Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Tús Nua
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	27 March 2023
Centre ID:	OSV-0005698
Fieldwork ID:	MON-0038696

About the designated centre

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

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

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	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 27 March 2023	09:30hrs to 17:30hrs	Sarah Mockler	Lead
Monday 27 March 2023	09:30hrs to 17:30hrs	Louise Griffin	Support

What residents told us and what inspectors observed

This was an unannounced risk based inspection completed following receipt of information of concern that was notified to the Chief Inspector of Social Services by the registered provider regarding a safeguarding incident in the centre. The incident described the use of an unplanned restrictive practice that was utilised during this incident. The registered provider was required to submit written assurances around the systems that would be put in place to reduce the likelihood of an incident such as this re-occurring. This inspection found that the systems in place had failed to address the ongoing incompatibility between two residents in the designated centre. This was having a negative impact on the lived experience of some residents within the centre.

Inspectors observed that there had been a reported increase in peer to peer incidents within the centre over the last few months. On the day of inspection residents were closely supervised at all times. Staff explained that residents required this level of constant supervision when they were in close proximity of each other. Staff had to remain upstairs if residents were upstairs. At night, the waking night staff was required to remain in the upstairs office and only leave this space if cover was sought from the other part of the designated centre.

The inspectors met with all three residents that lived in the designated centre over the course of the inspection. Residents were observed in their environments and in their interactions with staff while two of the residents briefly spoke with the inspectors. The inspectors' engagement with the residents combined with documentary review, discussion with staff that were familiar with the residents' specific needs and observation of staff practice are incorporated into the findings of this report.

The designated centre comprises two separate semi-detached houses that were located beside each other in a residential setting near an urban area in Co. Kilkenny and a short commute from all services and amenities. On the day of the inspection, the inspectors were greeted by a member of staff who showed the inspectors around one of the houses and introduced them to the two residents that lived there. One resident was sleeping in their bedroom and the other resident was watching TV when inspectors arrived to the centre. The inspectors had the opportunity to observe the residents as they engaged in activities over the course of the inspection.

Both these residents choose not to speak or interact with the inspectors. These residents were being supported by two staff members; one core staff member and one agency staff member. Later in the day a staff nurse, who was also a member of the core staff team, came to support the residents in this part of the centre. Core staff were very familiar with residents' specific needs, and communication skills and spoke in a caring and respectful manner about residents at all times.

Staff spoke about the daily activities that were planned with the residents on the

day of the inspection. One resident was going shopping and then would attend a horticultural course. The other resident was baking with support from staff and was going out for a drive in the afternoon. Staff were seen to help prepare residents' lunch and dinner. Staff checked in on residents on a regular basis to ensure they were ok and involved them in daily routines in line with their assessed needs.

The two residents that lived in this part of the centre had their own individual routines and did not choose to spend any significant amount of time in each others company. In addition, when out in the community the residents always accessed activities separately due to the level of staff needed to support them.

On the walk around of this part of the centre it was noted that the interior required some significant improvements. This will be discussed further in the report. All rooms internally required painting, parts of floors had chips or cracked tiles, bedroom cupboard doors and handles required repair, bathroom fittings in main bathroom and bedrooms required replacing. Pictures displayed in the first house only represented one resident who was engaging in activities with family, peers or staff. Parts of the home had not been cleaned for a period of time with dirt and accumulations of dust present. Improvements were needed to ensure the home was well kept, homely and would met the minimum standards of infection prevention control (IPC) standards.

Residents in this part of the centre were supported by social care workers, nursing staff and health care assistants. Due to residents' specific assessed needs residents either received one to one or two to one support in this part of the centre. In order to ensure sufficient staff numbers were in place at all times, agency staff were being utilised. From a review of daily notes and discussions with core staff it was found that the level of agency staff being used within the centre was at times having a negative impact on elements of residents care and support. For example, at times agency staff found it difficult to settle residents in their rooms at night which impacted the residents' sleep.

The inspectors went to meet the resident in the second house who was going out for a drive with staff. They appeared comfortable and content. This residents' home was clean, homely and nicely decorated. The resident had access to a small sitting room and kitchen, an individual bedroom and accessible bathroom. There was also an upstairs area with a staff office, two bedrooms which were being used for storage and a staff bathroom. The resident did not access this area. The sitting room door lead out to a concrete area with a ramp and two steps with a handrail to either side. A lovely well kept garden area lead off this area. Overall the interior was well kept, and repainting has been completed with resident's colour choice for their home.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in this centre, and how these arrangements impacted the quality and safety of the service being delivered. The inspection findings indicated that substantive improvements were required across key regulations to ensure that the service was safe and meeting all the assessed needs of residents. In particular oversight, at local and provider level

required significant improvements to ensure risks were appropriately assessed, managed and mitigated.

