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:	Idrone Lodge
Name of provider:	Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities
Address of centre:	Carlow
Type of inspection:	Announced
Date of inspection:	19 November 2025
Centre ID:	OSV-0005515
Fieldwork ID:	MON-0039952

About the designated centre

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

Idrone Lodge is a designated centre operated by Saint Patrick's Centre (Kilkenny)/trading as Aurora-Enriching Lives, Enriching Communities located in Co. Carlow. The service has the capacity to provide supports to four adults with an intellectual disability. The service operates on a full-time basis. Residents are facilitated and supported to participate in a range of meaningful activities within the home and in the local and wider community. The centre consists of a large bungalow located in a suburb of Carlow town. Each resident has a private bedroom, with a shared living area space. The staff skill-mix includes a social care worker, a staff nurse, and healthcare assistants, and the centre is managed by a full-time 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
Wednesday 19 November 2025	09:25hrs to 18:00hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This announced inspection was carried out as part of the regulatory monitoring of the centre and to help inform a decision on the provider's application to renew the registration of the centre.

The inspector used observations, engagements with residents, conversations with staff, and a review of documentation to form judgments on the quality and safety of the care and support provided to residents in the centre.

The centre is registered to accommodate four adult residents. At the time of the inspection, there were three residents living there, and one vacancy.

The centre comprises a large single storey house in a small town with amenities and services that residents can easily access. The centre is situated next to another designated centre operated by the provider. The inspector walked around the house with the person in charge. It contained two sitting rooms, bathrooms, residents' bedrooms, a kitchen and dining room, and a staff office. There was also a rear garden and an external laundry room. Overall, the house was observed to be very clean, well-maintained, homely and nicely decorated. The residents' bedrooms were personalised to reflect their individual tastes and personalities.

The inspector also observed good fire safety systems, such as fire detection and fighting equipment. The premises and fire safety are discussed further in the quality and safety section of the report.

The inspector met all three residents. They did not communicate their views, but some engaged with the inspector by smiling, making eye contact, and holding the inspector's hand. They appeared comfortable in their home, and familiar with the staff supporting them. During the inspection, residents engaged in different activities with staff support, including baking, going to a café, visiting friends, and having in-house therapeutic treatments.

In advance of the inspection, staff supported residents to complete surveys on what it is like to live in the centre. Their feedback was mostly positive, and indicated that they felt safe in the centre and were satisfied with the care and support they received. However, they also said that improvements could be made in how they were included in decisions affecting them and how they could spend their own money. The provider's recent annual review of the centre also noted that the residents said that the arrangements for including them in decisions about their home could be better. There was no specific detail about this matter, but staff told the inspector that it related to an recently introduced transport policy that the provider had implemented.

The inspector did not have the opportunity to meet any of the residents' representative. The annual review noted positive feedback from one resident's family on the quality and safety of the service they received in the centre.

The person in charge facilitated the inspection with support from their manager. They told the inspector that residents had a good quality of life, got on well together, and received good care and support from staff. They said that residents were listened to and could make decisions about their life, such as how they spent their time. They said that staff followed residents' communication care plans, and that residents were supported make decisions on a day-to-day basis as well as during weekly meetings where they discussed topics related to the centre.

The management team said that the location of the centre was ideal as it was close to many amenities and services. They spoke about the activities that residents enjoyed, such as attending baking, art, exercise and flower arranging classes, music groups, meeting friends and family, eating out, swimming and going to church. Some residents liked a slower pace life and to relax in their home, and this was respected.

Overall, the management team said that residents' needs were met in the centre and that they could access multidisciplinary team services. Some residents' needs were changing, and provider planned for the residents to move to a more suitable home for long-term living in the future. However, there was no immediate need for the move. There were also no plans for another resident to move into the centre.

The management team were satisfied with the staffing arrangements; however, a social care worker post was vacant and this posed a potential risk to the quality of the service. They had no concerns for residents' safety. They told the inspector that the residents did not have full access to their own finances, and how this issue posed a rights restriction. The provider was reviewing its policy for supporting residents to manage their finances, and was also reviewing learning related to this topic from recent inspections of their other centres to inform the improvements it planned to make.

