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:	Clannad
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 and 25 April 2023
Centre ID:	OSV-0005633
Fieldwork ID:	MON-0030272

About the designated centre

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

Clannad is a residential centre located in Co. Kilkenny. The centre affords a service to four adults, both male and female over the age of 18 years with an intellectual disability. The service operates on a 24 hour 7 day a week basis ensuring residents are supported by care workers at all times. The day to day operations of the service are provided by a clear governance structure. Supports are afforded in a person centred manner as reflected within individualised personal plans. The residence is a detached bungalow house which promotes a safe homely environment decorated in tasteful manner.

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	Sarah Mockler	Lead
Tuesday 25 April 2023	09:30hrs to 15:30hrs	Sarah Mockler	Lead
Monday 24 April 2023	12:00hrs to 17:30hrs	Louise Griffin	Support
Tuesday 25 April 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 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.

This inspection found that the governance and management arrangements in place did not always provide a quality driven service in this centre. There was a deterioration with levels of compliance in this centre since the previous inspection. Although, residents appeared reasonably comfortable in their home on the days of inspection, the provider had identified that the group of residents were not compatible to live in the same house. Some recent measures had been introduced to address this, however, time was required to see if these measures were effective in addressing the identified compatibility issues between residents to a meaningful degree.

The centre was located in a rural setting in Co. Kilkenny. It comprised a detached bungalow building surrounded by a very large garden area. As the inspector approached the front door they noted freshly planted plants/flowers present. The garden was neat and tidy. Internally the home had two sitting rooms, a small kitchen, four separate bedrooms, one bedroom was en suite, and a main bathroom. These areas of the home were clean and presented as homely with pictures on display. The kitchen had recently been renovated with a new counter top added. Each bedroom was clean and well presented, and residents had personal items on display. However, the laundry was completed in the garage which was also part of the designated centre. The cleanliness of this area required review to ensure to was kept in a condition that was conducive to ensuring infection prevention and control (IPC) standards were being met.

Throughout the course of the two day inspection the inspector met all four residents that lived in the home. All residents used different forms of communication. Some residents engaged in conversation with the inspector, while other residents communicated using sign language, gestures, vocalisations and non-verbal cues.

On arrival at the centre, the inspector was met by a staff member. One resident was present at this time. Two residents had left to attend an art session and the other resident had left to complete some shopping. The resident was in the sitting room on their chair. Shortly, the second resident returned with their shopping and staff members were seen support the resident with putting items away. The resident spoke about their upcoming plans for the day and the next day and were seen to

request items from the staff. They frequently called staff by their name. Staff interacted in a kind and patient manner. The resident enjoyed shopping and going out for coffee. They spoke about upcoming appointments that were occurring. The resident required assurance around different events and activities and staff were seen to provide this as required. They moved around the home with some support from staff. Specific aids were also in place in the form of talking tiles that the resident utilised to help them mobilise around the home.

The second resident present was watching TV. They had a preferred seat in the home and often choose to spend their time here. The staff had set up a bird feeding station near the window as the resident enjoyed this activity. Staff discussed that at times it was difficult to motivate this individual to leave the home. On the day of inspection, the resident initiated that they wanted to go out and this was immediately facilitated by staff. It was evident that the staff team present responded to the resident's preferences and specific assessed needs.

Later in the day the final two residents came home. They had enjoyed their art session and one resident with support from staff showed the inspector the work they had completed. Residents were seen to move around the home and help with evening meal preparation. One resident set the table for all three residents present.

On the second day of inspection all four residents were present and getting ready for the day ahead. One resident was leaving the home to attend an appointment. The other three residents were remaining in the home. There was one vehicle associated with the designated centre which at times, limited the time residents could spend in the community. This was managed as best as possible by the staff team and it was identified that access to the community was an area that required quality improvement.

In the morning time residents were supported with their morning routine. One resident was eating their breakfast while another resident sat beside them. Limited staff supervision was available at this time. It was noted that staff were not adhering to the resident's specific recommendations in their eating, drinking and swallowing plan as devised by the relevant health and social care professional. This was brought to the attention of the staff team. However, it must be noted that risk assessments in relation to this were not in place. This is discussed in further detail under regulation 26.

