bedroom to prepare for the day. The inspector met them in the kitchen as they were heading out to go shopping. The inspector was informed the resident was getting ready for family wedding at the weekend. The residents were well presented and the inspector observed positive interactions with the staff team.

Later in the morning, a music therapist came to the centre and the inspector observed two residents using the activation room for music therapy. One resident left the centre to attend a medical appointment. In the afternoon, the residents were observed returning to the centre. Overall, the residents appeared happy and comfortable in their home and in the presence of the staff team.

The inspector carried out a walk through of the house accompanied by the team leader. The bungalow consisted of four individual resident bedrooms, kitchen/dining room, sitting room, bathroom, office and utility room. Overall, the inspector found that the centre was decorated in a homely manner with residents' personal possessions throughout the centre. All residents had their own bedrooms which were decorated to reflect the individual tastes of the resident. There was a large well maintained garden to the rear of the centre which contained an activity room.

In summary, based on what the residents communicated with the inspector and what was observed, it was evident that the residents received a good quality of care and support. The residents appeared content and comfortable in their home and the staff team were observed supporting the residents in an appropriate and caring manner.

However, the staffing arrangements required further review. In addition, there was an inappropriate personal care practices which had been recently identified and ceased by the provider. However, this practice was in place for a prolonged period of time. The organisational arrangements in place for the governance and oversight of practices and safeguarding required review. There were also a number of areas which required some improvement including personal plans, risk management and

oversight of restrictive practices.

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

There was a clearly defined management system in place which ensured the service provided quality safe care and was effectively monitored. However, improvement was required in the staffing arrangements and governance and management.

There was a clear management structure in place. There was evidence of regular quality assurance audits taking place to ensure the service provided was effectively monitored. These audits included the annual review 2024, provider unannounced six-monthly visits and local audits. However, consultation with residents and their representatives as part of the annual review required some improvement. While, the quality assurance audits identified areas for improvement and action plans were developed in response, the inspector found that some improvement was required in effectively identifying and addressing areas of improvement. For example, this inspection found a number of areas in need of some improvement. In addition, the organisational arrangements in place for the oversight of practices required review.

On the day of inspection, there were sufficient numbers of staff to support the residents' assessed needs. The inspector reviewed the staff roster and found that the staffing arrangements in the designated centre required review. For example, the staffing arrangements in the morning required review. In addition, the provision of individualised staffing support for two residents required improvement. Staff training records were reviewed which indicated, for then most part, that the staff team were up-to-date with their training needs and were appropriately supervised.

Regulation 15: Staffing

The inspector found that the staffing arrangements required improvement.

There was a planned and actual roster maintained in the centre. From a review of the previous two months of rosters, the inspector found that there was an established staff team in place. At the time of the inspection, the designated centre was operating with three vacancies and two staff on long term leave. The vacancies and leave were covered by the existing staff team, regular relief staff and agency staff. This ensured continuity of care and support to the residents. The inspector was informed that there was ongoing recruitment to fill the vacancies.

On the day of the unannounced inspection, the registered provider ensured that there were sufficient staffing levels to meet the assessed needs of the residents. The four residents were supported during the day by at least three staff members. At night, the four residents were supported by two waking night staff. The staff team were observed treating and speaking with the residents in a dignified and caring manner throughout the inspection.

However, the staffing arrangements required review. For example, the inspector was informed that the minimum safe staffing level was three staff and that the four residents required specific staffing support including 2:1 staff support for transfers and 1:1 staff support at mealtimes. From a review of the rosters, at times in the morning only two staff were present between 08:00 and 09:00 to support the residents. It was unclear the rationale for this arrangement and this required review.

In addition, the four residents did not attend a day service and were supported by the staff team with activation. There was individualised staffing support in place for two residents to engage in activities and areas of interest. However, it was unclear from a review of the roster that the protected hours were implemented fully in practice and the arrangements required review. This had been self-identified by the provider in a recent audit.

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 the training records, it was evident that the staff team in the centre had up-to-date training in areas including fire safety, safe administration of medication, manual handling and safeguarding. Overall, this meant the staff team were provided with the required training to ensure they had the necessary skills and knowledge to support and respond to the needs of the residents. However, one staff member had not completed refresher training in manual handling. This had been identified by the provider and shortly following the inspection, the inspector was informed that this staff member had completed the refresher training.

There was a supervision system in place and all staff engaged in formal supervision. From a review of a sample of supervision records for three staff members, supervision meetings were occurring in line with the provider's policy. A supervision schedule was in place for the upcoming year.

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 to the centre. On the day of the inspection, the person in charge was on leave and suitable cover arrangements were in place. The centre was being managed by a team leader with support from senior management.

