Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Kilfane House
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Announced
Date of inspection:	24 April 2023
Centre ID:	OSV-0007863
Fieldwork ID:	MON-0030614

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 24 April 2023	12:00hrs to 17:30hrs	Tanya Brady	Lead
Tuesday 25 April 2023	09:30hrs to 13:30hrs	Tanya Brady	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 two days and was completed by one inspector. Three other inspections were also carried out over that time frame 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 to improvements required in financial safeguarding and the management of resident possessions. This report will outline the findings against this centre.

Overall the residents in this centre were in receipt of good quality and person-centred care and supports. This centre is registered for a maximum of four residents and is at full capacity. During this inspection the inspector had the opportunity to meet and spend time with all four individuals and to meet with members of the staff team over the two days. The inspection was facilitated by the person in charge who was newly appointed to the role in this centre.

The centre comprises one large, purpose built, single storey building set in it's own grounds in a small town in Co. Kilkenny. On arrival, to the centre the inspector was brought to sign in at a hall table which contained the visitors book. Personal protective equipment (PPE) was also available if required. The hallway was warm, spacious and flooded with light. The building appeared very comfortable with each resident having their own bedroom and there were two large accessible bathrooms shared between the four individuals. Their bedrooms were personalised to suit their tastes. They had their personal possessions on display in their rooms and plenty of storage for their personal belongings. Residents' family photos and art work were on display throughout their bedrooms and on the walls of the hallway. While these contributed to a homely and comfortable environment the communal areas were more sparsely decorated and almost bare in areas. The need for these to be more personalised and more comfortable had been identified by the provider and person in charge. The inspector observed a calm and relaxed atmosphere throughout the inspection.

Residents had access to a large communal open-plan kitchen, dining, living room which opened out onto a patio and small garden. This large room was for the most part empty space and held minimal items that reflected the residents who lived there. The person in charge was implementing some changes in soft furnishing, paintings and decor in consultation with the residents. The staff team and the residents had spent time planning and laying out the garden in a way that was inviting and a space to relax in. Raised beds had been built and planted and there were bird feeders and areas to sit and relax available. This outdoor space was important to the residents and could be seen from a number of the bedrooms.

Residents and staff gathered together for mealtimes around the table and one

resident was observed to go and buy potatoes and vegetables for the dinner supported by staff. The inspector observed that the staff member included the resident in food preparation and in planning for the shopping trip discussing what they needed to bring such as wallet and bags and how much they needed to buy. The inspector joined the residents for cups of tea or coffee at the table on both days of the inspection and engaged in conversation and observed warm interactions with the staff team.

At the time of the inspection the provider was aware that residents' opportunities to engage in their local community needed to be explored further as they had moved to this home during the COVID-19 pandemic. Since then the person in charge and staff had completed significant work on supporting residents to explore activities in line with their wishes and preferences. Once residents had tried new activities, these were reviewed to assess what their level of enjoyment was. After this new goals were developed and plans put in place to continue to support residents to access their community in line with their wishes and preferences and to continue to try different activities. Some of the examples of activities residents were now regularly enjoying included, trips to the local shops and cafés going to concerts, meeting friends for tea, cooking and baking, shopping, and going to visit local areas of interest. Where volunteering opportunities had been identified the person in charge was engaged in reviewing consent and risk assessments for participation in these.

There was evidence that residents went out together, in smaller groups or independently over the course of the inspection supported by staff. On one of the days two residents were supported to attend a funeral and they had brought a homemade floral wreath and personalised tributes with them. Where a cake had been provided for the tea break residents who ate modified diets were discreetly given the same cake in a modified form so they could fully engage with their peers.

While residents choose for the most part to remain in the communal areas with their peers, there were times during the day if they indicated a need for some quieter time the staff interpreted non-verbal cues and complex communication attempts and supported residents to relax in their rooms or go out for a short while. Over the course of the two days the inspector observed and heard warm and comfortable interactions between staff and residents. The residents were treated with kindness and respect at all times and there was an atmosphere of fun in the house. For example, when preferred music was playing residents were supported to dance, move or sing along. One resident liked a particular armchair and so staff moved this closer to the table to ensure the resident was not isolated while peers were socialising and sitting on the dining room chairs. Residents were supported to have their hair and nails done and looking well was important to them and facilitated by the staff team who ensured that appointments for these were made.