Overall, while the inspector found that aspects of the care and support residents received was safe and to a good quality, the oversight of their finances required improvement to ensure that appropriate support and safeguarding arrangements were in place. An urgent action was issued to the provider during the inspection in relation to non compliance found under Regulation 12: Personal Possessions. Improvements were also required under other regulations related to the governance and management of the centre, upkeep of health care plans, maintenance of contracts of care, and safeguarding precautions.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and how governance and management affects the quality and safety of the service being delivered.

Capacity and capability

This announced inspection was carried out as part of the provider's application to renew the registration of the centre. The application included an up-to-date statement of purpose and residents' guide.

The inspector found that there were some good management systems in place to ensure that the service provided to residents living in the centre was appropriate to their needs, and operated in line with the statement of purpose. However, improvements were required to the oversight systems to ensure that they were effective, and to the maintenance of residents' contracts of care to ensure that they were accurate, up to date, and agreed to.

The management structure was clearly defined with associated responsibilities and lines of authority. The person in charge was full-time, and met the requirements of regulation 14. They reported to a manager, and there were effective arrangements for them to communicate. The person in charge told the inspector that they could easily raise concerns and were satisfied with the support they received.

The provider and person in charge had implemented management systems to monitor the quality and safety of service provided to residents. Annual reviews and six-monthly reports, as well as various audits had been carried out in the centre to identify areas for quality improvement. While actions from the audits were being implemented to enhance the quality and safety of the services provided in the centre, improvements were needed. The findings in the next section of the report indicate that better oversight is needed over residents' finances and health care plans.

The person in charge was satisfied that the staff skill-mix and complement was appropriate to the assessed needs of the current residents. There was one social care worker vacancy. It was filled by health care assistants, and this posed a risk to the quality of the service as the social care worker role supported the person in charge with their administration and governance of the centre. However, the provider was recruiting to fill the post. The person in charge maintained planned and actual rotas. The rotas clearly noted the staff on duty and the hours they worked.

The inspector also reviewed a sample of the staff Schedule 2 files, and found that they contained the required information.

Staff were required to complete training as part of their professional development. The inspector reviewed the staff training log with the person in charge. The log showed that staff were up to date with their training requirements. There were effective arrangements for the support and supervision of staff working in the centre, such as management presence and formal supervision meetings.

Staff also attended team meetings which provided an opportunity for them to raise any concerns regarding the quality and safety of care provided to residents. The

meetings were scheduled monthly. The inspector read a sample of the 2025 minutes. The minutes noted topics including, learning from incidents, complaints, audits, staffing matters, and resident updates.

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person in charge was suitably skilled and experienced for their role, and possessed relevant qualifications in nursing and management. They had been in their role since 2021, and demonstrated a good understanding of the residents' individual personalities and needs.

The person in charge also had responsibility for another designated centre, which was located beside the centre concerned.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured that the staff complement and skill-mix of a social care worker, a staff nurse and health care assistants was appropriate to the number and assessed needs of the residents living in the centre at the time of the inspection.

The person in charge was satisfied with the staffing arrangements, and told the inspector that the number of staff on duty was sufficient. The social care worker role had recently become vacant, and was being filled by agency and relief staff. The vacancy posed a risk to the quality of the service provided in the centre and to the governance arrangements; however, the provider was recruiting to fill it.

The person in charge maintained planned and actual staff rotas. The inspector viewed a sample of the rotas from September, October and November 2025, and found that they clearly showed the names of the staff working in the centre during the day and night.

The inspector reviewed three staff Schedule 2 files during the inspection. The files contained the required information, including vetting disclosures, written references, and evidence of qualifications and photographic identification.

Judgment: Compliant

Regulation 16: Training and staff development

Staff were required to complete training as part of their professional development and to support them in the delivery of appropriate care and support to residents.

The inspector reviewed the staff training log with the person in charge. It showed that staff were up to date with their training needs, and had completed training in relevant areas including safeguarding of residents, fire safety, administration of medication, manual handling, supporting residents' eating and drinking, autism awareness, infection prevention and control, human rights, positive behaviour support, and advocacy.