Capacity and capability

Management systems within the centre were not effective in ensuring all residents were safe at all times, that care was consistently monitored, and that areas of improvement were identified and implemented in a timely manner. Furthermore, there a lack of a robust response in terms of implementing systems that would address the incompatibility between the residents within the home.

In the previous inspection, which took place in December 2021, it was identified that improvements were needed to ensure management systems within the centre were effective. Similar findings were also present on the current inspection. Such improvements were needed to ensure the service was consistently delivered, effectively monitored and safe. A number of areas of regulation required significant improvement to meet the minimum requirements of safe and quality care provision. This included staffing, training of staff and governance and management arrangements. Overall, it was found that there had been a deterioration in compliance levels in this centre over the last 15 months.

The inspection was facilitated by the core staff team. The community services manager visited the centre at the beginning of the inspection and was available to take calls during the course of the inspection as needed. There was a clear management structure in place in the centre. The person in charge reported into the community services manager. The person in charge occupied a full-time role and had remit over one other centre at the time of this inspection.

The registered provider had developed an audit schedule to ensure that a range of areas of service provision were monitored. An annual review of the quality and safety of care and the six monthly provider unannounced visits had occurred within the relevant time frames. Other audits such as medication, fire safety, infection prevention control and health and safety audits has occurred in line with the organisations stated time lines. However, the audits in place were not effectively identifying areas that needed improvement in line with the findings of the inspection.

On the day of inspection staff interactions were noted to be professional, caring and in line with residents assessed needs. Some staff had been working with some of the residents for a long period of time and were very knowledgeable of their specific needs. On the day of inspection there were three whole time equivalent vacancies. This meant that the required number of staff were not available to support residents in the community on a consistent basis. Some residents were assessed to have two support staff with them at all times in the community. At times, due to staff shortages from absences and staff vacancies, this staffing level was not available.

Community access for these residents was limited on these days.

Regulation 15: Staffing

Although staffing levels were sufficient to meet the care needs of residents in the home a number of staff vacancies resulted in insufficient staff being rostered to enable community participation for residents on some occasions. In addition, there were a number of different agency staff employed within the centre each week. This was having a direct impact on residents in terms of continuity of care.

From reviewing past and present rosters, inspectors found that the provider had been unable to attain a whole staff team to support the residents. The provider, at the time of the inspection, relied a number of agency staff to ensure safe staffing levels were maintained on a weekly basis. Inspectors found that while the provider was aware of this, they had not been successful in their recruitment drives and had not progressed the planned staffing review in the designated centre. Inspectors were informed that specific recruitment drives have been in place over the last eighteen months. In addition the provider was in the process of exploring the option of using one agency only.

It was noted that some residents' daily routine was impacted by unfamiliar staff. For example, it was recorded in one resident's daily notes, that a resident's nightly routine was not followed and they spent the night in the sitting room. The high use of agency staff was having a direct impact on the lived experience of residents within the centre.

Judgment: Not compliant

Regulation 16: Training and staff development

While there were systems for training and development in place further improvements were required. A staff training matrix was reviewed and a sample of staff training records were inspected. Training was provided to staff in a range of areas such as fire safety, managing behaviour that is challenging, low arousal, safeguarding, human rights, first aid, Children First, people handling, infection prevention control, food safety, Epilepsy awareness, and medication. The inspectors reviewed a sample of training records and found staff training was up-to-date however, a number of staff training courses were overdue.

For example, refresher training in fire safety, managing behaviour that is challenging, Epilepsy awareness, and infection prevention control were overdue for a small number of staff. There were 23 agency staff noted on the training records

and number of these agency staff required refresher training in fire safety,food safety, infection prevention control, vulnerable adults and managing behaviour that is challenging. One agency staff's Garda Vetting had also expired.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had not ensured that there were robust management systems in place to ensure the service was safe, appropriate to the residents' needs, consistent and effectively monitored. A number of improvements were needed in the areas of IPC, premises, staffing, risk, safeguarding, and positive behaviour support within the designated centre.

