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:	Tús Nua
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:	31 July 2023 and 01 August 2023
Centre ID:	OSV-0005698
Fieldwork ID:	MON-0031520

About the designated centre

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

In this centre a full-time residential service is provided to a maximum of three adults. In its stated objectives the provider strives to enable people to live a good life, with supports and opportunities to become active, valued and inclusive members of their local community.
Residents present with a broad range of needs and the service aims to meet these physical, mobility and sensory requirements. The premises comprises of two houses. Houses are two storey and semi-detached. Both houses are equipped with all facilities that a comfortable modern home would have. Each resident has their own bedroom and two residents share communal, dining and bathroom facilities. The houses are located in a populated suburb of the city and a short commute from all services and amenities.
The centre is operated on a social model of care. The staff team is comprised of social care staff and care assistants. The team work under the guidance and direction of the person in charge. Ordinarily there are four staff on duty each day, three in one house and one in the other house. There are two waking night staff except on occasions when there are only two residents in the house at night, when one waking night staff suffices.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 31 July 2023	12:00hrs to 17:30hrs	Sarah Mockler	Lead
Tuesday 1 August 2023	09:00hrs to 15:30hrs	Sarah Mockler	Lead
Monday 31 July 2023	09:00hrs to 17:00hrs	Louise Griffin	Support
Tuesday 1 August 2023	09:00hrs to 15:30hrs	Louise Griffin	Support

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision regarding the renewal of registration for the designated centre. The inspection took place over two days. Two 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 three centres inspected. In addition, improvements were also required in financial safeguarding, the management of resident possessions and submission of notifications to the Office of the Chief Inspector. This report will outline the findings against this centre.

The centre was previously inspected in March 2023. Very poor levels of compliance were identified at this time and appropriate regulatory actions were taken on foot of the findings. The current inspection identified that levels of compliance had significantly improved following actions taken by the provider. Improved outcomes were noted for one resident in particular.

The inspectors present met with both residents that lived in the centre. The residents had very specific needs in terms of their communication style and tolerance of new people in their personal space, therefore at times interactions with residents were limited. The inspectors spent time with the management team, staff team, reviewing key documentation in relation to care needs and observing care practices to get a sense of what it was like to live in the centre.

The designated centre comprises two separate semi-detached houses that are located beside each other in a residential setting near an urban area in Co. Kilkenny. On arrival at the centre, potted planters were located at each front door and the front of the homes were very well kept. In one house, significant works had been completed to bring this home up to standard. A new kitchen had been installed, new furniture had been purchased, soft furnishing and pictures had been added and new flooring installed. Sinks, that had been located in communal spaces and bedrooms that were not used, had been removed and replaced with wardrobes. The home presented as very clean, well kept and homely. The second home, was also presented in good condition. In this home many pictures and personal items were on display. It was presented as a very homely welcoming space and was designed to overall met the resident's needs. In both homes some minor improvements were required in aspects of infection prevention control (IPC) which will be discussed in the relevant section of the report.

On arrival at the centre, one resident was relaxing in their sitting room. They had the television on. There was a staff member present to support this resident who was very familiar with their care needs, likes and dislikes. The resident was happy to greet the inspector but did not engage in any type of conversation. They appeared very comfortable. The staff member discussed the plans for the resident's day. The staff member explained they were very much led by what the resident wanted to do

and it was clear that the resident's day was planned taking into account their specific preferences. The resident was going swimming, shopping for a new television and other items, going for a walk and getting their hair cut. Later in the day when the resident returned they were observed to move freely around their home. The staff member was very respectful of the fact that the resident at times preferred their own company. The staff member was always available to support the resident when needed.

A second resident lived on the other side of the centre in their own semi-detached home. The resident utilised the downstairs space of this home only and did not go upstairs. The resident had returned from an exercise class in the local day service. They were sitting in their favourite chair with preferred music playing on the television. There was a staff member there to support the resident on a one-to-one basis. The staff member was preparing lunch and the resident went to the kitchen to make some tea. The staff member was seen to prompt the resident through the steps in this task in a kind manner. The resident had a doctors appointment in the afternoon. The staff member again was very familiar with the resident's specific needs. They spoke about how it was important to encourage the resident to engage in new activities. Family connections were very important to the resident and the staff member spoke about recent family visits. Pictures of the resident's family were located on the wall beside the resident's chair. They were observed to frequently look towards these pictures and smile. The resident did not engage directly with the inspector but appeared very comfortable in their home.

