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:	JULA
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-0005694
Fieldwork ID:	MON-0031518

About the designated centre

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

Jula is a residential home located in Co.Kilkenny, catering for four adults with an intellectual disability over the age of 18 years. The service operates 24 hours, seven days a week. The property is a large bungalow which provides a homely environment for the residents. Each resident's private bedroom is decorated to their unique tastes. The person in charge works in a full time capacity with the support of the management team and the staff team.

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 31 July 2023	12:30hrs to 17:30hrs	Tanya Brady	Lead
Tuesday 1 August 2023	09:30hrs to 15:30hrs	Tanya Brady	Lead

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision on the registration renewal of the centre. Two other inspections were also carried out over the same 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 to improvements 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.

This centre had been most recently inspected in February 2023 as a risk based inspection to follow up on information of concern which had been submitted to the Chief Inspector. This current inspection also incorporated reviews of progress against provider identified actions arising from the previous inspection. The current inspection identified that levels of compliance had improved following actions taken by the provider.

Overall, the findings of this inspection were that residents were in receipt of a good quality and safe service. The provider was recognising the complexity of residents' needs and responding appropriately. They had systems in place to monitor the quality of care and support for residents, and these were found for the most part to be proving effective at the time of this inspection. Some improvement was found to be required in the following areas; managing residents personal possessions, complaints management, notification of incidents and governance and management and these are outlined under the specific Regulations below.

This centre is registered for a maximum of four residents and is home to four individuals. The inspector met and spent time with all four residents over the course of the two days. The inspector also had the opportunity to meet two family members and to spend time with the staff and management team in addition to reviewing documentation. Residents' representatives indicated they were happy with the care and support provided to their family member in the centre. Residents indicated they were happy, busy and enjoying taking part in the day-to-day activities of their home. One resident's representative said they were happy with the care their family member received, but were concerned with the location of the centre being so rural and potentially isolating for their family member.

This centre is a large bungalow in a rural area in Co Kilkenny which has ample space for parking and has a large manicured garden and patio area. Residents all have their own bedrooms and there is a kitchen-dining room with access to a sun room for all to share, in addition to a large living room. The provider has ensured that the premises is well maintained and laid out to meet the needs of the individuals who live here. Decoration had been completed since the last inspection and new furniture had also been purchased. Every effort had been made to ensure that there was equipment available to meet residents' needs and to ensure that they could

access their home comfortably. This included an accessible garden with hard surfacing, overhead hoists in the bedrooms to assist with moving from one position to another, adapted bathing and personal care equipment and wide hallways and open spaces that allow for the presence of residents' individual positioning systems such as standing frames, wheelchairs or comfort chairs.

Over the two days of inspection the inspector observed residents relaxing in both communal and private areas within the centre. In addition residents were supported by staff to engage in activities they enjoyed and were important to them. Residents favourite programmes were available for them to watch on television and the inspector observed residents laughing during programmes when anticipating familiar scenes or actors. One resident who enjoyed flowers had a flower arrangement that had been made by a peer on display and they were supported to attend some flower arranging classes or events. Another resident was supported by a staff member to visit the local stables as they were keen to try a horse ride. Residents took time in the garden or on the patio to enjoy being outside and when staff sat at the picnic table for a break they ensured residents joined them and were part of the conversation.

Throughout the inspection, kind, warm and caring interactions were observed between residents and staff. Residents were observed holding staff's hands, and to smile and laugh when staff interacted with them. Staff who spoke with the inspector were aware of residents' complex communication needs, care and support needs and staff were motivated to ensure that they were happy and safe in their home. They spoke with the inspector about residents' preferences, how they liked to spend their time, and the important people in their lives. A number of times during the inspection, staff were observed to quickly pick up on any signs that residents required their support, and they responded appropriately. Each staff who spoke with the inspector talked about increased opportunities for residents to engage in meaningful activities. A concerted effort was being made by staff to include residents in the everyday activities within their home or as part of running their home. This included putting away laundry, support to residents to go shopping to buy groceries or to tidy around the house. Staff described the importance of offering residents the opportunity to become involved in every step of everyday processes.