This was an inspection whereby the provider did not address a number of previously identified issues. For example, premises, fire evacuation and oversight and monitoring of the service had not met the requirements of the regulations on inspection in 2021. These issues were also present in the current inspection indicating that systems were continuing to fail to address ongoing issues. Furthermore there was a deterioration in compliance levels due to the incompatibility of residents in the centre.

Residents' specific assessed needs indicated that they were not compatible. Although the provider had taken some actions to address this, such as increased supervision of residents at all times, the inspection findings indicated that a comprehensive and robust response by the provider had not been taken to address this. This is addressed in more detail under Regulation 8.

The inspectors issued an immediate action in relation to medication on the day of the inspection due to the risk of how this was being stored. Additionally, improvements were required in relation to fire safety to ensure residents were safe at all times. This is addressed in Regulation 28.

The provider had completed an annual review and six monthly audit however they were not comprehensive and required review. For example, in a recent IPC audit it was asked was the centre 'clean' and no was ticked along with relevant action to be undertaken, which has been marked as completed. However,inspectors found that the designated centre was not clean. This is addressed in Regulation 17 and Regulation 27. Audits at times were not adequately identifying issues that were present as found by the inspector. Some actions that had been identified by the provider in May 2020, such a premises improvements still remained outstanding on the day of inspection.

Judgment: Not compliant

Regulation 31: Notification of incidents

The inspectors reviewed a sample of incidents and accidents which occurred in the centre and it was not evident that all incidents were notified to the Chief Inspector in line with Regulation 31. For example, safeguarding notifications. In addition a number of incidents were notified outside the required time frames. Systems required review to ensure incidents were reported in a timely manner.

Judgment: Not compliant

Quality and safety

Overall the absence of effective governance and management had a negative impact on the quality of care and support received by some residents. This inspection found that substantive improvements were required in resident safeguarding, evacuation of residents, protection against infection, premises condition and positive behaviour support.

Inspectors found that systems in place to safeguard residents and ensure residents were appropriately supported in this area was inadequate. Incidents that occurred described situations whereby there was a significant risk to residents' safety. Although the frequency of the incidents were low, the duration and magnitude of the incidents, in terms of impacting the others in the home was clearly evidenced. The incidents resulted in the use of unplanned restrictive practices.The review of these risks,to ensure all options had been explored in ensuring residents' safety, was not comprehensive or effective to address the ongoing incompatibility issues.

In terms of risk management a number of improvements were required in all areas. The identification, management and mitigation of risks in an effective manner was not in place on the day of inspection. While it was found that some risks had been identified, the control measures could not always be implemented due to the lack of access to information for staff. In addition, an immediate action was issued to the provider on the day of inspection due to the risks posed by the inappropriate storage of medication.

Regulation 17: Premises

The designated centre comprises two semi-detached homes located close to an urban area in Co. Kilkenny. All residents had their own bedrooms which for the most part were decorated to reflect their individual tastes with personal items on display for two of the residents' bedrooms. One resident's bedroom had little to no personal

items on display, the curtain pole was damaged and there were handles missing from their wardrobe and significant markings on walls were pictures had been removed. The condition and presentation of this room was poor.

From the information gathered on inspection it was noted that this room was in this condition for a number of months and there were no plans on how this was going to be addressed.

In the first home more significant premises works were noted. In the downstairs there was chipped and marked paint work in the kitchen, hall, sitting room and on the banister. Upstairs, there were press handles and a press doors missing from presses in bedrooms and sitting rooms. Areas of the this part of the centre had not been well maintained and required significant improvement.

In the second home, and the majority of rooms presented as inviting, well kept areas. Painting work as identified by the provider was complete on the day of the inspection. The sitting room at the back of the house had double doors that lead out to a garden area was large and overall well kept. To gain access to the garden area there were two steps down with a hand rail or a ramp to access the garden.

Judgment: Not compliant

Regulation 26: Risk management procedures

Although there were systems in place to assess and mitigate risks, such as a centre risk register and individualised risk assessments, improvements were required in this area to ensure all risks were identified and managed in line with best practice.