On the second day of inspection the inspectors met with the residents. Both residents were up and ready for the day. Staff discussed plans that were in place for the residents. One resident was heading to the beach and going for a swim. The other resident was attending mass in their local church. From a review of documentation and discussion with staff, residents enjoyed a variety of different activities. For example, one resident enjoyed art, fitness classes, dancing, drives, cinema, visiting cafés and pampering sessions with staff. They had been on a number of holidays and went on day trips. Each resident's day was tailored to their specific needs and each resident had access to a vehicle and staff support as required. The residents within the centre lived very separate lives and did not come in contact with each other.

All staff within the centre had completed training in relation to human rights. Discussions with staff indicated that they were very much led by each residents' preferences. They used respectful and professional language when talking about the residents. All staff identified the designated centre as the residents' home and were very respectful of this. There was an interconnecting door between the two homes. It was found that there were systems in place to ensure that each residents' right to privacy was respected accordingly when using this door. This is discussed in further detail under Regulation 9.

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, it was found that management systems had been put in place to ensure the service provided was safe, consistent and appropriate to residents' specific assessed needs. The provider had taken a number of actions to improve oversight in the centre. A full review of residents' needs had occurred. Following this assessment one resident had transitioned to another designated centre in the area. The reduction in the number of residents present in the centre was having a positive impact.

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 reported directly to the Assistant Director of Services and Director of Services. The person in charge was assigned to two designated centres. They also had additional managerial responsibilities including being on-call for all designated centres within the organisation. Although this was a large remit in terms of management, the person in charge had systems in place to ensure oversight was comprehensive and driving elements of quality improvement within their assigned centre. The person in charge had been appointed to the centre six weeks prior to inspection. Although only new to the post they had comprehensive knowledge around the needs of the residents and what needed to happen to ensure residents had consistent access to safe and quality services. For example, the person in charge had reviewed the six monthly provider audit and had developed a quality improvement plan to ensure relevant actions had been completed.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted the required information to apply for the renewal of the registration of the designated centre. Minor changes were required to the statement of purpose and floor plans to ensure it was fully reflective of the service being provided. The provider completed the required changes and had submitted the amended documentation in a timely manner.

Judgment: Compliant

Regulation 14: Persons in charge

The provider had appointed a full-time, suitably qualified and experienced person in charge. Although new to the post they had implemented a number of improvements within the centre and had ensured they were equipped with sufficient knowledge

around residents' needs to provide a safe and quality driven service.

Judgment: Compliant

Regulation 15: Staffing

The registered provider ensured that the qualifications and skill-mix of staff was appropriate to the assessed needs of the residents.There was an established staff team in place which ensured continuity of care and support to residents. The staff team consisted of one nurse who was appointed as the person in charge, healthcare assistants and social care workers. Due to the reduction in the number of residents, the registered provider was assessing the staffing requirements within the centre. The person in charge discussed how the timings of staffing shifts was under review to ensure residents' needs in the evening time could be met.

The person in charge maintained a planned and actual roster. The inspector reviewed the roster and this was seen to be reflective of the staff on duty on the day of inspection. Continuity of care was evident with overall a stable core staff team in place. Although agency staff were in use, the reliance on agency staff had reduced significantly. In addition, regular agency staff were utlilsed as much as possible.

The staff present across the two days of inspection were found to be knowledgeable of each resident's specific needs. The spoke about residents in a very respectful manner and were caring and kind in all interactions observed.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured all staff had up-to-date training across both mandatory requirements and specific training in line with residents' specific assessed needs. Where refresher training was required this had been identified by the person in charge and they had assigned the person to the relevant trainings over the coming weeks. For example, staff that required training in fire safety were assigned to complete it in the following two weeks. When staff were required to complete trainings this was represented on the roster to ensure staff were aware of the requirements and also were assigned specific time to complete this.

The provider had policies and procedures in place in terms of supervision of staff. This included one-to-one supervision sessions with a line manager and on the job mentoring. It was found that overall staff were in receipt of supervision in line with the provider's policy. A supervision schedule for the remaining year was in place.

Judgment: Compliant

Regulation 22: Insurance

The centre was adequately insured against accidents and incidents. They had submitted evidence of this in the application to renew the registration of the centre.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider ensured there was a clearly defined governance structure within the centre which ensured that residents received a service which met their assessed needs. The registered provider had appointed a full-time, suitably qualified and experienced person in charge who was knowledgeable around residents' specific needs and preferences. Although only recently appointed to this designated centre, they had ensured that areas of improvement were identified, with clear plans in place to ensure these matters were addressed.