Activities available at this time for the three residents that remained in the home included, art, baking and watching TV. Staff were seen to support the residents in a calm and caring manner and encouraged the residents to participate accordingly. Residents were also encouraged to take part in house hold chores such as laundry.

Some residents were assessed to require a low arousal environment. Due to differing assessed needs of the group of residents this was not always possible. At times when behaviours of concern were occurring this impacted on the lived experience of the residents within the home. Although this was not observed during the inspection process, there had been previous incidents were this had been recorded. Staff spoke about the impact of the same and the ongoing plans to

address this.

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 inspector found that the centre did not have adequate governance and management systems and arrangements in place to ensure consistent monitoring of the quality of care being delivered. A number of improvements were required across regulations to ensure they met the minimum requirements. Significant improvements were needed in areas of management systems, auditing and identifying actions and monitoring of the same from provider level.

The inspector requested to review the provider's systems to monitor the quality and safety of care and support provided as required by regulation. A recent annual review was presented to the inspector. This had been completed in January 2023 and a copy had been made available to the person in charge in March 2023. From reviewing this documentation it was found that it did not meet the requirements of regulation. Clear actions failed to be identified and they were not assigned to a specific person. Areas of improvement as identified in the report remained outstanding. This new system of auditing had recently been introduced by the provider, however, further review of the effectiveness and alignment with the requirements of regulation was required to ensure this document was fit for purpose and driving quality improvement.

The only other audit that was available to review on the inspection day was a local finance audit. This audit was not comprehensive or effective in identifying areas of improvement to a meaningful degree. For example in this audit, receipts were not cross referenced with actual expenditure. This is discussed in more detail under regulation 8. No other audits were available to review such as health and safety audits, medication audits, personal planning audits. There appeared to be limited oversight of the care and support being provided to the residents.

The provider had determined that two staff during the day and one waking night staff was sufficient to meet the needs of the residents. The skill mix of staff present encompassed social care workers and health assistants. From a review of a sample of rosters this level of staffing was present to support the residents. However, continuity of care was not always demonstrated. For example, a large number of agency staff were utilised on a frequent basis to cover staff absences. This had been self-identified by the provider as an area of improvement, and recently they had committed to using only regular relief staff.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted the required information to apply to the renewal of the registration of the designated centre.

Judgment: Compliant

Regulation 15: Staffing

There was a staff rota in place and it was not reflective of the staff on duty on the day of the inspection. One staff member had recently commenced in the designated centre and was on duty on the day of inspection. Their name was not represented on the rota.

Residents were supported by two staff during the day and one staff at night. The skill-mix of staff present was appropriate to their specific needs. Due to some vacancies and leave within the existing staff team, relief and agency staff were utilised to ensure there was sufficient staff on the rota. On review of the rota over a six week period 15 different agency staff completed shifts. This did not demonstrate continuity of care. The provider had identified this as an area of improvement and had committed to using only regular relief staff. In the last two weeks the number of agency staff had reduced. Time was required to evaluate the sustainability of this arrangement.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The inspector reviewed the staff training records. This indicated that the majority of staff had completed mandatory training in fire safety, safeguarding, manual handling, PPE, hand hygiene, food safety and managing feeding, eating, drinking and swallowing difficulties. Where staff required refresher training these were scheduled for dates in the coming weeks.

Supervision records known as quality conversations,were reviewed. One-to-one formal supervision was not occurring at intervals in line with the provider's own policy. On review of the supervision on file some staff had not received supervision since 2020.

Judgment: Not compliant

Regulation 22: Insurance

The provider had up-to-date insurance as per requirements of the regulations.

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 was in the process of appointing a full-time, suitably qualified and experienced person in charge.