In summary, residents' opportunities to participate in activities had increased since the last inspection. They were being supported to go shopping for food and personal items. They were being supported to make choices in relation to how, and where they wanted to spend their time.

The next two sections of the report present the findings of this inspection in relation

to the governance and management arrangements in place in the centre and how these arrangements impacted the quality and safety of the service being delivered.

Capacity and capability

Overall, the findings of this inspection were that residents were in receipt of a good quality service. The inspector found evidence however, that improvements were required in oversight by the provider in terms of their audits and reviews. They were not found to be identifying all areas for improvement in line with the findings of this inspection.

The person in charge facilitated the inspection. They were now to their role within this centre having started only a few weeks prior to inspection. The inspector found that they were working to become familiar with residents' care and support needs and were motivated to ensure that each resident was happy, well supported, and safe living in the centre. They were working full-time in the centre and were also counted as part of the staffing quota. Staff who spoke with the inspector were complimentary towards the support they received from the person in charge. The person in charge was supported in their role by a number of persons participating in the management (PPIM) of the designated centre. In addition, there was also an out-of-hours on-call manager available to support residents and staff both day and night.

There were no staff vacancies in the centre at the time of the inspection and a number of staff who met the inspector explained that they had worked with the residents since moving into the centre and in some cases prior to that move when the residents had lived in another home. The staff team had completed training and refresher training in line with the providers policies, and residents' assessed needs. A number of staff spoke with the inspector about the positive impact of training in ensuring that they were providing person-centred services, and safe supports for residents.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to renew the registration of this centre. The application was supported by the required documentation as outlined in the Regulation.

Judgment: Compliant

Regulation 14: Persons in charge

The person in charge was newly appointed to this centre and had the qualifications, skills and experience to fulfill the role. They had a strong focus on person-centred care and were striving to ensure that the centre was managed in a way that avoids any institutional practices. For example, they were focused on ensuring that residents were supported to have freshly made meals in their home daily, and to access activities they found meaningful in their community. They were working full-time in the centre and were also working as part the daily staffing quota in the centre.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured that the centre was resourced in line with the residents assessed needs and with the statement of purpose. There were no current vacancies on the staff team and the staff were found to be familiar with the residents and some staff had supported the residents for a number of years.

The rosters and the staff personnel files were reviewed by another member of the inspection team in the provider's offices. There were planned and actual rosters available in the centre. They were well maintained and contained the required information. The review of staff files completed in the provider's human resources department found that these files contained the information required by the Regulations. The rosters reflected consistency of staff support and and that there were at all times enough staff on duty to meet the number and needs of residents.

In the centre this consistency was reflected in terms of the number of staff on duty and with residents found to have opportunities to engage in activities they found meaningful both at home and in their local community.

Judgment: Compliant

Regulation 16: Training and staff development

Overall, staff had completed training and refresher training in line with the provider's policy and residents' assessed needs. There was a training policy and staff had access to training and refresher training in line with this policy in addition to aligning

with the residents' assessed needs. Staff who were identified as requiring training or refresher training in the upcoming months were awaiting dates for these at the time of the inspection.

Prior to the change in the local management team staff had not been in receipt of regular formal supervision and support as required by the providers policy. While the new person in charge had identified these as required and had completed a schedule to ensure that each staff had formal supervision sessions going forward in line with the providers policy, only one had been completed this year to date for all staff. The inspector found from a review of a sample of these supervision records that discussions were resident focused and supporting staff to be aware of and take responsibility for the care and support they were providing for residents.

Judgment: Substantially compliant

Regulation 22: Insurance

There was appropriate insurance in place against risks in the centre, including injury to residents.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place in this centre with some of these roles recently having changed. The inspector found that the staff roles and responsibilities were clearly defined and staff were aware of lines of authority and accountability.

