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:	Lunula
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-0007900
Fieldwork ID:	MON-0031361

About the designated centre

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

Lunula is a residential service operated by Aurora. The centre provides a community residential service to a maximum of three adults with a disability. The designated centre is a detached bungalow located in a rural area in Co. Kilkenny within a short drive to a town with access to facilities and amenities. The house comprises of three individual resident bedrooms, a sitting room, kitchen/dining room, utility room and a visitors room. To the rear of the house there is a enclosed garden. The designated centre is staffed by a staff nurse, social care workers and health care assistants. The staff team are supported by a person in charge.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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	Conan O'Hara	Lead
Tuesday 25 April 2023	09:00hrs to 13:30hrs	Conan O'Hara	Lead

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision regarding the renewal of registration for this designated centre. The inspection was completed over two days by one inspector. Three other inspections in other designated centres operated by the registered provider were also completed over that time frame. Overarching findings were identified in relation to the provider's governance and management arrangements in all four centres inspected. High level feedback was provided to the registered provider following these inspections. The areas for improvement included governance and management, financial safeguarding and the management of resident possessions. This report will outline the findings against this centre.

Over the course of the two day inspection, the inspector had the opportunity to met all three residents that lived in the home. All three residents used different means to communicate, such as spoken language, vocalisations, facial expressions, behaviours and gestures. The inspector endeavoured to gather an impression of what it was like to live in the centre, through observations, discussions with the staff team and management, monitoring care practices and reviewing documentation.

On arrival at the centre, the inspector was welcomed by the Person in Charge and the Community Service Manager. Two residents were being supported to access to the community, while one resident was being supported at home for the day as they had been unwell recently. The inspector met with the resident who was sitting on the couch in the kitchen drinking tea. The resident spent time relaxing in the kitchen observing and interacting with staff. The resident communicated their preferences through non-verbal methods and staff were observed responding to their requests in an appropriate and timely manner.

The inspector completed a walk-through of the centre and found that the centre was visibly clean, in a good state of repair and decorated in a homely manner. The designated centre consists of a sitting room, kitchen/dining room, utility room and a visitors room. Each resident had their own individual bedroom which were decorated in line with their preferences. One resident's bedroom had en-suite facilities while the other two residents had access to a main bathroom. To the rear of the house, there was a well maintained garden

Later in the day, the two other residents returned and appeared comfortable in their home. The inspector meet with one resident in the sitting room as they enjoyed having a soft drink and reading the paper they had bought in the local shop. The resident spoke to the inspector about their day and told the inspector what music they liked. A staff member told the inspector about developing connections to the local community including the shop and local pub. The third resident was observed moving between the kitchen and their bedroom. The staff noted that the resident was undertaking a walking challenge over the month to fundraise for a charity. There were plans to host event at the weekend in the centre to mark completing the

challenge and the money raised. Overall, the inspector observed the staff team supporting the residents in a respectful and caring manner.

On the second day of inspection, all three residents were present and were being supported to prepare for the day. One resident was leaving to attend a course and the other resident had plans to go shopping for items ahead of the event at the weekend. One resident remained in the house and was observed having a cup of tea before they engaged in personal care routines in line with their assessed needs. The resident had plans to access the community later in the afternoon.

Overall, it was found that the designated centre was striving to provide person centred care in a homely environment. However, there were a number of areas identified which required significant improvement including governance and management, oversight and support of resident's finances and fire safety. In addition, improvement was required in the staffing arrangements, staff supervision, notification of incidents and personal plans.

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

There was a clearly defined management system in place. On the day of inspection, there were sufficient numbers of staff to support the residents' assessed needs. However, improvements were required in the effectiveness of the governance and management arrangements, staffing arrangements, supervision and notification fo incidents.