The provider had not always ensured that there was always effective oversight systems in place in this designated centre. As a result, staff supervisions, staff meetings and audits had not been completed. A number of provider-level audits and reviews as required by the regulations, and essential for senior management oversight, had not been completed as required. For example, six monthly unannounced audits had not been completed in the centre since January 2022. In addition, the annual review required amendments to ensure it was effective in driving quality improvement.

The systems the provider had put in place were failing to ensure areas of quality improvement were being identified in a timely manner and that the service in place was ensuring optimal safety at all times. For example, the inspector identified a number of issues with oversight of risk and resident finances that had not been self-identified by the provider. This is discussed in further detail under the relevant regulations below.

Judgment: Not compliant

Regulation 3: Statement of purpose

An up-to-date statement of purpose was in place. This statement of purpose contained much of the required information as set out in Schedule 1 of the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

A review of notifications submitted to the Office of the Chief Inspector occurred. For the most part all notifications were submitted as required.

Judgment: Compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and care was provided in line with each resident's 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 residents' finances, risk documentation, fire safety documentation, and documentation around protection against infection. A number of improvements were required in a number of areas to ensure they met the requirements of the regulations and that a quality and safe service was being delivered at all times.

Although there were systems in place to assess and mitigate risks, such as a centre risk register and individualised risk assessments, on review of a sample of risk assessments it was evident that a number of risks were not being updated as required. For example, there were incidents that described the occurrence of significant behaviours of concern within the service. The first incident occurred in November 2022, however, the risk assessment was only updated in April 2022. No control measures had been considered and the was limited evidence that the identified risks had been effectively evaluated through the risk management process. In addition, effective trending of incidents and accidents was not occurring due to how staff were reporting this. Overall risks were not being managed in line with best practice.

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.

Regulation 12: Personal possessions

The provider had identified that residents did not have access to bank accounts

which was as a result of the systems in place within the organisation. 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. 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.

In addition, the inspector reviewed the bank statements that were present. Some residents has spent considerable amounts of money on personal items such as furniture and blinds. There was no record of these items on the residents' personal asset list. Some personal asset lists had not been updated since 2021. Effective management of residents' personal belongings was not occurring and staff had limited knowledge or references to what belonged to the residents within the centre.

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 lat 12 months. Bank statements present were dated to September 2022. No up-to-date bank statements were available. It was unclear how finances were effectively audited.

Judgment: Not compliant

Regulation 17: Premises

Overall, the designated centre was decorated in a homely manner and well maintained. The designated centre comprises a detached bungalow located in a rural area in Co. Kilkenny. All residents had their own bedrooms which were decorated to reflect their individual tastes with personal items on display. The kitchen had some recent upgrades, such as a new counter-top. The garden area was large and overall, well kept with suitable seating available for residents if they so wished to sit outside.

Judgment: Compliant

Regulation 18: Food and nutrition

Residents' food and nutritional needs were appropriately assessed. There were systems in place to monitor residents' nutritional intake. Staff had appropriate training in this area. A variety of food was available to residents at all times. Food was stored in an appropriate manner. The inspector had the opportunity to observe mealtime experiences for residents. The residents appeared relaxed at these times.

Improvements were needed in terms of appropriate support at these times. This has been addressed under regulation 26.

Judgment: Compliant

Regulation 20: Information for residents

The required information was present in the residents guide. This guide was submitted as part of the renewal of registration process and was updated in line with any staff changes as required.

Judgment: Compliant

Regulation 26: Risk management procedures

It was found that risk management within the centre required significant improvements. There were systems in place to manage risks, however, they were not effective. For example, on review of accident and incidents within the centre there were some patterns and trends emerging. These risks were not managed through the organisations risk management system. In additions, the timeliness of identifying and managing risks was not effective. Risks that occurred in November 2022 where only subject to the risk management process in April 2023. During this time line similar incidents had occurred which may have been prevented if appropriate risk management procedures were followed.

In addition, there was ineffective recordings of incidents and accidents. Some incidents were recorded in the incident and accident log, whereas others were recorded in daily logs .It was unclear how all incidents were appropriately reviewed, analysed and trended to effectively inform risk management processes.