Although a number of provider led reviews had occurred this was an area that required additional attention. A six monthly provider lead audit was completed in April 2023. The previous audit to this was not available so it was unclear if they were occurring within the relevant time frames. Although the audit was identifying areas of improvement, the audit was a very large document with actions embedded within it. They had not been assigned to anyone. The person in charge had reviewed this document and worked on identified actions, however, further review of this document was required to ensure it was driving quality improvement.

The inspection highlighted improvements that were needed in residents finances, asset management and notification of incidents. This was an area that required continued focus from the provider. This is discussed in the relevant sections of the report.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

Following a review of the statement of purpose prior to the inspection it was found that this document did not accurately contain all the required information as set out by the regulations. This was subsequently reviewed and re-submitted following the

inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

Documentation in relation to notifications which the provider must submit to the Chief Inspector under the Regulation were reviewed during this inspection. Such notifications are important in order to provide information around the running of a designated centre and matters which could impact residents. Not all notifications had been submitted as required. The provider had failed to notify information around the use of restrictive practices within the centre and information around minor injuries. Systems required review to ensure incidents were reported in a timely manner.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and care was provided in line with each residents' assessed needs. A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review of residents' finances, risk documentation, fire safety documentation, safeguarding documentation and documentation around protection against infection. Due to the centre providing individualised care to each resident in separate homes, it was found that improved levels of compliance had been achieved in a number of key areas such as safeguarding and residents' rights. However, ongoing improvements were required in healthcare and managing residents' finances.

The management of residents finances required significant review from an organisational stand point. Due to the current systems in place, at times residents had limited access to their finances. In addition, the systems in place to ensure residents finances were safeguarded were inadequate. Limited oversight systems were in place that were not effective in ensuring residents monies were adequately safeguarded. Although, these areas of improvement were known to the provider, effective actions to address these issues were still required.

For the most part the healthcare provided to residents was overall in line with their assessed needs, however, improvements were needed in this area. Ongoing health checks had not occurred in line with best practice and to ensure residents optimal health. In addition, important documentation to guide staff practice and to monitor

resident's risks around medication allergies was not in place.

Regulation 12: Personal possessions

All residents in this centre had Health Service Executive (HSE) Private Patient Property Accounts (PPPA) with clear pathways in place to guide access to these accounts. Access to finances had 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. Although the provider had identified the limitations of the types of accounts in place and had taken some action to try and rectify this, on the day of inspection the current practice remained in place.

Financial safeguards were very limited within the centre. Although the person in charge completed an audit on a monthly basis, the audit did not require the person in charge to cross reference receipts and expenditure with bank statements. There were no audits in place in the centre that had completed this process within the last 12 months. Although up-to-date bank statements were present, they had not been utilised to effectively review and manage residents spending and assets. It was unclear how finances were effectively audited. For example, a significant amount of money had been spent on bedding for one resident. This had not been identified as no review of bank statements had occurred.

Although asset lists were in place they were inaccurate at times. There seemed to be a lack of systems in place in terms of what should be on an asset list or how it should be recorded. One resident had repeated items on a list and another resident had a list with every item they had ever purchased. There was limited oversight in place around the lists therefore there was inaccurate references to what belonged to residents within the centre.

Judgment: Not compliant

Regulation 17: Premises

The designated centre comprises two semi-detached homes located close to an urban area in Co. Kilkenny. All residents had their own bedrooms which for the most part were decorated to reflect their individual tastes with personal items on display. The provider had completed a number of premises works over the last few months to bring the condition of the home to a good standard. In one of the semi-detached homes, flooring had been replaced, the home had been painted, new photographs were on display, new furniture had been put in place. All rooms were clean and well organised. In the second semi-detached home painting had taken place. All of the

centre was now homely and well presented.

Judgment: Compliant

Regulation 20: Information for residents

The provider had devised a guide for residents that contained all the required information as set out by the Regulations.

Judgment: Compliant

Regulation 26: Risk management procedures

There were a number of risk management systems in place in the centre with evidence of good oversight of ongoing risks. A centre-specific risk register was in place which identified a number of specific risks and had been reviewed on a regular basis. There were also individualised risk assessments in place which were also updated regularly to ensure risks were identified and assessed.