Residents were supported to keep in touch with, and spend time with their family and friends if they wished to. There were numerous areas of the house where residents could spend time with their family and friends in private. Residents could also entertain their guests in communal areas if they so wished and areas of the garden had been adapted so that younger family members were welcome to play when they visited such as on a swing set.

In summary, residents appeared relaxed and content in their home and with the levels of support offered by staff. They were supported to decorate their rooms in line with their preferences, and had increased opportunities to take part in activities they found meaningful. They were supported by regular staff who were were familiar with their needs and preferences.

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

This announced inspection was completed following an application by the provider to renew the registration of this designated centre. Overall, the findings of the inspection were that the provider and the local management team were for the most part identifying areas for improvement and taking action to bring about the required improvements. However, some further improvements were required in relation to managing resident personal possessions, complaints management, submission of notifications and governance and management.

The person in charge was full-time and responsible for this centre, one other designated centre and also had some governance responsibilities such as being on-call. They were new in the position since the most previous inspection of the centre and were supported in their role by a full time team leader. The person in charge reported directly to the Assistant Director of Services and Director of Services. Despite the large remit in terms of management, the person in charge had systems in place to ensure they had oversight of the service provided to residents and they were introducing quality improvement within the centre supported by the team leader.

The inspector spoke to the person in charge, team leader and members of the staff team during this inspection. Staff described how important it was to them to make sure that residents were happy, safe and taking part in activities they found meaningful. They said that they felt supported in their role and spoke about training courses they had accessed. A number of staff also spoke about the positive impact of the successful recruitment of a number of new staff for the centre in addition to the introduction of a team leader on a full-time basis.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted all of the required information with the application to renew the registration of the designated centre. Minor changes to the statement of purpose and the residents' guide were required to reflect a recent change in personnel and the provider completed same following the inspection.

Judgment: Compliant

Regulation 15: Staffing

The provider had recruited staff to fill vacancies in the staff team since the last inspection. The introduction of these new staff had improved the consistency of care provided to residents. Staff spoken with all stated that there was a stable team of staff now in place and that this supported them in carrying out their role to provide high quality care to residents. Where there had been gaps on the roster due to planned or unplanned leave these had most recently been filled with regular relief staff.

Planned and actual rosters were in place, and these were maintained by the team leader with oversight from the person in charge. While staff roles were not consistently noted on the roster the skill mix of staff on duty was monitored and ensured by the person in charge.

A sample of staff files were reviewed and found to contain the information required by the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

There was training and refresher training available for staff in line with the organisation's policy and residents' assessed needs. Where staff required refresher training such as percutaneous endoscopic gastrostomy feeding (PEG feeding) this had been identified by the provider and was scheduled and provided in-house by a qualified staff member. While some staff were found to require refresher training in the area of managing behaviour that challenges this was not a required training need for this house.

Previous inspections of this centre had identified that formal staff supervisions had not been completed in line with the provider's policy. On this inspection however, all staff had now been in receipt of at least one formal supervision or quality conversation this year and there was a schedule in place to ensure that staff were supported to carry out their role effectively. Staff who spoke with the inspector said they were well supported in their role. Staff meetings were occurring regularly and agenda items varied.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined management structures and staff had specific roles and responsibilities in the centre. The centre was managed by a person in charge who was supported by a team leader and both were familiar with residents' care and support needs and their responsibilities in relation to the regulations. There was a clear focus on quality improvement in the centre. The person in charge and team leader were both new to their role in the previous months prior to inspection and while there had been improvement in the centre oversight some areas such as reporting of notifications or oversight of complaints had not yet been completed. In addition the systems regarding oversight of resident finances required review.

The provider and person in charge had systems in place to ensure oversight and monitoring of care and support for residents such as, an annual review and regular audits in the centre. The audits and reviews completed to date were identifying areas for improvement and the actions on foot of these audits and reviews were resulting in improvements in relation to residents' care and support and in relation to their homes. The person in charge and team leader had put clear action plans in place for all staff to complete as part of their delegated duties and there were also action plans in place for the local management team that were subject to regular review.