Improvements continue to be required however, in the oversight systems as put in place by the provider. The provider's audits and reviews required by the Regulation to ensure oversight had not all been completed as required. The last six monthly unannounced audit was for example, completed in April 2022 with none since.

The provider's annual review for 2022 was completed in February 2023 using a new format however, the inspector found it did not take the views of the residents or their representatives into account. In addition while outcomes were for the most part identified as part of this review, an action plan of measurable targets assigned to an individual or department was not clearly available. The person in charge was however, reviewing the report and assigning targets to individuals. It was also found that the provider's audits were not consistently identifying all areas that required review. This was of particular importance in the oversight of residents finances and personal possessions where the inspector found a number of examples where in the

absence of oversight systems in place errors had occurred and these are detailed against Regulation 12 below.

While there were systems in place to ensure that the local management team were now monitoring the care and support provided to residents this had not consistently taken place up to the date of the inspection as was evident in the gaps in formal staff support and supervision, team meeting schedules and completion of previously identified actions. The effective oversight of the centre appears to date to be person dependent and while the provider is working to establish consistent systems across the service these are not yet embedded nor reliably in place. These identified gaps in the governance arrangements continue to occur in the absence of effective provider oversight.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose is an important governance document that outlines the service to be provided to the residents within the centre. The inspector reviewed the current statement of purpose and found that it contained the information that is required by the Regulation.

Judgment: Compliant

Regulation 31: Notification of incidents

The person in charge was aware of the requirement to notify the Chief Inspector of incidents and accidents that occur in the centre. A record of incidents occurring in the centre was maintained however, from the sample reviewed not all incidents had been submitted to the Chief Inspector as required. This included a fall resulting in an ambulance being required for a resident.

In addition a number of notifications while submitted were not done so within the timeframe identified in the Regulations. This included some notifications that should have been submitted within three days of occurring in addition to those that are to be submitted quarterly.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the quality of care provided for residents was of a good standard. Residents were supported by a staff team who were familiar with their needs and preferences, and they were supported to make choices in their lives. Residents were supported to make choices and decisions in their lives and were supported by a staff team who were motivated to ensure they were happy and safe in their home.

Overall the premises was found to be warm and clean and while communal areas within the centre required some changes to make them homely these had been identified by the person in charge and the provider. Residents, staff and visitors were protected by the infection prevention and control (IPC) policies, procedures and practices in the centre. There were contingency plans in place for use in the event of an outbreak of infection. Improvements were required in the documentation of cleaning schedules as outlined under Regulation 27 however, the centre was visibly very clean and well presented.

Staff who spoke with the inspector were aware of residents' current needs, and their preferences. The documentation in place was found to clearly guide staff practice. Documentation was person-centred and resident specific documents were being reviewed and updated regularly in line with their changing needs. Residents were protected by the safeguarding policies, procedures and practices in the centre although improvement was still required in the management of their personal possessions.

Regulation 12: Personal possessions

The provider had ensured that the residents had access to personal items and their photographs and personal mementos were displayed in their bedrooms. Residents had access to items of furniture that were theirs also in their rooms. However, improvement was required in financial oversight systems and in the practices to safeguard resident's finances and the access to their monies.

The provider had identified that residents did not have access to bank accounts. All residents in this centre had Health Service Executive (HSE) Private Patient Property Accounts (PPPA) with clear pathways in place to guide in the use of these. Access to finances have to be requested through the main central office. As staff here were only available during office hours, access to resident monies after these hours was limited. These restrictions had previously been identified and the provider has acknowledged that this practice requires review and there is a plan in place,

however, on the day of inspection the practice remains in place.

In addition to the difficulty in freely accessing their monies the inspector found that the residents are not safeguarded by the financial oversight practices in place. The inspector found that while daily checks and monthly audits and oversights were completed for all residents as required by the provider's policy, these took the form of cash and receipt checks only. Neither the provider's policy nor the 'residents finances pathway' contained detail or direction on checking statements or balances to ensure that these overall balances were reconciled and that oversight of spending was happening. The inspector sampled bank statements and receipt records during the inspection and found evidence of two incidences of a resident paying twice for items as expenditure was entered in error and incidences of resident's paying for items that should have been purchased by the provider. These errors were not being identified by the provider as there were no overarching oversight mechanisms in place. This was of particular importance in this centre as there had been identified financial safeguarding concerns notified to the Chief Inspector and the provider had given written assurances that an audit of resident finances had been completed. The inspector found that this audit had not included bank statement reconciliation. The errors identified by the inspector were reimbursed to the residents before conclusion of the inspection.

