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:	Lolek
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:	06 October 2025
Centre ID:	OSV-0007740
Fieldwork ID:	MON-0038921

About the designated centre

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

Lolek is a designated centre located in Kilkenny City. The centre provides 24 hour care and support to two residents over the age of 18 with an intellectual disability. The house consists of a kitchen/dining room, two sitting rooms, two bedrooms, one bathroom and WC, a dressing room. Lolek is staffed at all times when a resident is present. The core staffing consists of a combination of Social Care Worker and Health Care Assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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 6 October 2025	09:30hrs to 16:00hrs	Marie Byrne	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. Three other inspections were also carried out at this time in other centres operated by the registered provider. Some overarching findings in relation to the provider's oversight and governance and management arrangements were identified in all four centres inspected. In addition, improvements were required in financial oversight to ensure a comprehensive approach to managing residents' finances was in place. This report will outline the findings against this centre.

This inspection was completed by one inspector of social services over one day and had mostly positive findings, with the majority of regulations found compliant. Some areas for improvement were identified in relation to the provider's annual review, residents' contracts of care and the systems in place to support residents to manage their finances.

In Lolek residential care is provided for two adults with an intellectual disability. The designated centre comprises a bungalow with two resident bedrooms, a dressing room, a main bathroom, a living room, a kitchen come dining room, a visitors/music room, a utility and a small bathroom.

The inspector found that the house was warm, clean and homely. Both resident's bedrooms were decorated differently in line with their preferences. They both had space available to store and display their possessions. There were a number of photographs of residents enjoying activities and of the important people in their lives. There were numerous communal areas where residents could choose to spend their time.

During the inspection, the inspector of social services had the opportunity to meet and speak with a number of people about the quality and safety of care and support in the centre. This included meeting both residents living in the centre, two staff, the team leader, the person in charge, and wellness, culture and integration manager. Documentation was also reviewed throughout the inspection about how care and support is provided for residents, and relating to how the provider ensures oversight and monitors the quality of care and support in this centre.

On arrival, the inspector observed one resident watching television after their breakfast. They appeared very relaxed and content. The second resident was having a lie on. The inspector met them later when they got up to have their breakfast. They greeted the inspector and staff and proceeded to have their breakfast. Over the course of the morning both residents were observed mobilising freely around their home. They spent time in their preferred spaces and were observed to seek out staff support, as and if they required it.

One resident choose to go out shopping in the morning with staff. They went on the bus and while they were out completed some recycling. Later in the day they went out with staff for a walk and a coffee in a local coffee shop. While at home, they spent time observing staff cooking and baking, watched some television and spent some time in their bedroom. The other resident chose to relax and listen to some music after breakfast and then to go out with staff for the afternoon. Both residents interacted with the inspector at intervals and times that suited them during the day. For example, they shook hands, came over to see what the inspector was doing, brought the inspector to see parts of their home, gestured to the inspector to play some musical instruments for them and gave the inspector a football to play ball games with them.

At lunch time and in the afternoon the inspector observed staff making meals and snacks for residents from scratch. For example, one resident had a hot sandwich prepared for lunch, while another resident had a bowl of soup. The evening meal had been prepared and was slowly cooking on the hob in the afternoon. In addition, staff made a homemade apple tart for desert after the main evening meal. Residents could choose to take part in food preparation, cooking and baking if they wished to. However, they both chose to observe the staff at intervals as they prepared and cooked the food.

In both residents' plans the inspector observed pictures of them engaging in activities both at home and in their local community. Examples of activities they were regularly engaging in included, going to local GAA pitches and beaches for walks, bowling, swimming, going to the cinema, going to local restaurants and pubs, social farming and attending reflexology. Residents could choose to attend a local day service on a sessional basis and were attending regularly for flower arranging and music sessions. One resident was regularly volunteering at their local GAA pitch.

Residents and their representatives' opinions on the quality of care and support in the centre were sought by the provider in a number of ways. However, this was not being reflected in the provider's annual review. This will be discussed further under Regulation 23: Governance and Management. The inspector reviewed both residents recently completed annual surveys. Both surveys indicated that residents were happy and well supported in the centre.

The inspector also reviewed two questionnaires "tell us what it is like to live in your home" which had been sent out prior to the inspection taking place. Residents were supported by staff to complete them. Feedback in these questionnaires was mostly positive with residents indicating they were happy with, the house, their access to activities, their safety and security, the staff supporting them, visiting arrangements and the complaints process. Examples of comments under the section "Do you have anything else you want to tell us" included, "I know my neighbours and like to meet people", "I have friends with similar interests to me that I meet" and "I like my bedroom". Both residents referred to the use of relief and agency staff to support them and this will be discussed further under Regulation 15: Staffing.