The designated centre was being audited as required by the regulations and an annual review of the service had been completed for 2024. There was some evidence of consultation with residents and/or their representatives. However, this consultation was limited as only two of the four resident representative views on the quality and care of the service were captured. The provider had completed six-monthly unannounced provider visits to the centre in August 2024 and December 2024. In addition, a weekly work plan was completed by the team leader 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.

The quality assurance audits identified areas of good practice and areas for improvement. Action plans were developed to address the areas identified. However, the systems for effectively identifying and addressing areas of improvement. For example, this inspection found a number of areas in need of attention.

In addition, as noted the provider had recently identified that there was an inappropriate personal care practice. While there had been immediate action by the provider and the practice was ceased, this practice was in place for a prolonged period of time. The organisational arrangements in place for the governance and oversight of practices required review. This is outlined further under Regulation 08: Protection.

Judgment: Not 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 a sample of incidents and accidents occurring in the centre since January 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 service provided person-centred care and support to the four residents in a homely environment. While the provider had systems in place, the inspector found that improvements were required in implementing the systems in areas including safeguarding, personal plans, risk management, oversight of restrictive practices.

The inspector reviewed the four residents' personal files which contained a comprehensive assessment of the residents personal, social and health needs. The personal support plans reviewed were found to be up to date and to suitably guide the staff team. However, assessments in place around supporting residents to manage their money required improvement. In addition, some areas of risk assessment required review to ensure the control measures accurately reflected practice.

There were systems in place to safeguard residents. However, the organisation's systems to safeguard residents required review. For example, while an inappropriate personal care practice was identified and robustly responded to by the provider, it was in place for a prolonged period of time.

Similarly, there were systems in place to identify and review restrictive practices. While it was evident, for the most part, that restrictive practices were identified and reviewed, night-time welfare checks had been reintroduced for two residents following a positive development in their sleeping arrangements. The reintroduction of night-time welfare checks had not been reviewed by the restrictive practice committee.

Regulation 10: Communication

The residents used alternative methods of communication, such as vocalisations, facial expressions, behaviours and gestures to communicate their needs. Each residents' communication needs were outlined in their personal plans which guided the staff team in communicating with the resident. The staff team spoken with demonstrated an clear understanding and knowledge of the residents communication methods and were observed communicating with residents throughout the inspection.

Judgment: Compliant

Regulation 17: Premises

The designated centre comprises of a single detached bungalow located on its own grounds. The house consisted of four individual resident bedrooms, kitchen/dining room, sitting room, bathroom, office and utility room. There was a large garden to the rear of the house which contained an activity room for residents to use if they

wish. Overall, the premises was decorated in a homely manner and generally well maintained.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider had systems in place 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.

However, two risk assessments in place in relation to self injurious behaviour and behaviour noted that all staff had up to date training in de-escalation and intervention techniques. This required review as the inspector was informed that the provider had assessed that this training was not required for this centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the four residents' personal files. Each resident had a comprehensive assessment which identified the residents health, social and personal needs. This assessment informed the residents' personal plans to guide the staff team in supporting residents' with identified needs and supports. The inspector found that the person plans were up-to-date and reflected the care and support arrangements in place.

However, the systems in place to support resident manage their money required improvement. For example, the inspector identified two residents which did not have financial assessments completed to identify which supports the resident needed to manage their finances.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Residents' were supported to manage their behaviours and behaviour support guidelines were in place, as required. There was evidence that residents were supported to access psychology and psychiatry as required.

There were systems in place to identify, manage and review the use of restrictive practices. However, the systems to review restrictive practices required review. For example, night-checks had been previously removed for two residents at the last review by the restrictive practice committee on October 2024. Since the review, there was positive developments in the sleeping arrangements for the two residents as they had changed the type of bed used. However, due to this change night-checks had been re-introduced for the two residents. Since the practice had been reintroduced, it had not been identified as restrictive and reviewed in a timely manner.

Judgment: Substantially compliant

Regulation 8: Protection

There were systems in place to safeguard residents. There was evidence that incidents were appropriately reviewed, managed and responded to. The residents were observed to appear content and comfortable in their home. The staff team had up to date training in safeguarding vulnerable persons and demonstrated good knowledge of how to identify a concern and the steps to take in the event of a concern.

The provider had identified an inappropriate care practice which had been in place for the previous two years for three residents. From a review of documents and discussion with management and the staff team, it was demonstrable that the provider had taken immediate action to cease the practice, inform the relevant parties including the residents, meet with the staff team and began formal investigations as required. However, as noted the inappropriate personal care practice occurred for two years and was not in line with the residents' intimate care plans that respected their dignity and bodily integrity. Therefore the operating safeguarding systems in the organisation did not adequately protect residents and the organisational arrangements to ensure practices are in line with the residents assessed needs and respect their dignity required review.