Further to the lack of statement reconciliation procedures in place there was not guidance on the monitoring for the resident's payment of rent. The person in charge had requested a statement of rents paid as none were available for review in the centre and guidance on this is also not present in the policy nor in the finance pathways. For the residents reviewed by the inspector in this centre they had been overpaying rent and were owed reimbursement but this had not been previously identified by the provider.

Judgment: Not compliant

Regulation 17: Premises

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

The premises was well maintained and had recently been painted, during the inspection, members of the providers maintenance team were present in the house to fix a leak that had occurred. There were systems in place for the logging and monitoring of repairs that were required and this was seen to be effective.

Internally the residents bedrooms were personalised and decorated in line with their taste and preferences. The inspector observed comfortable seating, crocheted blankets, ornaments and photographs that were important to residents on display. There were two large accessible bathrooms available to the four individuals who

lived in the centre both were wet rooms and one also had a bath for use as required. In addition to a large open-plan kitchen, dining and sitting room there was a smaller living room that could be used for visitors and was also in use as a staff office. As previously mentioned the communal areas required a review of their decor as they did not present as comfortable and homely or in line with residents preferences however, this had been identified and actions identified. These included providing soft furnishing, art for the walls and resident possessions available throughout the centre. The external area of the centre was also important to the residents and substantial work had been completed both planting of flowers and shrubs and installing bird feeders and other items of interest.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents' nutritional needs were assessed and those who required it had the support of dietitians and speech and language therapists. Residents' preferences, dietary requirements, associated risks and the supports they required were documented in their personal plans.

The inspector had the opportunity to observe a number of mealtime experiences for residents. The environment was quiet and relaxed, mealtimes were not rushed, and residents were supported by staff in a kind and sensitive manner. The staff could clearly outline how they modified food textures and gave examples of situations when they were out of the centre and managed to ensure residents were safe and did not miss out on any social experiences of eating and drinking.

Meal planning was completed weekly at residents' meetings and there were photo menus available. Meals were prepared fresh daily in the house by the staff team, and residents could get involved in shopping for, and preparing meals should they choose to. Alternatives were offered at mealtimes, and there were plenty of snacks and drinks available. The fridge, freezer and kitchen presses had many options for snack and meals. Mealtimes were observed to be at times that suited residents. For example, residents who chose to stay in bed had a later breakfast, and therefore a later lunch.

The use of a thickening agent was required by some residents to ensure their drinks were of a safe consistency. The storage of this agent which is a prescribed medication was identified as requiring review. The person in charge responded immediately by developing a risk assessment, guidance on it's location and safe storage practices and these were in place and communicated to the staff team by the end of the inspection.

Judgment: Compliant

Regulation 20: Information for residents

There was a residents' guide available in the centre. It contained the information required by the regulations, and was available in an easy-to-read format. It included a summary of the services and facilities provided to residents, the terms and conditions of residency, arrangements for resident involvement in the running of the centre, how to access inspection reports, the complaints procedures, and arrangements for visits.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider's risk management policy contained the information as required by the Regulation. The provider and person in charge were, in this centre 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, while promoting their independence and autonomy. The inspector reviewed samples of centre specific risks in addition to individual resident risks and found them to be detailed with control measures in place that had been considered and regularly reviewed. The inspector found that there was positive risk taking also in evidence that supported the rights of residents, such as going out into the community and use of a bath.

Arrangements were also in place for identifying, recording, investigating and learning from incidents, and there were systems for responding to emergencies. Where restrictive practices were in use in the centre these had been risk assessed and were subject to review. There was evidence of learning when control measures in place had not been met and evidence that the person in charge reviewed the risk assessments in an ongoing capacity. For example when it had not been possible to provide support to a resident as required when unwell and away from the centre, the person in charge made changes to aspects of the service provided such as the roster to ensure control measures that were identified as required could be met.