In summary, residents were being supported to a engage in a variety of activities at home and in their local community. They were in receipt of a service which

promoted and upheld their rights. As previously mentioned, some areas for improvement were required in relation to the provider's annual review, residents' contracts of care and supporting residents to manage their finances.

The next two sections of the report present the findings in relation to the governance and management arrangements in the centre and how these arrangements impacted on the quality and safety of residents' care and support.

Capacity and capability

This announced inspection found good levels of compliance with the regulations reviewed. Some improvements were required to ensure that residents and their representatives opinions on care and support in the centre were reflected in the annual review of the quality and safety of care and support in the centre. In addition, improvements were required in relation to residents' contracts of care and the provider's systems to support residents to manage their finances.

The provider's systems for oversight and monitoring included a number of audits and reviews. This included an annual review, six monthly-reviews and a number of area-specific audits. Overall the inspector found they were identifying areas of good practice and areas where improvements were required. They were also implementing the required actions to bring about these improvements. However, action was required to ensure that the provider's systems for oversight of residents' finances. This will be discussed further under Regulation 12: Personal Possessions.

There were clearly defined management structures and staff were aware of the lines of authority and accountability. The person in charge receives support and supervision from a wellness, culture and integration manager. They were supported with the day-to-day management of the centre by a team leader. The provider had arrangements in place for out-of-hours on call supports for staff.

The centre was not fully staffed in line with the statement of purpose but this was not found to be impacting on residents' continuity of care and support. Staff were supported to carry out their roles and responsibilities through probation, supervision, training, and opportunities to discuss issues and share learning at team meetings.

Regulation 14: Persons in charge

The inspector reviewed Schedule 2 documentation for the person in charge in advance of the inspection and found that they had the required qualifications and experience to meet the requirements for this regulation. They were also identified as person in charge of two further designated centre operated by the provider which were close to this one. During the inspection, the inspector found that they were

present in this centre regularly and had systems to ensure oversight and monitoring in this centre.

It was evident from their interactions with residents on the day of the inspection that residents knew them well. They were motivated to ensure that both residents were in receipt of a good quality and safe service.

Judgment: Compliant

Regulation 15: Staffing

There was a 0.3 whole time equivalent (WTE) vacancies on the day of the inspection. This vacancy was not found to be impacting on continuity of care and support for residents in the centre.

The inspector reviewed a sample of rosters for three months and found that they were well-maintained. Regular staff were completing additional hours and relief or agency staff were completing the remaining shifts. Both residents' questionnaires completed in advance of the inspection mentioned the use of relief and agency staff. However, they both referred to attempts to ensure the same relief or agency cover shifts, where possible. They also referred to the importance of an induction for new staff in order to support them to get to know residents' needs and preferences.

Throughout the inspection, staff were observed to be aware of residents communication preferences. Warm, kind, and caring interactions were observed between residents and staff.

Judgment: Compliant

Regulation 16: Training and staff development

A review of the staff training matrix demonstrated that staff had access to training identified as mandatory in the provider's policy including safeguarding, the safe administration of medicines, and manual handling. Staff had also completed additional training in areas such as supporting decision making in health and social care, autism awareness, infection prevention and control, first aid, and positive behaviour support.

A number of staff spoke with the inspector about how important it was to them to support residents to maintain their independence and to spend their time engaging in activities they find meaningful. They said they were well-supported to carry out their roles and responsibilities and aware of who to raise any concerns they may

have in relation to residents' care and support or the day-to-day management of the centre.

There was a supervision schedule in place which demonstrated that staff were in receipt of supervision at least four times a year in line with the provider's policy. A sample of three staff supervisions were reviewed and detailed conversations were held in relation to staff roles and responsibilities, incidents, safeguarding, complaints, risk management, fire safety, audit findings and follow up and residents goals and plans.

The minutes of six staff meetings, and a sample of five shift planners for 2025 were reviewed. Staff meetings were well attended by staff and agenda items included areas such residents' wellbeing, incidents, safeguarding, advocacy, fire safety, restrictive practices, risk management, resident feedback, audits and actions, and complaints and compliments.

Judgment: Compliant

Regulation 22: Insurance

The contract of insurance was available in the centre and reviewed by the inspector. A copy was also submitted with the provider's application to renew the registration of the designated centre.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider had good governance and management arrangements in place to monitor and oversee residents' care and support. There was a clear management structure in place which outlined roles and responsibilities and lines of reporting.