As previously stated on the walk around of the premises the inspectors opened an unlocked cupboard which contained the medication press. The medication press was open and the key was present in the lock. In addition, four medication bottles were being stored on the floor of this unlocked press. There was medication present in the bottom of each of these bottles that could have been accessed at any time. These risks were immediately addressed by the staff present. Under this regulation the provider was required to address an immediate risk that was identified on the day on the inspection. The manner in which the provider responded to the risk did provide assurance that the risk was adequately addressed

On review of a sample of risk assessments it was evident that a number of control measures had been introduced to mitigate the risks of residents spending time together in close proximity. These risk assessments were found to be stored in a very accessible manner so that staff could access this information as needed. However, control measures as stated in these risk assessments were not all in place.

Incidents had occurred in the centre whereby unplanned restrictive practices had been utilised for a resident. Following the first incident a number of measures had been taken by the provider, such as risk assessments being put in place. However, a

second occurrence of the use of an unplanned restrictive practice occurred. There was limited evidence on how this incident was reviewed to ensure appropriate learning was identified and addressed.

Judgment: Not compliant

Regulation 27: Protection against infection

Due to the condition of some parts of one of the homes the inspector was not assured that all parts of the home could be cleaned to a high standard to ensure effective IPC measures were in place.

Door handles to both bedrooms were sticky, with a build up of visible dirt on the thumb lock on one bedroom door. Sinks in bedrooms had a build up of dirt around taps and plugholes. Bathroom fittings were broken and there were marks on the bath. Paint work was chipped and there were marks on walls, skirting and doors. In addition the inspectors observed the presence of a build-up of dirt in two of the bathrooms, behind toilets, around taps in sinks and bath and on the floor. The floor tiles in one bathroom had chips and one floor tile was cracked. There were holes present on the floor in the hall upstairs. Overall the cleanliness and condition of aspects of the premises did not assure that the centre was being cleaned in line with the requirements of IPC standards.

There were sinks present in upstairs rooms. Not all sinks were being used on a regular basis. For example, one room upstairs was used as a sitting room and the sink present in this room was never used. There were no systems in place to ensure regular flushing of unused taps which posed a significant IPC risk.

Judgment: Not compliant

Regulation 28: Fire precautions

Although there were some systems in place, such as fire fighting equipment, regular fire drills and emergency lighting. Other elements of fire safety were not always effective, therefore residents were not adequately protected from the risk of fire at all times.

On review of fire drills it was found that one resident had refused to partake in a fire drill. This was well documented in a number of fire drills reviewed for 2022 and 2023. No risk assessments had been developed and the residents personal evacuation plan had no details in relation to how to assist the resident to evacuate. There was no evidence of any input from an multi-disciplinary team perspective in relation to this or consultation with a suitable person qualified in fire safety. No

effective measures or contingency plans had been taken to ensure this resident could be evacuated if required.

Judgment: Not compliant

Regulation 7: Positive behavioural support

The inspectors reviewed the residents positive behaviour support plans that were in place. It was found that the plans were not being updated in line with best practice. For example, one residents plan had not been updated since June 2022. Following incidents of behaviour of concern in recent months no updates on this plan had been documented. Therefore there was limited guidance to staff in terms of measures to be taken to reduce the likelihood of these incidents re-occurring and how to manage these incidents effectively when they did occur.

Due to the lack of guidance in place, an unplanned restrictive practice was utilised on two separate occasions to ensure all residents were kept safe during incidents of concern. The use of these practices were not in line with least restrictive approach and compromised residents rights.

Judgment: Not compliant

Regulation 8: Protection

Appropriate measures were not in place to keep residents safe at all times. From a review of documentation, discussion with staff and reviewing the residents individual assessed needs clear, compatibility issues were noted which were having a direct impact on some residents in the home. For example, it was documented that one resident was spending large periods of time in their room due to the ongoing safeguarding concerns and incompatibility issues.

Inspectors were informed of two significant incidents had occurred within the centre whereby one resident was locked into their bedroom (to ensure their safety) while behaviours of concerns were occurring in the centre. During a third incident a resident was required to leave their home to ensure their safety. This level of impact highlights the significant incompatibility between the residents living in this part of the centre and does not indicate a safe and stable living environment.