Judgment: Compliant

Regulation 27: Protection against infection

Overall, residents, staff and visitors were protected by the infection prevention and control policies, procedures, and practices in the centre. The physical environment was found to be very clean and there were systems in place to minimise the risk of the spread of infection. Improvement was required however, in the documentation of cleaning and the detail in the cleaning schedules to guide staff. Four large storage areas including rooms identified for files and resident mobility equipment had not been identified on the cleaning schedule and neither had the hallway or corridors. Additionally, in one of the bathrooms was a bath accessed by residents using a bath chair and these pieces of equipment were also not identified on the schedule. The inspector acknowledges that all these areas were very clean however, there was nothing documented that indicated when or by whom they were last cleaned.

There were risk assessments and contingency plans in place. There were stocks of PPE available and systems in place for stock control. There were also appropriate systems in place for waste and laundry management.

Staff were observed to adhere to standard precautions such as hand hygiene throughout the inspection. Staff had completed a number of infection prevention and control related trainings and there was information available for residents and staff in relation to infection prevention and control and how to keep themselves safe. The staff team discussed the cleaning procedures they used and were familiar with the providers systems.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had systems in place to ensure there was a range of precautions in place in the centre to protect residents from the risk of fire. Systems were in place for the assessment and detection of fire. Additionally there were fire containment measures in place in the centre including fire doors and self-closing mechanisms. There were systems to ensure fire equipment was serviced and maintained. Daily, weekly and monthly inspections of all fire safety systems were taking place.

Residents had risk assessments and detailed personal emergency evacuation plans in place which were reviewed and updated following learning from fire drills. Fire drills were occurring regularly. The provider and person in charge had identified that the drills to demonstrate that each resident could evacuate the centre when the least number of staff are on duty required review as the time line for these was lengthy at almost six minutes when residents were not in bed. This was currently a priority for the person in charge and was being actively reviewed.

Judgment: Compliant

Regulation 8: Protection

The inspector found that notwithstanding the areas identified under Regulation 12 that residents in this centre were protected by the safeguarding policies and procedures in place. Work had been completed by the person in charge and the provider to review all safeguarding plans and to implement clear guidance for staff in supporting residents. Residents' safeguarding plans where required were current and had been reviewed in line with national guidance. The inspector found that following review plans were closed or updated in a timely manner as required.

Residents had up-to-date intimate and personal care plans and guidance for staff was detailed and clear. The inspector found that in response to an incident of concern the person in charge was reviewing guidance for staff in relation to intimate care plans and ensuring bedroom doors safely remain open so that residents' can freely access the bathrooms at night.

Following a review of safeguarding incidents the provider also instigated prompt investigations and actions identified as required were seen to have been completed or to be underway, this included a review on the management of resident's personal post or updates to some provider policies.

Judgment: Compliant

Regulation 9: Residents' rights

In line with the statement of purpose for the centre, the inspector found that the rights and diversity of residents were being respected and promoted in the centre. Residents' personal plans, keyworker meetings and their goals were reflective of their likes, dislikes, wishes and preferences.

Residents themselves were observed making choices and the staff were observed respecting their wishes and listening to what resident's had to say. The resident's wishes were central to the day-to-day running of the centre and in how they spent their time and who they spent time with. The resident's daily and weekly planners and schedules had recently been reviewed and the staff talked about their awareness of their use of language in describing everyday activities to enhance the resident's position in the centre of their day. For example, moving from writing 'put away laundry' to 'support resident to put away their laundry' on staff task lists for the day.