The provider's systems to monitor the quality and safety of service provided for residents included; unannounced provider visits every six months, area specific audits, and an annual review. The inspector reviewed the last two six-monthly reviews, the latest annual review, the complaints and compliments log, the centre's risk register and a sample of incident reports for a three month period. Through a review of this documentation and discussions with staff, the inspector found that the provider's systems to monitor the quality and safety of care and support were being utilised and proving effective at the time of the inspection. However, as previously mentioned the provider was not reflecting residents and their representatives views on the quality and safety of care and support in their annual review and action was

required to ensure that the provider's systems for oversight of residents' finances was strengthened and this will be discussed further under Regulation 12: Personal Possessions.

Judgment: Substantially compliant

Regulation 24: Admissions and contract for the provision of services

The inspector reviewed both residents' contracts and found that they did not reflect the current long-stay changes that residents had been paying since December 2024.

In addition, their contracts (including the easy-to-read versions) did not contain sufficient detail in relation to the transport costs that the provider was responsible to pay, and those which residents were responsible to pay.

The provider had an admissions policy and admissions to this centre were found to be in line with this policy and the centre's statement of purpose.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The statement of purpose was available and reviewed in the centre. It was found to contain the required information and had been updated in line with the time frame identified in the regulations.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector reviewed a sample of incident reports for a three month period in 2025 and completed a walk around the premises. They found that the person in charge had ensured that the Chief Inspector of Social Services was notified of the required incidents in the centre in line with regulatory requirements.

Judgment: Compliant

Quality and safety

Overall, the inspector found that residents were supported to enjoy a good quality of life in this centre. They were regularly taking part in activities they enjoyed and supported to make decisions about their care and support. They lived in a warm, clean and comfortable home. However, some improvements were required in relation to the provider's systems for oversight and auditing of residents' personal possessions and finances.

The inspector reviewed both residents' assessments and personal plans. These documents were found to positively describe their needs, likes, dislikes and preferences. They were supported by health and social care professionals in line with their assessed needs.

Residents, staff and visitors were protected by the fire safety policies, procedures and practices in the centre. There was a system for responding to emergencies and to ensure the vehicle was serviced and maintained.

Residents were also protected by the safeguarding and protection policies, procedures and practices in the centre. Staff had completed training to ensure they were knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse.

Regulation 12: Personal possessions

It was not demonstrated during the inspection that some residents had easy access to their personal finances, or that the provider's systems for oversight and audit were fully effective. In addition, the provider did not have full oversight of one residents' finances prior to September 2024.

Both residents had client accounts held and managed by the providers' finance department. They were receiving statements from these accounts which were issued quarterly by the finance department. The provider had introduced a card system to support residents to have more regular access to their money which was held centrally in the provider's finance department. With this card they could make purchases, including online purchases. On a weekly basis their cards were topped up by the finance department by at least €100. If more money was required this was applied for during the work hours of the finance department on week days. Therefore, it could not be demonstrated that residents could freely access their finances at all times. The inspector acknowledges that these arrangements were recognised, recorded and regularly reviewed as restrictive practices. In addition, each resident had a risk assessment in place in relation to the restrictive practice of the provider's "finance department holding and managing their funds". There were easy-to-read documents available to support residents to understand the provider's systems and relating to difficulties encountered supporting them to open accounts in

financial institutions. Residents also had an assessment around managing their finances and a support plan on managing their finances.

The inspector reviewed the systems for oversight of residents' finances. There was a number of documents to record residents' income and expenditure. Daily checks were being completed of residents' balances and monthly cash expenditure sheets were being completed. Residents had detailed assets lists that and spot checks on residents assets were being completed as part of monthly financial audits in this centre.

A sample of five finance audits were reviewed in the centre. These were found to be picking up on discrepancies. For example, one audit reviewed picked up on a double charge for a resident, and an occasion where there was no receipt logged for money spent by a resident while in the cinema. However, the audits did not demonstrate that every receipt was checked or that residents statement of client accounts were reconciled as part of the audits. For example, in one audit reviewed a sample of five receipts were reviewed.