The person in charge ensured that staff were supported in their roles, and provided them with formal supervision in line with the provider's policy. The person in charge also felt well support in their role, and said that they could easily raise any concerns with their manager.

The inspector reviewed the supervision records for four staff in 2025, and found that staff had received supervision on a regular basis. The records noted that topics, such as understanding key worker duties, staff roles and responsibilities, policies, and residents' needs were discussed.

Judgment: Compliant

Regulation 23: Governance and management

Generally, there were good management systems in place to ensure that the service provided in the centre was resourced, monitored and met residents' needs. However, improvements were required to the effectiveness of the oversight systems.

There was a clearly defined management structure in the centre with associated lines of authority and accountability. The person in charge was full-time, and reported a senior manager. The inspector found that they had a rich understanding of the residents' individual personalities, interests and needs.

There were arrangements for the management team to communicate, including scheduled meetings and informal communications. The person in charge also attended meetings with other managers for shared learning, and completed weekly reports to support the manager's oversight of the centre. The inspector reviewed a sample of the recent reports; they included information on staffing, incidents, notifications, complaints, safeguarding, and restrictive practices.

The provider and person in charge had implemented systems to monitor and oversee the quality and safety of care and support provided to residents in the

centre. The provider carried out annual reviews and six-monthly unannounced visit reports. The audits were found to identify actions for improvement where required, which were monitored by the management team.

However, improvements were required to the effectiveness of oversight systems to ensure that issues found during this inspection were fully addressed by the provider.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

Contracts of care, referred to as service provision agreements, had been prepared for residents. The inspector reviewed two resident's contracts, including the easy-read versions, and found that they included information such as the fees to be charged to residents. However, both contracts required improvement to ensure that they were accurate and agreed to.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1. It was last reviewed in September 2025, and was available in the centre for residents and their representatives to access.

Judgment: Compliant

Quality and safety

Aspects of the residents' safety and welfare was maintained by a good standard of care and support. Residents appeared relaxed in their home, and the premises was meeting their current needs. However, improvements were required under regulations 6, 8, and in particular, 12.

The premises comprises a large single-storey house in a small town. The house contains residents' bedrooms, and communal spaces, including sitting rooms, a kitchen and dining room, and bathrooms. The house was seen to be bright, homely, comfortable, clean, nicely decorated, and well equipped. Some minor upkeep was

required; for example, the veneer on a bathroom storage unit was damaged which posed a potential infection prevention and control risk.

The inspector also observed good fire safety systems, including fire detection equipment throughout the centre, and written plans to guide staff on safely evacuating the centre.

Residents were consulted with on a day-to-day basis, and also attended house meetings where they discussed common interest topics. The inspector viewed a sample of the September, October and November 2025 meeting minutes. They noted discussions on residents' rights, such as to vote in the presidential elections, activities, health and wellbeing, finances, and the upcoming HIQA inspection. However, as noted earlier in the report, the HIQA surveys and provider's annual review of the centre showed that improvements could be made to how the provider consulted with residents about decisions affecting them.

Residents had varied health care needs, and the inspector found that they were receiving support and care from a wide array of multidisciplinary team services. Written health care plans had also been prepared to guide staff on the interventions that residents required. However, the inspector found that some of the care plans required updating, and this posed a risk to the quality and safety of the care and support they received.

The inspector reviewed the support that two residents received to manage their finances. Both residents' income was paid into an account that was managed that the provider. The residents accessed their money using debit cards. The cards were allocated a set amount each week. The cards could be topped up with extra money if needed; however, only during normal working hours Monday to Friday.

The provider was aware that these arrangements restricted residents from freely accessing their money, and was reviewing its associated policy with the aim of improving these arrangements and the related oversight systems. Due to the poor findings discussed under regulation 12, an urgent action was issued to the provider during the inspection.

Generally, there were good arrangements for the safeguarding of residents. However, improvements were required to ensure residents were safeguarded from all forms of abuse including financial abuse.

Regulation 12: Personal possessions

The inspector found that the provider's oversight of residents' finances was poor which in turn raised potential safeguarding risks for residents.