On review of individual risks, there was minimal risks on each resident's file. They had been removed as they were being updated. The staff present found the some recent risk assessments on the desk in the office or on their email account. It was unclear what documentation was guiding staff practice at this time. For example, one resident was at risk of choking. There was no risk assessment around this. On the day of inspection it was found that staff were not clear on the appropriate control measures that should be in place at this time. This was brought to the attention of the staff present.

Judgment: Not compliant

Regulation 27: Protection against infection

Overall, the home was clean and well maintained which promoted good practices in relation to infection prevention and control measures. However, improvements were required in some areas to ensure all elements of practice promoted adherence to IPC measures. For example, laundry was completed in the garage. There was a build up of large cobwebs and dust in this area. Although this area was included on the cleaning scheduled it was evident that it was not being cleaned to a suitable standard.

There had been a recent COVID-19 outbreak within the centre. The inspector asked to review the most recent COVID-19 contingency plan. The staff present were not aware where this document was stored. A staff member found a document that was kept on the organisation on line system. This document had not been updated since early 2022 and did not encompass the current risks within the centre. However, the staff present had good knowledge around what needed to be done during a COVID-19 outbreak. Improvements were needed in the guidance to ensure staff could refer to this if needed.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The designated centre was provided with fire safety systems which included a fire alarm, emergency lighting and fire extinguishers. All equipment was serviced on a regular basis. Fire containment measures were in place in the form of suitable fire doors with self closing mechanisms. Staff completed daily and weekly fire safety checks to ensure equipment was appropriately maintained. There was a centre specific fire evacuation procedure as well as personal evacuation procedures that accurately reflected the supports needed to evacuate residents.

However, improvement was required regarding fire drills. While multiple fire drills had occurred over the last 12 months, from records reviewed, these all reflected scenarios with high levels of staff support. There was no evidence of a fire drill occurring with the minimum number of staff present.

Judgment: Substantially compliant

Regulation 8: Protection

Although there were a number of systems in place to ensure each resident's safety and ensure appropriate safeguarding occurred some improvement was needed in

this area.

Staff had completed training in relation to safeguarding and protection. A number of incidents had occurred within the centre that were appropriately investigated and reported as required. Recently additional oversight had been put in place around safeguarding. It had been identified that there was a delay in formalising safeguarding plans. A number of formal safeguarding plans were required in the centre and they were due to be completed in the coming weeks.

The provider discussed how the group of residents were not always suitable to live in the same house safely together. Incidents had occurred where behaviours of concern had impacted some people living in the home that were assessed to need a low arousal environment. A number of measures had been put in place to ensure all resident's safety. For example, a recent behaviour support plan was introduced. However, these measures had been only recently introduced and required time to embed.

Judgment: Substantially 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 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	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	Not compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Clannad OSV-0005633

Inspection ID: MON-0030272

Date of inspection: 24/04/2023 and 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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: Following recent inspection, the PIC and Team Leader have reviewed the current roster on 08.05.2023 to ensure the roster is fully reflective of current staffing, this included update of the Time Management System (TMS). As part of Social Care Workers delegated duties, an eight-week roster is uploaded to the TMS this will be reviewed by Team Leader on a weekly basis. PIC & TL reviewed the roster in terms of use of agency staff: - based on current staffing requirements two regular relief staff have been identified to cover the use of previous agency bookings, both relief staff are familiar with the centre and have completed shifts in centre. - This will decrease the use of agency, however in relation to the monthly agency staff approval process, the PIC and Team Leader priorities the use of consistent agency staff where necessary to ensure continuity of care.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC and Team Lead have reviewed the status of Quality Conversations and have developed a schedule for all staff's QCs till year end, (employees to receive a QC quarterly as per policy) the Team Leader will communicate the QC dates/schedule with team members by 30.05.2023. The training schedule will be reviewed on a monthly basis by the PIC and the Team Lead ensuring employees attend required training by 30.06.2023. Training will be discussed at	

QC and is also added to Team Meeting Agenda and to PIC monthly checklist.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The PIC and Team Lead have reviewed the status of Quality Conversations and have developed a schedule e for all staff QC for the remainder of 2023. Team Lead will communicate to share dates with team members by 30.05.2023

A suitable qualified Person in Charge has been identified for the designated centre as of 29.05.2023. A Team Leader is supporting the PIC in the governance and management of Clannad.