Although some measures had been taken, such as increased staff supervision and staff training in low arousal environments the effectiveness and sustainability of these measures had not been considered. Not all incidents has been reviewed in a comprehensive manner and there was no plan in place in terms of how the compatibility issues were going to be addressed to a meaningful degree by the

provider. Significant improvements were needed in safeguarding systems to ensure all residents safety with the centre.
Judgment: Not 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 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Tús Nua OSV-0005698

Inspection ID: MON-0038696

Date of inspection: 27/03/2023

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: Tus Nua currently has 1 WTE vacancy and 2 WTE on maternity leave. One HCA returned from maternity leave 16.04.23 since inspection took place. One long term familiar agency staff who has a good knowledge of the gentlemen will be redeployed to Tus Nua/The Manor for full hours from 1st of May 2023. The remaining gap will be filled with familiar agency staff. Rosters are under consistent live monitoring and review by PIC and PPIM. Agency staff are only rostered together with core staff on day duty. It is acknowledged that some opportunities for people supported had to be rescheduled due to staffing shortages. As part of an Action Learning Analysis completed on the 20.4.2023 and facilitated by the CEO, the importance of options for redeployment of employees across the service has been highlighted to ensure non-negotiable opportunities are being facilitated for people supported. As part of the Director of Services re-configuration operational structure and resource management, a position paper and plan has been developed by the Director of Strategic Planning and Assistant Director of Service on managing WTE and Agency staffing across the service to ensure safe service for the people supported. The position paper will be made available to the regulator for review. Whilst Aurora has an ongoing recruitment strategy to drive the onboarding of qualified and suitable employees, the Assistant Director of Service is overseeing a profiled and planned booking of agency staff across service.	
Regulation 16: Training and staff development	Not Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
Following update re training for employees and agency staff:

- Three employees have completed their outstanding HSE Land training by the 24.4.2023, which is reflected on the training report available in the house and on Aurora Q drive.

- Two employees now due for MAPA training are booked for course completion on the 16.05.23.

- One employee who's MAPA training was out of date at time of inspection has now commenced career break and will attend all training and induction prior to returning to Aurora.

- One employee is booked for refresher first aid training on 25.05.23.

- Valid Garda vetting for an agency staff member is now on file in Aurora

Aurora Training Department has completed a review of training record for agency staff and the training record template is now including mandatory and non-mandatory training.

A Risk Assessment has been developed for agency staff who do not have the same level of training as core team in Tus Nua to guide the team and agency and ensure adequate rostering. In the event of an agency staff member without buccal training is rostered in Tus Nua/The Manor, the Aurora employee working in Tus Nua/The Allium will have this training completed and provides support in the event of a seizure.
The agency staff identified for Tus Nua will be prioritised for Epilepsy and Buccal Training which will be completed in latest June 2023.

Aurora has advised the agencies that they must ensure Schedule 2 documentation is available to the provider for agency staff booked across the service.
All Aurora training is available to agency staff, which is communicated to the agencies.
Aurora medication management policy has been updated in April 2023 to include facilitation of consistent agency staff to complete the training and be supervised by the PIC of the house where they are located.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
Aurora's new provider audit system has been implemented in January 2023 and is now

rolled out as per schedule. Provider audits are completed across functions now in Aurora to ensure comprehensive action plans for the PICs and their teams in designated centres. Trends of provider audits are now also reported and discussed at Quality Assurance meetings, first time facilitated by the PPIMs and PICs on the 26.4.2023.

The CEO held a meeting on the 04.04.2023 to discuss findings of the HIQA inspection in Tus Nua, in order to identify and agree urgent actions and develop action plan for PIC, PPIM and provider functions. Roles and responsibilities of all involved were discussed. As a follow up from this provider meeting an Admissions Meeting was held on the same day to discuss and review the compatibility and safety of both people supported living in Tus Nua/The Manor. Minutes can be made available to the regulator.

PIC and PPIM meet with the Tus Nua staff team on 12.04.23 to discuss the HIQA inspection and report in detail. All staff are requested to read and sign the report, the medication management policy and the restrictive practice policy.

Aurora CEO facilitated an Action Learning Analysis on the 20.4.2023 with the Director of Services and the Wellness, Culture and Integration team to analyse and discuss the incident management and learnings relating to the unplanned restrictions in Tus Nua.

As a result from the provider meeting on the 4.4.2023 and the ALA from 20.4.2023 local and provider level oversight have been clarified to PICs and PPIMs on various levels:
- Discussion held at both meetings with PIC and all PPIMs present to outline roles and responsibilities in reporting and highlighting incidents on various levels (e.g. increase in severity or frequency in incidents, behavioural changes, wellbeing of persons supported, etc.)
- Safeguarding oversight committee available to PICs and PPIMs as needed and requested.
- Call for review of Personal Plan/Case Conference if needed.
- Restrictive Practices Committee reviews available, outside set meetings.
Importance of escalation procedures were discussed and strengthened on provider level.