The centre was managed by a full-time, suitably qualified and experienced person in charge. While, there was evidence of quality assurance audits taking place, it was found that it did not meet the requirements of regulation. For example, the annual review 2022 did not demonstrate consultation with residents or their representatives. While a a recent six monthly unannounced provider audit had been completed, the timeliness of the unannounced provider audits were not in line with the regulations. This was also identified at the previous inspection.

On the day of inspection, there were sufficient numbers of staff on duty to support residents' assessed needs. From a review of the roster, it was evident that there was an established staff team in place which ensured continuity of care and support to residents. The inspector observed positive interactions between the residents and the staff team. However, the arrangements in place regarding the skill mix of staff required review.

There were systems in place for the training and development of the staff team. From a review of a sample records, it was evident that the staff team in the centre

had up-to-date training. The staff team took part in formal supervision. From a review of records, some improvement was required in ensuring formal supervision occurred in line with the provider's policy.

Regulation 14: Persons in charge

The registered provider had appointed a full-time, suitably qualified and experienced person in charge to the centre. The person in charge had recently been appointed to their role in December 2022. The person in charge was also responsible for one other designated centre. They were supported in their role in this designated centre by the staff team.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained a planned roster for the centre. The inspector reviewed a sample of the roster and found that there was a core staff team in place. The provider ensured continuity of care through the use of an established staff team and a small number of regular relief and agency staff. The inspector found that there was sufficient staffing levels in place to meet the needs of the residents. The three residents were supported by three staff members during the day and supported by two staff in the evening. At night, one staff member on a waking night shift were in place to support the three residents.

However, the staffing arrangements, particularly in relation to the skill mix of the staff team in place, required review to ensure they meet the needs of the residents at all times. The statement of purpose identified that a staff nurse is assigned to this designated centre to monitor and ensure the residents' individual health care needs are being met. On review of the roster, the centre was operating with a nursing staff on long-term leave. The staff nurse role was covered by care assistants and social care workers and required review.

A sample of staff files were reviewed and found that they contained all of the information as required by Schedule 2 of the regulations.

Judgment: Not compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team.

From a review of a sample of training records, the staff team had up to date training in a range of areas such as fire safety, safeguarding, manual handling and safe administration of medication. This meant the staff team were knowledgeable and skilled to meet the assessed needs of residents.

The previous inspection identified that supervision was not occurring at intervals in line with the provider's own policy. The inspector reviewed a sample of the supervision records for the last year. The inspector found that the staff team that supervision had not provided in line with the provider's policy. However, there was evidence of recent improvement in the provision of staff supervision meetings. A supervision schedule had been developed for the upcoming year.

Judgment: Substantially compliant

Regulation 23: Governance and management

There was a clearly defined management structure in place. The person in charge reported to the Community Services Manager, who in turn, reported to the Assistant Director of Services. The person in charge was responsible for the management of two designated centres and was supported in their role by the staff team.

There was evidence of quality assurance audits taking place. The quality assurance audits included the annual review 2022 and a recent six-monthly provider visit. These audits identified some areas for improvement and in some cases developed action plans. For example, the recent six monthly audit identified that improvements were required in the frequency of staff supervision and in areas of the premises. Plans were in place to address same.

However, the provider had not always ensured that there was effective oversight systems in place in this designated centre. For example, the annual review 2022 did not demonstrate consultation with residents or their representatives in line with the requirements of the regulation. In addition, the six monthly unannounced audits had not been completed in line with the regulations. For example, the last two unannounced provider six-monthly audits were undertaken in March 2023 and January 2022. The timeliness of the unannounced provider audits was also identified at the previous inspection in March 2022.

The inspector was informed that the provider had plans in place to ensure the six monthly unannounced visits would be completed in line with the regulations. The inspector reviewed a schedule for the six monthly inspections for the upcoming year for a number of designated centres. This practice did not ensure that the six monthly inspections were unannounced.