The provider had completed one six monthly unannounced visit to the centre and not two as required by the Regulation however, the inspector acknowledges that schedules were in place for the provider to ensure another was completed as required going forward.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents occurring in the centre and the Chief Inspector of Social Services was notified of the occurrence of incidents. However, not all of these that are required to be submitted on a quarterly basis had been notified in line with the timeframe requirement of the regulations.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had a complaints policy and procedures in place. There was a nominated complaints officer and their picture was on display in the centre. The inspector reviewed the record of complaints received in the centre and found that not all had been managed in line with the process identified in the provider's policy.

While complaints had been recorded as received there were no consistent records available to determine what actions had been taken to resolve the concern. The person in charge reviewed all complaints over the course of inspection and while these were found to have been resolved to the satisfaction of the complainant the steps taken in doing so were not recorded.

Judgment: Not compliant

Quality and safety

Through discussions with family members and staff, observation of and engagement with residents and a review of documentation it was evident that every effort was being made to ensure that residents were in receipt of a good quality and safe service. They lived in a warm and clean home which was designated and laid out to meet their needs. Continued focus and improvement was required in relation to the management of resident finances. This would ensure that best practice could be achieved in safeguarding and managing of residents' personal possessions.

Residents were being supported to develop skills and be involved in the routines for upkeep of their home. They were also being supported to engage in activities they had previously enjoyed prior to the COVID-19 pandemic, and to sample different activities at home and in their community to see what they found meaningful. Residents were being supported by a staff team who they were familiar with and who were skilled in interpreting the residents' communication cues.

Regulation 10: Communication

The person in charge and team leader were familiar with the residents' complex communication skills and needs. All residents in the centre were non-verbal and relied on a combination of intentional and non-intentional communication cues to express themselves and to be supported to understand. The staff team spoke about supporting residents to understand their choices and to make informed decisions. They also spoke about the importance of respecting people's choices.

Each resident in the centre had a communication tool box in place which was a document outlining the actions and gestures used by that individual and how these could be interpreted to ensure consistent responses were provided by staff. Residents had been supported to attend multidisciplinary health and social care professional appointments to further support staff in the development of their skills when engaging with residents.

Judgment: Compliant

Regulation 12: Personal possessions

The provider and person in charge ensured that the residents had access to their personal items. The residents' belongings, photographs and personal equipment were available to them in their home both in their bedrooms and in communal areas. However, improvement was required in the recording of personal assets and in the financial oversight systems and in the practices to safeguard resident finances and the access to their monies. From review of resident expenditure sheets the inspector found that residents had purchased a number of personal items that were not recorded as belonging to them on their asset sheets, these included electronic items and furniture or fittings such as window blinds.

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 in other centres operated by the provider. 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 did find however, that the provider updated their oversight systems in response to previous identified concerns. In addition to the cash and receipt checks, subsequent oversight via reconciliations against bank statements was also now being established.

The inspector sampled bank statements and receipt records during the inspection and found evidence of incidences of residents contributing to gifts in differing amounts with no clear record of residents being involved in the decision making for this expenditure. Finance audits also recorded in error amounts as expenditure which were in fact income and these errors had not been identified or amended. Improvement was required in the oversight of recording in daily records as the inspector found for example that balanced amounts carried over from one month to another differed and rounding of amounts were not consistently recorded.

Judgment: Not compliant

Regulation 17: Premises

This centre was a large bungalow in a rural setting with a spacious garden and patio

area to the rear. The provider had ensured that the premises was laid out to meet the complex needs of the residents and the house was accessible to all. All residents had their own bedrooms that were personalised to them and decoration had been completed since the last inspection. Some works such as fitting of new wardrobes was outstanding but these had been identified and was scheduled for completion. The provider and person in charge had overseen painting and decorating, replacement of flooring and the fitting of new radiator covers.

Laundry facilities were not as easily accessible for residents and located in an area external to the house. The inspector acknowledges these were not part of the designated centre.