The DOS called an Accountability Meeting with the Behaviour Support Specialist and line manager on the 13.4.2023 with a follow up meeting on the 20.4.2023 to discuss responsibilities as part of the current findings in Tus Nua. Actions were agreed and reviewed.

The Director of Services held a meeting with the Wellness, Culture & Integration Managers on the 17.4.2023 as part of further implementation of re-configuration of PIC and PPIM changes. Local vs. Provider Governance responsibilities were discussed. As an outcome from this meeting 2 further workshops were developed and scheduled for PICs to build capacity:
- Governance workshops led by the PPIMs on the 3rd and 10th May 2023
- Workshops to develop PIC workplans as part of final step of capacity building and implement PIC Peer partnership, delivered by WCI Manager between 4th. and 9th. May 2023.

The Assistant Director of Service has taken on full responsibility and oversight of Safeguarding and has finalised implementation and support for PPIMs on Safeguarding

Co-ordination oversight. PPIMs will complete bi-monthly safeguarding reviews in their designated centres.

Provider and PPIM oversight has resulted in further actions taken re Behaviour Support and Protection for persons supported, which are also outlined under each regulation: -
- A comprehensive behavior support plan for one person supported is currently being updated with clear guidelines for staff to follow for each identified behavior. Meeting held with PIC, PPIM & BSS on 19.04.23 to finalise plan. BSS to lead out on implementing plan with the full staff team by 28.04.23 with oversight from PPIM.
- PIM and PIC exploration of a more responsive Psychiatrist who has availability to support this person when experiencing distress. Meeting held with person supported Ward of Court committee on 13.04.23 in relation to this and follow up email sent by Director of Services.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The outstanding NF06 for the incident from 4.12.2022 has now been submitted via HIQA portal. Action Learning Analysis completed on the 20.4.2023. Responsibility of PPIM to submit monitoring notifications in line with timeframes has been highlighted at provider meeting on 4.4.2023 and at ALA 20.4.2023.

A review of incidents on the DMS was completed to ensure all Notifications have been submitted as per regulations.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As part of the implementation of works on premises, one person supported Behaviour Support Plan is being reviewed and updated to be reflective of the environment and how to support the person to replace items that may be destructed in his bedroom and in the house. Evidence of this support will be seen through monthly reviews in Personal Plan Framework.

H&S carried out a full review visit in Tus Nua since the inspection took place and identified outstanding works that were required. Please find following updates and timeframes re premises works: -

- A meeting was held on the 19.04.2023 between Housing & Estates Manager and RFM construction & PIC re: Floor Tiling, RFM to source one replacement tile. If replacement cannot be sourced total replacement will be necessary and actioned.

- Bedroom floors will be replaced when new wardrobes are in situ. Wardrobes expected to be replaced by latest 01.06.2023. All sinks will be removed when new wardrobes are being installed.

- Housing & Estates manager requested replacement kitchen from Respond (housing body), however measurements and quotations currently been sought by Aurora in the event the provider has to purchase the replacement of the kitchen. Replacement of the kitchen floor will also be completed in conjunction with the kitchen being replaced by latest 30.6.2023

- Painting of internal walls of the house has been completed 20.04.2023

- Resource requests forms had been submitted and approved by PPIM prior to inspection for soft furnishings. People supported living in Tus Nua will be supported to choose items for their home to make it more homely.

One person supported was supported earlier in the year to purchase new furniture & curtains for the bedroom. The room was also painted at this time. The person was also supported, as part of the personal plan, to purchase a new shed (workshop) for tools as these were previously stored inside the house. The shed is now providing storage and space for his interest in maintenance work.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
A full review of Tus Nua's risk register has been completed by the PIC. Control measures have been updated and are now reflective of actions to be taken. Further risk assessments developed where a risk still remains, such as non-mandatory training for agency staff.
Adherence to Aurora Medication Policy was discussed at team meeting on 12.04.2023. Key points discussed were: -
- keeping press locked at all times.
- The authorised person is responsible for holding the keys when medication is being administered.
- The keys must be stored in the key box which is located beside the medication press when not in use.
- Also highlighted the management of empty bottles of medication, these are to be stored in the locked part of the medication press until they can be safely disposed of.