Overall, the systems the provider had put in place to ensure areas of quality improvement were being identified and addressed required further improvement. For example, the inspector identified a number of areas for improvement in relation to staffing skill mix and oversight of resident finances. In addition, areas for

improvement identified at the previous inspection required further review including the frequency of supervision, notification of incidents and fire safety. These areas had not been self identified through provider auditing and oversight and no appropriate corrective actions were put in place.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of adverse incidents and accidents occurring in the designated centre and found that the Chief Inspector was notified as required by Regulation 31.

However, the previous inspection found that improvement was required in the timely submission of notifications as required by Regulation 31. On review of notifications submitted in the last year, the inspector found that not all notifications had been submitted in a timely manner. For instance, two incidents of a serious injury occurring in September 2022 were submitted 17 and 28 days after the incident. This was not reported within the three day time period as required by Regulation 31. Similarly, quarterly notification reports in relation to restrictive practices and minor injuries for Quarter 2 2022 and Quarter 3 2022 were submitted in October 2022 and February 2023, respectively.

Judgment: Not compliant

Quality and safety

Overall, the service strived to provide person-centred care and support to the residents in a homely environment. The inspector found that the residents being well supported in some areas such as health care and positive behaviour support. However, improvements were required in the oversight of residents' finances, fire safety and personal plans.

The inspector reviewed a sample of residents' personal files which comprised of an up-to-date comprehensive assessment of the residents' personal, social and health needs. Personal support plans reviewed were found to be up-to-date and to suitably guide the staff team in supporting the resident with their personal, social and health needs. However, one plan in place required review in order to accurately guide staff in supporting one resident with an identified need.

The previous inspection found that improvements were required in residents finances including completing individual assessments to support residents to manage their finances and residents not having their own bank accounts. There was

evidence that action had been taken to explore options to open residents' bank accounts. However, the inspector found that there remained areas for improvement in supporting residents' to manage their financial affairs and in the oversight systems in place, as they did not ensure that residents finances were appropriately protected.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. The residents had Personal Emergency Evacuation Plans (PEEPs) in place which appropriately guided staff in supporting the resident to evacuate. However, the previous inspection found that improvements were required to ensure that all residents could evacuate safely in the event of an emergency. While, it was evident the provider had undertaken some steps to address this through consulting with the local fire station, their internal fire officer and behavioural therapist, it remained an area for improvement.

Regulation 12: Personal possessions

The systems in place to support residents to manage and protect their finances required significant improvement.

The residents' did not have their own bank accounts. Residents' finances were managed through an internal financial system within the provider's organisation. At times, this meant that residents had limited control and choice around their finances as access to finances had to be requested through the provider's main central office. As staff were only available during office hours, access to resident monies after these hours was limited.

The previous inspection identified that assessments of the financial supports for residents to manage their own finances had not been completed. This had been addressed for two residents. However, the inspector found that the assessment of support was not completed fully for one resident.

There were local systems in place to provide oversight of monies held by residents physically in the centre. For example, local systems included day-to-day ledgers, storage of receipts and daily checks on the money held in the centre. The inspector checked the money in the centre against the ledgers for all three residents and found that they matched. However, some improvement was required to complete the expenditure ledgers for residents' debit cards which in one case had not been completed since June 2022. This had been self-identified by the provider in a finance audit completed in March 2023.

The oversight systems in place to support the residents to manage and protect their finances required improvement. For example, while financial statements were available from the provider for review they were not part of regular auditing. In addition, the information set out in each residents' contract of care did not match the contributions being paid by each resident. The residents' contributions were

based on the service providing part-time (less than 24-hour) medical or nursing care. As noted, under Regulation 15, nursing care was not present in the service for a significant period of time. This had not been identified by the provider or the finance team in their quality assurance finance audits and required review.

Judgment: Not compliant

Regulation 17: Premises

The designated centre was designed and laid out to meet the needs of the residents. The designated centre was decorated in a homely manner and generally well-maintained. The resident's bedrooms was decorated to reflect their individual tastes and pictures of the residents and people important in their life were located throughout the centre.