Judgment: Not compliant

Regulation 9: Residents' rights

Notwithstanding, the findings outlined under Regulation 08: Protection, the residents living in the centre were supported to exercise choice and control over their daily lives. Staff were observed to speak to and interact respectfully with residents. Weekly meetings were held with residents which discussed plans and activities for the upcoming week. The staff team were supported to completed training in human

rights.

There was evidence of the provider completing a computability review of their organisation which aims to support residents move to more suitable homes that will meet their needs more, either during change of needs or to live with peers more suitable.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Blossom Hill OSV-0007921

Inspection ID: MON-0047088

Date of inspection: 14/08/2025

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: The WCI Manager & PIC have undertaken a full of review of roster for the designated center to ensure sufficient staffing levels at all times of the day. This included a review of meaningful day hours and implementation of same for people supported including 2:1 and 1:1 supports in line with funding. All will be clearly identified on roster and daily shift planner. PA hours will be clearly identified on the house roster and implementation of these protected hours is then evident also through weekly planner for each person. The PIC ensures a core team is in place with consistent regular relief staff and agency staff where required. The PIC is currently also providing 10 hours direct support hours which are included in the roster. The Director of HR has committed to continue with ongoing recruitment for vacancies in the designated center. Risk assessments to be reviewed and updated. The above to be implemented 17.10.2025.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: There is a full-time person in charge in place since 10.9.2025, this person had previously managed the designated centre prior to maternity leave and is therefore familiar to the service. The WCI manager developed an induction plan for the PIC returning from maternity leave, this covered the operational and social health care needs of persons supported. It also included a two-week handover from a Team Leader to PIC.	

On review it has been identified, that errors in filing led to only two consultations with people supported being available on file from the most recent annual provider audit, this has since been rectified and all consultations are available on file now for people supported for 2024. Training has been implemented for staff team re filing and archiving.

The Director of Services and Quality Department will meet on 30.09.2025 to review the annual and six-monthly providers audits to further develop the providers completion of audits and enhance quality of same.

The Policy on Supporting People's Intimate/Personal Care was reviewed and updated and sent out as a practice development to all designated centres on 01.09.2025. This practice developed required all staff to read policy and all intimate & personal care plans to be reviewed and updated by 26.09.2025. The four people supported intimate care plans reviewed and updated on 11.8.2025, 13.8.2025, 18.8.2025. Internal notifications completed and TIC process activated. Recommendations to complete action learning analysis, same scheduled for 10.10.2025.

Regulation 26: Risk management procedures

Substantially Compliant

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

The PIC & Behaviour Support Specialist have commenced a full review of risk assessments in relation to self-injurious behaviours for people supported, which will be completed by 30.09.2025. PIC to review training schedule and schedule 4 staff for MAPA on 11/11/2025 and 4 staff on 2/12/2025.

The Behaviour Specialist will attend the next team meeting on the 17.10.2025 where Risk assessments, de-escalation and interventions techniques will be discussed with staff team.

Regulation 5: Individual assessment and personal plan

Substantially Compliant

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

PIC will complete a full review of finance folders in the designated centre, to include support people supported to manage their money, by 3.10.2025.

Training for staff team to be scheduled with finance department to be completed by

31.10.2025	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: A full review of restrictive practices was held with the Restrictive Practice Committee on 17.09.2025, this included review of updated documentation for all people supported inclusive of bed trial for one person supported. A further meeting has been scheduled with restrictive practice review committee for 24.10.2025 Restrictive Practice Policy will be printed for all staff to read and sign prior to October'25 team meeting where further discussion and learning will take place. - same to be documented on team meeting minutes. On the job mentoring for staff team to be provided regarding restrictive practices within the center and the associated documents- same to be provided by PIC & WCI by 31.10.2025	
Regulation 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The PIC and staff team completed a full review of intimate care plans completed on 11.8.2025, 13.8.2025, 18.8.2025 as part of service wide approach following safeguarding concerns. Safeguarding focused team meeting was held on 12.8.2025 with Aurora's social worker. Full review of safeguarding training to ensure same is up to date for all staff team. Completion of induction of new team members to the center to be completed on an ongoing basis-induction forms to be completed and stored in house & sent to training dept. A review of the safeguarding audit will take place taking into consideration content of this report. Intimate Care focused team meeting scheduled for October 2025 to discuss intimate care and consent, to be facilitated by WCI Manager. TIC process activated and recommendations- action learning analysis to be completed on 10.10.2025.	

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 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	17/10/2025
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	17/10/2025
Regulation 23(1)(e)	The registered provider shall ensure that the	Substantially Compliant	Yellow	23/09/2025

	review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.			
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	17/10/2025
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/10/2025
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based	Substantially Compliant	Yellow	31/10/2025

	practice.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	10/10/2025