The provider had now moved to recording incidents on the National Incident Management System. In addition, training had occurred with staff on how to effectively record incidents. Incidents were being reviewed by senior management and members of the multi-disciplinary team as required. This was resulting in more informed risk management processes.

Judgment: Compliant

Regulation 27: Protection against infection

Although there were a number of good practices were identified in relation to the infection prevention and control needs of the centre, some minor improvements were required.

The home itself was well organised, clean and well presented. There were cleaning schedules in place. However, the washing machine was located near a food storage area and there were no systems in place to ensure that this was managed in line with best practice. On the day of inspection there were chopping boards and a fruit board stored above this area.

In addition, a resident had limited access to hand hygiene facilities in the main bathroom. It was unclear how regular hand hygiene could occur in this area or what

systems were considered to minimise the risks associated with this.

Judgment: Substantially compliant

Regulation 28: Fire precautions

There were systems in place of fire safety management such as suitable fire safety equipment, staff training, emergency exits and lighting. There was an up-to-date centre specific evacuation plan and up-to-date person specific evacuation plans. Suitable fire containment was in place. Fire drills were occurring at regular intervals that practiced a variety of emergency situations. Learning was identified following fire drills and suitable actions were taken.

Judgment: Compliant

Regulation 6: Health care

For the most part residents were in receipt of a service that ensured the majority of residents' healthcare needs were being met. For example, each resident had access to their own General Practioner (GP). However, it was not clear if residents' were accessing all appointments in relation to potential healthcare needs, for example no resident had a record to when they last visited an optician. In addition, both residents had a documented allergy to medication. One resident had a detailed risk assessment in place and a hospital passport that detailed this information. This information was not present for the other resident within the home. There was limited information available to staff in relation to this allergy.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Overall there were some good practices in relation to positive behaviour support. Residents' had an updated behaviour support plan in place that identified proactive, early warning signs and reactive strategies. Residents were referred to psychology and behaviour support specialists as needed. The person in charge had commenced the self-assessment questionnaire in relation to restrictive practices within the centre. In addition, all restrictive practices were to be reviewed at the restrictive practice committee meeting in the coming weeks.

The person in charge had identified that two restrictive practices were in place that

were no longer required. Due to the nature of these environmental restrictions specific work was required to remove them. The person in charge had demonstrated that this work had been requested. In addition, they had reduced one restriction to the best of their ability, as an interim measure, until it could be physically removed from the home. This entailed the code number to keypad lock being displayed beside this device so that the resident could use the code if they needed to leave the home.

Judgment: Compliant

Regulation 8: Protection

Overall, appropriate measures were in place to keep residents safe at all times. The concerns in relation to the systems around financial safeguards have been addressed under Regulation 12. Staff received appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse. Staff spoken with, were found to be knowledgeable in relation to their responsibilities in ensuring residents were kept safe at all times. Residents had intimate care plans in place which detailed the level of support required.

Both homes were now single occupancy home, where both residents' lived very separate lives and choose not to interact with each other. The single occupancy nature of the service had mitigated a number of significant safeguarding risks that has previously been present.

Judgment: Compliant

Regulation 9: Residents' rights

Overall in the service was striving to provide residents with choice and control across service provision. Although residents had limited access to finances this has been addressed accordingly under Regulation 12.

Residents daily timetable was individualised to their preferences and needs. Both residents had access to a vehicle which meant that they could decide when and what activities were to occur.

Residents had been consulted over different elements of service change and provision over the last few months. Social stories had been devised to help explain to a resident around the transition of their peer from the service. Residents had been involved in the premises works and had been asked to pick colours of kitchen's, furniture and paint.

An interconnecting door was in place in the centre. This was only used as required

and staff were observed to enter each resident's front door (as opposed to using the interconnecting door) when entering the residents' homes.

When speaking about residents, staff used positive, professional and caring language. Interactions were kind and patient and in line with residents' specific assessed needs.

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	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	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 6: Health care	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Tús Nua OSV-0005698

Inspection ID: MON-0031520

Date of inspection: 31/07/2023 and 01/08/2023

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 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
QA have a schedule in place for Annual review and six-monthly provider audits. Lead auditor will hold oversight of reviews and audits complete date.
The Audit folder will be brought to Team meeting 26.09.2023 with PIC providing clarity on audits received, and how actions are addresses and documented.