In line with the findings of previous inspection, the provider did not have full oversight of one residents' finances. This particularly related to their income and expenditure prior to September 2024. The provider had taken a number of responsive steps following an inspection in 2022, including supporting the resident to access the support of an independent advocate and the provider's social worker and members of the local management team had held a number of meetings with the resident and their representative to attempt to support the resident to have full access to their finances. Since September 2024 their income was being lodged into their account held centrally in the provider's finance department, and work was ongoing to support them to get oversight and access to their finances prior to this date. This resident had built up a debt to the provider relating to accommodation. A meeting was held to write off this debt; however, an error occurred and the amount owed was taken from their account by the provider. Following this, the provider made arrangements to reimburse the resident. The inspector reviewed this residents' statements of account for their client account in 2025, which demonstrated that the resident had been fully reimbursed.

Judgment: Not compliant

Regulation 17: Premises

The inspector completed a walk around the premises with the team leader and found that the premises was clean, warm, well-maintained and designed and laid out to specifically meet the needs of residents living there. For example, there was one room with a number of musical instruments and activity options. The inspector was told and observed that this was one residents' preferred space to engage in activities in during the day. During the inspection they were observed spending time

relaxing in this room, playing musical instruments, listening to staff playing musical instruments and singing and playing with a football.

During the inspection, one resident took the inspector by the hand and showed them around their bedroom. It contained a large double bed, a locker, an armchair and a a specially designed space to store their clothes. They had pictures, photos and some of their medals and achievements on display. They also had a large wall mounted television.

Judgment: Compliant

Regulation 20: Information for residents

The inspector reviewed the residents' guide submitted prior to the inspection and it was also reviewed in the centre. It had been recently reviewed and contained all of the information required by the regulations including information on the service and facilities, arrangements for residents being involved in the centre, responding to complaints and arrangements for visits.

Judgment: Compliant

Regulation 28: Fire precautions

During the walk around of the premises the inspector observed that emergency lighting, smoke alarms, fire-fighting equipment and alarm systems were in place. There were fire doors and swing closers, as deemed necessary. The inspector observed the fire alarm and systems in operation during the inspection as the fire alarm was activated due to smoke while lunch was being prepared. The alarm activated, staff responded to check the fire panel and the fire doors on automatic self-closers, closed automatically. Following a staff review, it was determined that a full evacuation of the centre was not required.

The inspector reviewed records for 2024 and 2025 to demonstrate that quarterly and annual service and maintenance were completed on the above named fire systems and equipment. The evacuation plan was also on display.

A sample of eight fire drill records for 2025 were reviewed. These demonstrated that the the provider was ensuring that evacuations could be completed in a safe and timely manner taking into account each residents' support needs and a range of scenarios. Learning from drills was shared with the leading to actions. For example, a night drill had been completed and it had been identified that the time to evacuate was higher than previous night drills. A review was completed and a follow up drill completed implementing learning following the previous drill. This proved effective

as the repeat drill was completed in a more timely manner. Learning from drills was also leading to the review and update of residents' personal emergency evacuation plans.

Both residents' personal emergency evacuation plans were reviewed and they were found to be sufficiently detailed to guide staff practice to support them to evacuate safely.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were a number of restrictive practices in place. For example, doors locked or on a keypad lock, welfare checks every four hours at night in line with a residents' healthcare needs, locked presses, and restrictions relating to residents' accessing their finances. From a review of both residents' plans, these restrictions were reviewed quarterly by the local management team, and at least annually by the provider's rights committee. A detailed restrictive practice register was maintained in the centre. In addition, each restriction had a restrictive practice management plan in place. Residents had an easy-to-read document available to them relating to each individual restrictive practice in place.

Both residents' positive behaviour support plans were reviewed. These demonstrated that they were developed and reviewed by the behaviour support specialist. Residents were also accessing psychiatry services and could access psychology supports, if required. Both positive behaviour support plans were found to be detailed in nature. They contained both proactive and reactive strategies and provided clear guidance for staff on how to best support them both.

Judgment: Compliant

Regulation 8: Protection

From a review of the staff training matrix, 100% of staff had completed adult safeguarding and protection training. The inspector spoke with the person in charge, team leader and the two staff on duty and found that they were all found to be knowledgeable in relation to residents' care and support needs and their roles and responsibilities should there be an allegation or suspicion of abuse.

The provider had a safeguarding policy which was available and reviewed in the centre. There were had been no safeguarding concerns notified to the Chief Inspector since the last inspection. However, the provider's systems were reviewed to ensure that safeguarding plans were developed and reviewed, if required. Both

residents had detailed intimate care plans in their personal plan folder. These detailed their abilities, support needs and preferences.

The inspector reviewed the systems in place to ensure that residents finances were safeguarded. The provider did not have full oversight of one residents' finances and this is discussed further under Regulation 12: Personal Possessions.