Judgment: Compliant

Regulation 27: Protection against infection

There was evidence of contingency planning in place for COVID-19, with relevant guidelines and policies and procedures in place. All staff had adequate access to a range of PPE as required. There was sufficient access to hand sanitising gels and hand-washing facilities observed through out the centre. Staff had completed a range of training to enable them to practice effective infection control measures.

Judgment: Compliant

Regulation 28: Fire precautions

Improvements were required in the arrangements in place for the safe evacuation of all persons in the event of a fire, particularly at night-time. This was also identified at the previous inspection. While there was evidence that the provider engaged with the local fire station, internal fire officer and behavioural therapist since the last inspection, it remained an area for improvement.

At night time, the three residents were supported by one staff member on a waking night shift. In the event of a fire at night-time, the provider had identified staffing supports in another designated centre, ten kilometers away, to support with the evacuation of the centre.

From a review of fire drill records, the inspector found that the night-time fire drills

did not accurately reflect the night-time scenario where residents would be in bed. For example, the two night-time fire drills completed in February 2023 and July 2022 took place at eight o' clock in the evening when residents were up and awake. The night-time fire drill in February 2023 took 7 minutes and 54 seconds to fully evacuate all residents from the centre and it took 14 minutes for the identified staffing support to travel from the other designated centre. In the night-time fire drill completed in July 2022, a resident chose not to participate in the fire drill.

It was documented that one resident may refuse to to take part in a fire drill. In the six months before the inspection, the resident had failed to take part in a fire drill on two occasions and required significant support on two other occasions. A risk assessment had been completed and identified completing night-time drills four times a year as one of the measures to manage this risk. As noted, only two night-time fire drills had been completed within the last year.

Overall, it had not been demonstrated by the provider that the right arrangements were in place to ensure that all persons would evacuate the designated centre in a safe and timely manner, particularly at night-time.

In addition, the arrangements in place for reviewing fire precautions were not adequate. For example, a number of recent fire drills identified an issue in accessing emergency medication in the event of an evacuation of the centre due to its location within the building. While this learning had been first identified in February 2023, the plans in place to address same were not clear.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of resident's personal files which contained an up to date comprehensive assessment of the residents' health, social and personal needs. The assessment informed the resident's personal plans which guided the staff team in supporting resident's with identified needs, supports and goals. However, one plan required review to ensure it was up to date and accurately guided the staff team to manage an identified care need.

Judgment: Substantially compliant

Regulation 6: Health care

Not withstanding, the area for improvement in the staffing arrangements. The residents' health care supports had been appropriately identified and assessed. The health care plans appropriately guided the staff team in supporting the resident with

their health needs. The provider had ensured that the residents were facilitated to access appropriate allied health professional as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents' were supported to manage their behaviours and positive behaviour support guidelines were in place, as required. Residents were supported to access psychology and psychiatry as required.

There were systems in place to identify, manage and review the use of restrictive practices. There were a number of restrictive practices in use in the designated centre which had been appropriately identified as restrictive practices and reviewed.

Judgment: Compliant

Regulation 8: Protection

Notwithstanding the concerns in relation to oversight of residents' finances which is discussed under Regulation 12, the provider had systems in place to safeguard the residents. There was evidence that incidents were reviewed, managed and responded to. All staff had up-to-date safeguarding training. Staff spoken with, were found to be knowledgeable in relation to their responsibilities in ensuring residents were kept safe at all times. The residents were observed to appear content and comfortable in their home.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Lunula OSV-0007900

Inspection ID: MON-0031361

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: There is an established team in place in Lunula that know all three gentlemen very well. This core team in the absence of the staff nurse (due to leave) have ensured and will continue to ensure the continuity of health care needs for the people supported with the support of Aurora link nurse (Medication Manager) and the two-night managers who are both registered nurses. Assistant Director of Service is holding full clinical oversight on people supported across service. Through the Aurora Personal Plan Framework, the gentlemen's health needs are assessed, monitored and actioned. Ongoing recruitment is in place to recruit nursing staff across the service. A Task Force Group in relation to recruitment & retention has met on 19.5.2023 and an immediate action is an Open Day on the 27.5.2023 to attract new employees.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: The PIC has completed all Quality Conversations in line with Aurora's policy since taking over the designated centre in December 2022. The PIC has developed a schedule for 2023 completion of QCs in Lunula, which is available in the folder and to all employees on the one drive with their rosters.	