Some residents had accessed independent advocates to support them in dealing with professionals outside of the provider and in making choices. There was

information available and on display in relation to independent advocacy services and the confidential recipient.
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	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kilfane House OSV-0007863

Inspection ID: MON-0030614

Date of inspection: 25/04/2023

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. Employees are booked since the 14.05.23 to ensure all mandatory training will be completed as per training schedule. 2. Training both mandatory, non- mandatory and On the Job Mentoring (OJM) skills ongoing discussion at Quality Conversations & Team Meeting on the 24.05.23. Agency Plan: 1. Create a team of three regular agency staff. All mandatory training and relevant training completed since 21.05.23. 2. OJM conversations with two identified agency staff have been completed on 15.05.23 and 21.05.23. PIC discussed with both the expectations and responsibilities of the job. Both driving and willing to train and upskill. 3. PIC identified training courses that are required to be completed and is currently awaiting dates of Hseland courses, complete 10.06.23. PIC e-mailed Agency coordinator on 21.05.23 seeking dates and list of courses completed, agency to book with Aurora or the agency provider the courses that are required. 4. The mandatory courses are: fire safety/manual handling/safeguarding/ children 1st/ Amric hand hygiene Hseland/amric standards &transmission infection prevention. Non-mandatory but relevant to Kilfane: food safety/managing feeding, eating etc. /putting on, taking off PPE Hseland/Epilepsy Buccal. Training report completed and submitted to training department 21.05.23 including training needs of the staff team. 5. Training for a further two agency staff identified by PIC will commence once current training is completed.	
Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. 6 monthly provider audit has commenced in Kilfane and will be completed by 15.6.2023.
2. Actions from previous provider audits are under review by PIC and will be completed by 30.6.23
3. Actions from Audits delegated to team members and added to their Compliance action plans ongoing review of same
4. Ongoing OJM re delegated duties – delegated duties are part of PIC workplan folder.

Aurora Senior Management Team met on 4.5.2023 and 18.5.2023 to discuss and review HIQA feedback from the 4 inspection that took place on 24th and 25th April. An action plan was developed and progression of actions reviewed.
Following main actions were agreed at SMT level:
1. Interim Governance & Management Plan to ensure PIC cover for all designated centres and change of line management of PICs. Plan was communicated to all relevant personnel on the 17.5.2023 and copy sent to HIQA for information purpose.
2. The provider auditing system is a new system, which was implemented in January 2023 and is continually reviewed to develop quality of same. On review it has been identified that auditors across service will need further guidance and mentoring on how to conduct a good quality audit. DOS and Quality Department have agreed that all annual audits will now be completed by the Aurora Lead auditor to ensure a high-quality audit and also full implementation of actions in the designated centre.
3. Review of Aurora Finance policy and oversight on person's finances to safeguard same completed on .

A meeting took place also to further progress implementation of provider audit system on Viclarity online system by latest 30.10.2023.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
1. PIC and WCI manager discussed notification of incidents 12.05.2023. PIC completing OJM with all staff in regards to submitting incidents and timeframe. Identify additional training if required outgoing.
2. PIC in conjunction with the safeguarding department to provide OJM. Training is to provide staff with full knowledge and understanding of Aurora & HSE safeguarding policy and procedures 20.06.2023.
3. PIC is aware of requirements of HIQA monitoring notifications and will ensure compliance with same.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
PIC ensures ongoing Governance over person supported financial accounts. Persons supported accounts are currently under review with Aurora Quality and Financial department.

Finance Department has reviewed the Aurora Finance Policy and audit system to amend with further clarification on
- Completion of finance checks (including financial statements)
- Quality of audits completed, review of guiding questions.
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Expenditure ledgers of debit cards used by the persons supported needed improvements, interim plan development and devised. As per our Finance department, a new debit card, Soldo will be rolled out as Quality Initiative across Aurora for house budgets in June 2023. As a next development Soldo cards will be implemented for people we support. Actions for this are to be completed in advance of a meeting on the 24th May so the finance department will have full suite of guidance out after that.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
24-hour cleaning schedule has been updated and reviewed by H&S department 18.05.2023 and is now being used in line with IPC policy. PIC ensures adherence to same.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/06/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	14/05/2023
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	Not Compliant	Orange	30/05/2023

	and effectively monitored.			
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.	Not Compliant	Orange	30/06/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	30/05/2023
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the	Substantially Compliant	Yellow	25/04/2023

	standards for the prevention and control of healthcare associated infections published by the Authority.			
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	26/05/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	31/07/2023
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the	Not Compliant	Orange	31/07/2023

	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).			