PIC has delegated actions to relevant departments, staff team. Updates on action to be completed on provider audits with dates and updates to ensure oversight of actions and quality improvement. Audits are now a standing agenda on team meetings.

The provider is presently developing audit on Viclarity an online system and aims to launch this system by 20.10.2023.

Notifications of incidents will be monitored by new PIC and since May 2023 all notifications have been submitted on time via portal.

The provider has developed a process through the QA department to monitor and check on quarterly notifications been submitted within relevant timeframes.

Notifications will be sent from the QA department as a reminder to all PIC and Team Leaders to submit quarterly notifications.
PIC has been in contact with finance department and bank statements are now present in finance folder up to March 2023. Next quarter has been requested from Finance department and to be present by 30th September 2023

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
New PIC in place since 29th May 2023. All Notifications have been submitted on time since this date and PIC will be ensure all notifications going forward are submitted within relevant time lines

The provider has developed a process (July 2023) through the QA department to monitor and check on quarterly notifications been submitted within relevant timeframes. Notifications will be sent from the QA department as a reminder to all PIC and Team Leaders to submit quarterly notifications.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
A new Entitlements, Income and Expenditure Form has been issued on 01.09.2023, this will be filed as page 1 in person supported finance folder and will provide an over view of person supported finances, and will be audited. Entitlements, Income and Expenditure Forms will be completed for people supported by 14.09.2023.

People supported have an asset list these were reviewed 04.08.2023.

Asset list has been added to:
(i) Finance section on Annual Review Visioning Meeting template to ensure individuals assets are reviewed annually, (01.09.2023) it has also been added to
(ii) Monthly Review template (01.09.2023) to ensure checks are completed on a monthly basis.

In June 2023 Aurora Finance department commenced the roll out of a new debit card, Soldo as Quality Initiative (QI) across all designated centres this is in regards to their house budgets. This QI has been monitored and measured and any identified improvement implemented.

The next development of Soldo cards will be implemented for people supported, it is anticipated that people supported soldo card will be rolled out by 13.10.2023.

Finance Department has reviewed the Residents personal property, finances & possessions Policy.
This policy will be discussed at staff team on 26.09.2023 by PIC.

Aurora developed a Finance Position Paper in February 2023 to outline the challenges re person's bank accounts. This position remains and has been made available to HIQA in February 2023.

Finance Department have identified an experienced member of the team to complete audits on provider level to ensure further oversight at six monthly audits.

Aurora promotes the concept of Circle of Supports, therefore the PIC will ensure people supported have their Circle of Support to support them in all decision making around their finances.

QA are reviewing monthly audit tool by 19.09.2023 to ensure PIC signs off on cross referencing receipts, expenditure and bank statements.

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
Staff to be complete Skills Teaching documentation with person supported for the next 4 weeks till 30th of September to support the person supported with the basic steps of hand hygiene. Soap to be stored in the press under the sink in the upstairs bathroom and to be taken out when hand hygiene will be preformed. This is a preference for the person supported as he likes to remove all items from sink area. Person supported will be supported ongoing with hand hygiene following skills teaching piece.

Immediate action- chopping Boards & Fruits removed away from counter from washing machine area - completed

Regulation 6: Health care	Not Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
In line with Aurora Persona Plan Framework each person has an annual review visioning where health assessment will be completed.

Staff are planning annual review visioning meeting for one person supported by 30.09.2023, full health review for previous year will be reported on and an up-to-date health assessment will also be completed.

For second person supported a review of health assessment and associated documents will be completed by 30.08.2023 to ensure all health needs are addressed and documented.

Appointments for Opticians were made for both people supported by 01.09.2023.

Risk Assessment completed in August'23 following inspection for Allergy to medication and details regarding same.

Red, Amber and Green has been reviewed 24.08.2023 and placed back in person supported file - completed

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	26/09/2023
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 and effectively monitored.	Substantially Compliant	Yellow	30/09/2023
Regulation 23(2)(a)	The registered provider, or a person nominated	Substantially Compliant	Yellow	12/09/2023

	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.			
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 standards for the prevention and control of healthcare associated infections published by the Authority.	Substantially Compliant	Yellow	10/09/2023
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	Not Compliant		05/09/2023

	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.			
Regulation 31(3)(d)	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 injury to a resident not required to be notified under paragraph (1)(d).	Not Compliant	Orange	05/09/2023
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Not Compliant	Orange	30/09/2023