PIC and TL have reviewed annual provider audit completed in January 2023. Actions from internal audits currently actioned on PIC Local Governance Compliance Plan and to be completed by (31.07.2023).

Lead auditor in Aurora has confirmed that six monthly audits X 2 will be scheduled in 2023.

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

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions: PIC & TL have ensured each Person Supported has an up-to-date asset list. A plan has been implemented to ensure asset lists for each Person Supported are reflective of all current belongings and will be in place by 31.05.2023. Person in Charge and Team Lead are currently working with Keyworkers reviewing spend and cross referencing spends and receipts to ensure all assets are identified on asset lists this will be completed by 30.06.23. Asset lists to be discussed at upcoming Team Meeting on 30.05.23. On the job mentoring in relation to person supported assets and finance policy to be completed by 30.06.2023 Member of Finance department will complete financial audit before 16.06.23. 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. Residents' personal property, finances and possessions policy presently being reviewed, updated policy to be circulated by 16.06.2023. Policy to be discussed in June Team Meeting with on the job mentoring to follow with all staff by 31.06.2023. 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 26: Risk management procedures	Not Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: On the Job mentoring using Aurora Incident Accident pathway is currently being completed by management in the centre, to support staff with appropriately recording incident reports and will be closed out by 09.06.2023. Incident reporting pathway has also been added to agenda for Team Meeting on 30.05.2023.	

Person in Charge has requested the Behavioral Specialist to complete an analysis for incidents that occurred over the past twelve months (May 2022 – May 2023)

Person in Charge and Team Lead scheduled meeting with Behavioral Specialist to discuss incident analysis and to consider any trends. Agreed actions required in regards to the Behavioral Support Plan or risk assessments will be actioned in minutes with realistic time frames.
Risk assessment has been implemented for one person supported in relation to choking risks. A review of all risk assessments will be completed by 23.06.2023

Further review of the designated centres risk register will be completed by PIC & TL by 30.06.2023.
Risk Assessment training will be planned and delivered at June meeting.

Review and update risk register for designated centre by 30/06/2023

Regulation 27: Protection against infection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
The 24-hour cleaning schedule reviewed, and environmental actions identified and requested through the maintenance department with a completion date of July 2023

Infection Prevention and Control Policy has been circulated to staff team to be read and signed. IPC to be discussed at upcoming Team Meeting on 30.05.2023.
Contingency Plan to be reviewed to include guidance for staff members within the delegated centre. Weekly spot checks are also in place to be completed by and TL.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire Drill schedule to be implemented by 31.05.2023.
Fire drill reflective of minimal staff completed on 10.05.2023. Fire Drills including detailed scenarios to provide staff with knowledge of evacuating the centre under different circumstances with fire drills to be completed monthly and twice a year to reflect minimum staffing.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Person in Charge (WCI Manager) (Safeguarding Co Ordinator) and Team Lead met with Assistant Director of Services and reviewed safeguarding for the delegated centre on 08.05.2023.

ADT meeting that took place in March'23 the People supported and their compatibility discussed.
ADT meeting to take place on 01.06.23.

Two Person Supported have been referred to behavioral specialist to review behavioral support plans and to discuss or consider the Behaviors Specialist facilitating a session on group living for person supported.

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	23/06/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	08/05/2023
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Substantially Compliant	Yellow	08/05/2023

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	30/06/2023
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Orange	20/06/2023
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.	Not Compliant	Orange	30/05/2023
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	Not Compliant	Orange	26/05/2023

	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 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.	Not Compliant	Orange	30/06/2023
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 standards for the	Substantially Compliant	Yellow	30/07/2023

	prevention and control of healthcare associated infections published by the Authority.			
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/05/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	16/06/2023