Judgment: Compliant

Regulation 26: Risk management procedures

Residents, staff and visitors were protected by the policies, procedures and practices relating to risk management in the centre. The provider's risk management policy contained all information as required by the Regulation. The provider and person in charge were identifying safety issues and putting risk assessments in place. Arrangements were also in place to ensure that risk control measures were relative to identified risks. The inspector reviewed a sample of both individual and centre specific risks and found that these were regularly reviewed and there was evidence of the risk ratings increasing or decreasing in line with changing needs. All actions for each risk were noted to be clear and detailed in guiding staff practice.

There were systems in place for responding to emergencies and feedback and learning from incidents was shared amongst the team at team meetings.

There were systems to ensure vehicles were roadworthy and well maintained. General and individual risk assessments were in place and these were being reviewed and updated in line with residents' changing needs, and in line with incidents in the centre. There was evidence of shared learning across the team following incidents and adverse events, both during staff meetings and at handover.

Judgment: Compliant

Regulation 27: Protection against infection

The health and safety of residents, visitors and staff was being promoted and protected through the infection prevention and control policies, procedures and practices in the centre. Residents and staff had access to information on infection prevention and control, and there were contingency plans in place in relation to

outbreaks of infection. Staff had completed a number of additional infection prevention and control related trainings.

There were cleaning schedules in place to ensure that each area of the house was regularly cleaned. There were suitable systems in place for laundry and waste management and for ensuring there were sufficient supplies of personal protective equipment (PPE) available in the centre. The person in charge and team leader had ensured all resident's personal equipment was included on the cleaning schedule and where minor gaps in recording were noted these had been identified via the provider's auditing system.

Judgment: Compliant

Regulation 28: Fire precautions

Suitable fire equipment was provided and serviced as required. There were adequate means of escape, including emergency lighting. The evacuation plans were on display and each resident had a personal emergency evacuation plan outlining any supports they may require to safely evacuate the centre in the event of an emergency. There was some discrepancy found between the method to be used for escape if residents were in bed, on the centre evacuation plans and in personal evacuation plans. This had however, been identified, reviewed and was due to be amended.

Fire drills were occurring regularly in the centre and staff had completed training to ensure they were aware of their roles and responsibilities in the event of an emergency. A drill with minimum staffing was completed in line with policy, this had demonstrated that when all residents were in bed it had taken 18 minutes for full evacuation, the provider was to liaise with their fire safety specialist to ensure that this timeframe was within safe limits.

Judgment: Compliant

Regulation 6: Health care

The provider and person in charge ensured that residents were being supported to enjoy best possible health. An annual overview of assessed health needs and supports was in place and this was also used to maintain an overview of appointments and other health related matters. Health assessments informed residents' plans of care and these were found to be regularly reviewed and updated to ensure they were reflective of their needs.

All residents accessed a GP of their choice and health and social care professionals

in line with their needs and the resulting care plans were detailed in nature and guiding staff practice. Where residents had hospital admissions they were supported during their visit or stay with up-to-date hospital care plans and staff support as indicated. Residents were accessing national screening programmes in line with their age profile, and in line with their wishes.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge and staff team used the communication documentation and their knowledge of residents' non-verbal cues in determining the communicative function of behaviours and this was incorporated into residents care plans.

There were a number of restrictive practices in the centre associated with the residents' specific assessed needs around the use of mobility equipment. These were being reviewed regularly to ensure they were the least restrictive for the shortest duration. Residents also had restrictive practice reduction plans in place.

Staff spoke about using easy-to-read documents and residents' preferred communication styles to support them to understand what restrictive practices were in place. They also spoke about ongoing work with residents and the multi disciplinary team to implement restrictive practice reduction plans where indicated.

Judgment: Compliant

Regulation 8: Protection

Notwithstanding the areas discussed under Regulation 12, the residents in this centre were protected by the policies, procedures and practices relating to safeguarding and protection. The provider's policy had recently been reviewed and there was an easy-to-read version also available for residents to access.