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
People supported in Tus Nua are promoted to live independent lives. They are supported to clean their own bedrooms regularly and this is evident on their daily and weekly planners.

24hr cleaning schedule has been updated and made more individual to Tus Nua.

Team meeting held with Tus Nua staff team on 12.04.23 IPC policy was discussed in detail and examples of the standard of IPC were given. H&S attended this meeting and discussed the implementation of the new H&S folder and cleaning products to use to remove hard dirt and limescale.

PPIM and H&S to visit Tus Nua unannounced weekly to carry out IPC check and review of IPC documentation.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
PEEP for person supported who may not want to engage in a fire drill to leave the home has been updated to reflect guidance as outlined in the Behaviour Support Plan.

A Fire officer is scheduled to visit Tus Nua on the 11.05.2023 to carry out fire evacuation walkthrough with the people supported and staff team. A member of the H&S team will also be present on the day.

Further skills teaching will be implemented with person supported in relation to evacuation in line with the BSP, also involving any feedback receiving from the visit of the Fire officer.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
PPIM, PIC & Behaviour Support Specialist met on the 12.04.23 to discuss the current Behaviour Support Plan for a young gentleman supported, review took place and updates to guide the staff team identified. A follow-up meeting was held on 19.04.23 to finalise the Behaviour Support Plan and the Behaviour Support Specialist has scheduled On the Job training for implementation of the plan with the staff team for 25.4.2023 and 02.05.2023. This is to confirm the understanding of the plans throughout the team and ensure everyone is taking the same approach.

As part of the Behaviour Support Plan review and updating of Supervision guidelines, guidelines and support for the team have been identified and outlined in the event of a person presenting with behaviours that challenge, reactive and proactive techniques are guiding the team on this.

As part of the meetings on provider level with PPIM, Behaviour Support Specialist and other team members of the Wellness, Culture & Integration Team responsibilities are clarified in the oversight and leadership on review and connectivity of relevant documentation and information for a person supported.
The Behaviour Support Specialist, PIC and PPIM have now ensured that the Behaviour Support Plan, PEEP, Restrictive Practice Management Plan and all allied risk assessments and supervision guidelines are reflective of each other. The inclusion on Fire safety for one person supported and the inclusion on when to consider PRN for another person supported has also been included as part of the BSP.

PPIM and PIC finalising a restrictive practice review for the Aurora committee; measures to ensure person supported privacy is upheld and maintained at all times to be put in place on bedroom door.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Meeting has been held with PIC, PPIM & Behaviour Support Specialist on 13.03.23 in relation to the time a person supported spends in their room on occasions. As part of the review, it is evident that there is no concern that the time spent in the bedroom is linked to a possible safeguarding concern. Recording logs to monitor the occurrences and provide data for review with the Behaviour Support Specialist is forming a review scheduled for the 25.4.2023 to discuss this matter including meaningful live opportunities presented to person supported.

An unplanned restrictive practice had been put in place on two occasions on the first

occasion a post incident review had taken place. Aurora acknowledges that Restrictive Practice Policy and Pathway had not been followed and on review of the minutes of the post incident review it is evident that the quality and detail of information was not sufficient. This has now been addressed at the ALA meeting from 20.4.2023.

An Admission and Discharge committee meeting was held 04.04.23 to discuss the compatibility of both young men. A number of robust actions were identified in order to ensure both men are safe. Minutes available to the regulator.
Both men will continue to live together with additional actions and safeguards in place and this will be closely monitored by the PIC and PPIM by 10.5.2023.

Referral has been sent for a psychologist for one person supported. Referral was also sent to OT to carry out sensory needs assessment for both people supported.

BSS to carry out analysis of incidents from July 2022 to present and present to PIC and PPIM by latest 01.05.23. This will support a review of the causation of incidents to identify further supportive strategies and measures.

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 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	24/04/2023
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.	Not Compliant	Orange	25/04/2023
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	30/06/2023

	are of sound construction and kept in a good state of repair externally and internally.			
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	25/04/2023
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	25/04/2023
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 prevention and control of	Not Compliant	Orange	25/04/2023

	healthcare associated infections published by the Authority.			
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	11/05/2023
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	25/04/2023
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical,	Not Compliant	Orange	25/04/2023

	chemical or environmental restraint was used.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/04/2023
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation every effort is made to identify and alleviate the cause of the resident's challenging behaviour.	Not Compliant	Orange	30/04/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	25/04/2023