The inspector reviewed a sample of two resident's financial records from 2025, including their statements, expenditure sheets, receipts for purchases, and monthly audits by the person in charge.

The inspector found examples of poor practice, oversight, and issues, such as discrepancies between the fees charged by the provider to residents and what was detailed in their service provision agreements (contracts of care).

Additionally,

- Not all purchases made from residents' personal monies had receipts to evidence the purchases.
- An ATM (automated teller machine) cash withdrawal, using a resident's debit card, had not been recorded in their expenditure sheet to indicate how the money was used.
- The provider's recent annual review of the centre had also found issues in relation to the management of residents' finances; however, the issues had not been adequately addressed.

Overall, it was not demonstrated that the oversight systems were effective and sufficient to mitigate the risk to the safeguarding of residents' finances.

In response to these findings and associated risks presenting, the inspector issued the provider with an urgent action requiring them to review the matters, as described, within a short time frame and make arrangements to address the deficits found.

Judgment: Not compliant

Regulation 17: Premises

The centre comprises a single-storey house in a small town with local amenities and services for residents to use. The premises were found to be appropriate to the needs of the residents living in the centre at the time of the inspection, and met the requirements of Schedule 6.

The house was found to be clean, bright, homely, warm, comfortable, and nicely furnished. There was sufficient communal space including bathroom facilities, an open-plan kitchen and dining room, and two sitting rooms. The house was well equipped and the facilities appeared to be in good working order. Residents' bedrooms had en-suite bathrooms, which were personalised to their tastes.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider has prepared a residents' guide. The guide was up to date and included the required information. It was in an easy-to-read format using pictures and had been discussed with residents to help them understand it.

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had implemented good fire safety precautions in the centre. There was fire detection and fighting equipment, and emergency lights throughout the house, and it was regularly serviced to ensure that it was maintained in good working order. Staff also completed weekly fire safety checks. The fire panel were addressable and easily found in the front hallway. The inspector observed that a sample of the fire doors closed fully when the fire alarm activated.

The person in charge had prepared an evacuation plan for the centre and individual evacuation plans for residents, which outlined the individual supports they required. Fire drills were carried out to test the effectiveness of the fire plans. During the inspection, the person in charge updated the main fire evacuation plan to ensure that it provided clear guidance and was readily available in the centre.

Judgment: Compliant

Regulation 6: Health care

Overall, the provider and person in charge had ensured that residents received appropriate health care.

Residents could access a wide range of internal and external multidisciplinary team services, including occupational therapy, chiropody, physiotherapy, dietitians, psychiatry, general practitioners and dentists. There was also a full-time nurse allocated to the centre to oversee the residents' health care needs.

However, the inspector reviewed two residents' health care plans and found that improvements were needed to ensure that they were subject to a thorough review, cohesive and kept up to date. For example, some of the plans referred to discontinued interventions. This posed a risk to the quality of the care provided to residents. The inspector was also told that a resident had participated in a particular

national screening programme; however, the person in charge and staff nurse could not provide written evidence of this during the inspection.

Additionally, a specific care plan had not yet been prepared for one resident. The person in charge told the inspector that the provider's nursing department were due to develop an advanced care plan that would encompass all of the resident's needs in the coming weeks.

Judgment: Substantially compliant

Regulation 8: Protection

The provider and person in charge had implemented systems to protect residents from abuse. Staff had completed safeguarding training and there was a written policy for them to adhere to. The provider's social work department were also available to provide guidance and support. However, improvements were required to ensure that residents were safeguarded from all forms of abuse.

This inspection found poor governance and oversight of residents' finances. Some of the issues found had not been escalated and addressed prior to the inspection. For example, missing receipts and poorly maintained records had not been investigated to determine if there were risks to residents. This required improvement to ensure that residents were protected from the risk of financial abuse.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Idrone Lodge OSV-0005515

Inspection ID: MON-0039952

Date of inspection: 19/11/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
The provider and PIC have taken a number of immediate actions to address areas of improvement identified on local and provider level in relation to auditing and further develop clarity in relation to Service Provision for people supported, of which all are outlined in this compliances plan under the relevant regulations.