Previous safeguarding actions identified and reviewed on the last inspection of this centre were now closed and plans that had been developed had been reviewed and referred for closure in line with best practice. Safeguarding plans were found to have been developed and reviewed as required. Staff had completed training in relation to safeguarding and protection, and those who spoke with inspector were knowledgeable in relation to their roles and responsibilities. Allegations and suspicions of abuse were reported and followed up on in line with the provider's and national policy.

Judgment: Compliant

Regulation 9: Residents' rights

The residents who lived in this centre were supported to experience activities as part of the day-to-day running of their home and to be aware of their rights through residents' meetings and discussions with staff and their keyworkers. Over the course of the inspection the staff were observed talking residents through routine events and ensuring they were present for activities such as peeling vegetables or putting away laundry.

They had access to information adapted for them on how to access advocacy services and were supported to access information in relation to their rights, safeguarding, and advocacy supports. There was information available in an easy-to-read format, or in spoken script that could be repeated on the centre in relation to infection prevention and control, and social stories developed for residents in areas such as fire safety.

Staff practices were observed to be respectful of residents' privacy. For example, they were observed to knock on doors prior to entering, to keep residents' personal information private, and to only share it on a need-to-know basis

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 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for JULA OSV-0005694

Inspection ID: MON-0031518

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:

The provider through the QA function has developed an audit schedule for the service. The annual audit was completed in designated centre in April'23, a six-monthly inspection has been completed in August'23 and next six monthly is on schedule for Jan2024. Audits will be added to team meetings agenda for discussion and actions they will also be discussed at individuals QC in relations to specific actions. The audits have been printed and put into audit folder, staff are directed to this folder to understand their actions and record when completed.

The Team Lead and PIC will report on progression of same through PIC monthly status report to DOS and ADOS.

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

The provider has developed a process through the QA function to monitor and check on quarterly notifications being submitted within relevant timeframes. Notifications will be sent as a reminder to all PIC and Team Leaders.

The QA have developed a Ways of Working and sent to PIC and staff teams in regards to notifications and associated timelines.

All outstanding complaints were addressed and resolved by the PIC by the 01/08/23. The Complaints Officer will attend the team meeting on 06.09.2023 to discuss the complaints policy, with a focus on how to process a complaint. The Complaints Officer will complete an audit on complaints in the centre to include the content of Complaints folder on the 07.09.2023

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
All outstanding notifications have been completed and submitted by the PIC on the 31/07/2023.The provider has developed a process 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.

The QA department have developed a Ways of Working and sent to PIC and staff teams high lightening the notifications and associated timelines.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
All outstanding complaints were addressed and resolved by the PIC by the 01/08/23. The PIC & Team leader have invited the Complaints Officer to the team meeting on 06.09.2023 to discuss and explain the Complaints policy, with a focus on how to process a complaint. The Complaints Officer will complete an audit on complaints in the centre to include the content of Complaints folder by the 07.09.2023

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Record of all significant purchases are now evident on person supported Asset list updated on the 10/08/2023. All people supported have an asset list and this has been added to
(i) Finance section on Annual Review Visioning Meeting template to ensure individuals assets are reviewed annually, it has also been added to
(ii) Monthly Review template 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.

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.

Residents personal property, finances & possessions policy will be discussed at staff team on 06/09/2023 by PIC & Team Leader.

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. Finance officer is also completing fortnightly checks during top up and highlighting any discrepancies directly to PIC, Director of Finance and DOS.

Team Leader will provide weekly oversight of finances in the designated centre and will complete monthly audits, she will report findings directly to PIC.

Aurora promotes the concept of Circle of Supports, therefore the PIC & Team Leader will ensure each of the ladies have their Circle of Support to support them in all decision making.

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	10/08/2023
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	30/10/2023
Regulation 23(2)(a)	The registered provider, or a person nominated	Substantially Compliant	Yellow	20/09/2023

	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 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 chief inspector at	Not Compliant	Orange	31/07/2023

	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).			
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Not Compliant	Orange	01/08/2023
Regulation 34(2)(d)	The registered provider shall ensure that the complainant is informed promptly of the outcome of his or her complaint and details of the appeals process.	Not Compliant	Orange	06/09/2023
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Not Compliant	Orange	07/09/2023