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
One six monthly provider audit had been completed in March 2023 and action plans developed. A further six-monthly visit will take place before year ending (2023). The PIC, SCW and staff team have been processing completion of the identified actions.
The annual provider audit is currently in process for completion, auditor will meet with the PIC to discuss findings once completed by latest 20.6.2023.

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. Review of Aurora Finance policy and oversight on person's finances to safeguard same.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Some notification submissions were submitted late for 2022, but in 2023, to date notifications have been submitted as per requirements including three day notifiable and quarterly returns.
Full oversight from the PIC for notifications of incidents will be ensured, as per HIQA requirements, especially with the services new PIC configuration.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Aurora followed national RSSMAC guidance in relation to classes and charges in regards to staff nurse on WTE for Lunula.
In light of concern identified through HIQA inspection re the financial impact on the gentlemen due to been charged under a certain category, Aurora sought clarification from the HSE RSSMAC team. As the nurse was not replaced, they identified the specific category that should be applied for the duration of leave of the staff nurse. Aurora has made the decision to reimburse people living in Lunula from the date of leave commencement of the nurse. This specific category will remain in place until a nurse returns to Lunula designated centre.

Expenditure ledgers of debit cards used by the gentlemen needed improvements, interim plan development and devised. As per our Finance department, a new debit card, Soldo will be rolled out as Quality Initiative across Aurora for house budgets in June 2023. As a next development Soldo cards will be implemented for people we support. Actions for this are to be completed in advance of a meeting on the 24th May so the finance department will have full suite of guidance out after that.

Competency assessment plan finished on the day of inspection for one gentleman.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
The PIC, a numberof the staff team and two of the three gentlemen met with the local fire officer on the 4th May 2023 in Lunula.
Meeting was documented and recommendations made by the fire officer. These recommendations have been actioned.
PIC has since completed a pre fire/ incident planning form, as required by Kilkenny fire and rescue service.
Local fire officers are planning to call to Lunula again, on one of their training nights to meet the men again and calculate respond times from Callan to Lunula. Current time to response to the fire station is between 4 & 5 minutes-fastest respond time in the county of Kilkenny.

Complete four night time drills in total, in 2023 with minimal staffing and when the three gentlemen are in their beds. May night time drill to occur on the 22ND May.
The two remaining drills planned across the rest of the year.

Gain further support from our Behaviour Support Specialist to make some recommendations directly related to one person we support.

Consultation with Hospital in regards to this person's condition and the impact these fire drills may have on him.

As per issues identified in the recent fire drills and access to emergency rescue medication from the utility room for seizure activity lasting more than 3 minutes, a new lock box has been sourced and to be located in this person's bedroom.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
One support plan sentence needed review to guide the staff accurately, this support plan has been amended and will be discussed at the next team meeting.

Section 2:

Regulations to be complied with

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

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

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	30/06/2023
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	26/05/2023
Regulation 16(1)(b)	The person in charge shall	Substantially Compliant	Yellow	26/05/2023

	ensure that staff are appropriately supervised.			
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	26/05/2023
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	26/05/2023
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any	Not Compliant	Orange	20/06/2023

	concerns regarding the standard of care and support.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	26/05/2023
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Not Compliant	Orange	26/05/2023
Regulation 31(1)(d)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any serious injury to a resident which requires immediate medical or hospital treatment.	Not Compliant	Orange	26/05/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any	Not Compliant	Orange	26/05/2023

	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	26/05/2023
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	26/05/2023