Actions taken and in progress:
- An audit was completed between Finance team and PIC for all people supported in Idrone Lodge on 26.11.25.
- The Director of Services reviewed the findings of the audit with both team members and identified actions were completed by PIC.
- The PIC monthly finance audit template has been reviewed based on the above audit with input from PIC to safeguard people supported's finances. Quality of spend and all person supported monthly purchase have to be reviewed by the PIC within the audit to ensure full oversight.
- The providers review of annual and six-monthly provider audit system on Viclarity has commenced in October 2025; this will be further developed with input from Quality in 2026. An update on the Viclarity system is required for same.
- Senior Management Team have met on the 3.11.25 and 10.12.25 to further review Aurora Service Provision for Residential and Day Service to ensure equity and fairness in applying charges and contributions.
- A review of all people supported means and contributions has commenced based on SMT discussion. Whilst it was anticipated to have this review finalised by 15.12.2025 the provider has identified a more in-depth review of each person's means and contribution is required to ensure equitable and fair decision making in relation to service delivery.
- The Director of Services, Director of Finances and Aurora Human Rights Lead are commencing this in-depth review at a meeting on the 18.12.25 and will present outcome to Aurora Senior Management in January 2026 for review.

- Aurora will ensure that all decisions made in relation to Service Provision will then be communicated to the people supported.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
As outlined under Regulation 23,
- A review of all people supported means and contributions has commenced based on SMT discussion at November and December meeting. Whilst it was anticipated to have this review finalised by 15.12.2025 the provider has identified a more in-depth review of each person's means and contribution is required to ensure equitable and fair decision making in relation to service delivery.
- The Director of Services, Director of Finances and Aurora Human Rights Lead are commencing this in-depth review at a meeting on the 18.12.25 and will present outcome to Aurora Senior Management in January 2026 for review.
- Aurora will ensure that all decisions made in relation to Service Provision will then be communicated to the people supported.

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
Following actions have been taken to ensure all people supported Finances are safeguarded all concerns reviewed and closed:

- An urgent compliance plan was completed by the provider and PIC immediately after the inspection on the 21.11.25.
- Full review of all ladies' finances was completed by PIC and Finance department on 26.11.25.
- All errors of missing receipts were identified and the necessary error forms completed to rectify same.
- A cash withdrawal of 40 euro for a person supported, which the PIC and inspector could not identify on the day of inspection has since been identified by the PIC on the expenditure sheet from a previous month 2025. This error has been rectified.
- All cash spent by the people supported in Idrone in 2025 has been reviewed and all transactions approved on balance sheet by the PIC and Finance department.
- The PIC is currently completing On the Job Mentoring with all team members on

managing person's finances on a daily basis.
- The Provider has further developed the PIC monthly Finance audit and communicated the new template to all managers and teams as Practice Development on the 17.12.25.
- The PIC is completing monthly finance audits for oversight based on the new template as per Practice Development from the 17.12.25.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care:
Following actions have been taken since the inspection took place to address areas of improvement:
- Ongoing updating and reviewing of all health support plans for people supported by PIC and staff nurse has commenced since the inspection. Same will be completed in full by 7.1.2026.
- GP review scheduled for person supported re bowel screening and non- attendance at colonoscopy- clear rationale to be documented post appointment. Evidence available in house for national bowel screening programme.
- Ongoing desensitisation programme in place for a person supported for phlebotomy.
- Advanced health plan currently in draft for person supported to be completed and reviewed by GP by 7.1.2025

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
As outlined under Regulation 23 and 12, the provider and PIC have taken actions to ensure people supported finances are safeguarded on local and provider level:

- Audit of all people supported finances was completed on the 26.11.25.
- PIC Monthly Finance Audit was reviewed and updated; Practice Development sent to all employees on 17.12.25.
- PIC ensures completion of monthly finance audit.
- PIC to ensure weekly soldo statements are in place and reviewed going forward.
- Person supported finances, policies and procedures around same is discussed at team meetings in Idrone Lodge, next team meeting scheduled for January 2026.

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	21/11/2025
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	17/12/2025
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall	Substantially Compliant	Yellow	30/01/2026

	include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			
Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	07/01/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	17/12/2025