Judgment: Compliant

Regulation 9: Residents' rights

The inspector found that the staff team were focused on implementing a human-rights based approach to care and support for residents in this centre. Each staff member had completed four modules of a human-rights based approach in health and social care.

Based on what the inspector observed, was told and read, every effort was being made to ensure that residents rights were respected. For example, one resident liked to observe what was happening in their neighbourhood and privacy screen had been added to the inside of the window to afford them the opportunity to do this, while also ensuring their right to privacy. In addition, efforts were being made to support one resident to have full-access to and oversight of their finances. This is captured under Regulation 12: Personal Possessions. They had been supported to apply for and access the support of an independent advocate. In addition, a number of meetings between the resident and the provider's social worker.

Weekly focus on future planning meetings were occurring for each resident. A sample of eight of these were reviewed. At these meetings, easy-to-read documents were reviewed with residents around specific topics such as safeguarding, restrictive practices, finances, complaints, rights and how to access advocacy services. The provider's communication bulletins were also reviewed at these meetings. These included details on events and celebrations that had occurred and upcoming events. Menu and activity planning was also discussed. Both residents had a tablet computer and mobile phone ands were using these to take photos of them engaging in their favourite activities. One resident was observed bringing their mobile phone with them when leaving the house.

Throughout the inspection, the inspector observed staff treat residents with dignity and respect. Staff who spoke with the inspector discussed residents' strengths, talents and goals. They described how important it was to them that each resident was happy, safe and engaging in activities they find meaningful.

Residents were meeting their keyworkers monthly to set and review their goals. During the inspection the team leader and person in charge were observed meeting with one resident to discuss their upcoming annual visioning meeting. This was a pre-meeting and their goals and wishes around community access were being discussed. They reviewed some of the pictures on their tablet computer of the

activities they had enjoyed, and were making plans around what new activities they would like to explore in the future.
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	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	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
Regulation 31: Notification of incidents	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 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Lolek OSV-0007740

Inspection ID: MON-0038921

Date of inspection: 06/10/2025

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 Quality department have met with the Director of Services on 09.10.2025 and discussed a number of actions required to update audits. The actions include each function reviewing audit questions, to avoid repetitiveness, and cut down on number of questions. The DOS also agreed on a number of changes to the providers Annual Review Report that included feedback from people supported & their representatives and has actioned these changes to QA department. The QA department will update the system in Q 1 2026 when functions audit questions are updated. An immediate action for the Auditor will be to document within the annual report the observations made while in the designated centre on how people supported and staff interact. The findings of this report will be shared at team meeting on 12.11.2025.	
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 part of the improvements in finances, a more in-depth review of the Person Supported Finance Policy is ongoing and yet to be finalised to ensure detail and transparency in processes and the policy. Director of Finances, Director of Services and both teams have met on the 29.10.25 to discuss the findings from most recent HIQA	

inspections and issues identified in provider audits to agree on next actions for improvements. Senior Management Team have met on the 3.11.25 to further review Aurora Service Provision for residential and Day Service to ensure equity and fairness in applying charges and contributions. This will be finalised by 15.12.25 and the policy and service provision documents will be updated accordingly and communicated to employees
Each person supported has received correspondace relating to changes in LSC following service review in January 2025. Updated contracts will be devised as part of upcoming transition

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
The provider takes responsibility for the people supported in Aurora to safeguard finances, as most people supported are not in a position to open their own bank account. Based on this, the provider has implemented the least restrictive finance system and maximized safeguarding over person's finances, by using a smart card system.
The provider has set weekly limits, based on the person's spending patterns; those weekly limits are reviewed regularly and can be increased as required and requested to meet the person's needs.

Since implementing the smart card system and the provider's finance system, the provider is still in the improvement phase to make adjustments, where errors have been identified. The Director of Finances has put controls in place to mitigate and reduce errors due to manual processes. As part of the improvements, a more in-depth review of the Person Supported Finance Policy is ongoing and yet to be finalized to ensure detail and transparency in processes and the policy. Director of Finances, Director of Services and both teams have met on the 29.10.25 to discuss the findings from most recent HIQA inspections and issues identified in provider audits to agree on next actions for improvements. Senior Management Team have met on the 3.11.25 to further review Aurora Service Provision for residential and Day Service to ensure equity and fairness in applying charges and contributions. This will be finalized by 15.12.25 and the policy and service provision documents will be updated accordingly and communicated to employees and people supported.

The PIC & Social Worker have completed the following actions in regards to one person supported finances
1. The PIC completed internal notification and preliminary screening and NF06 W/E 23.10.25
2. Interim safeguarding plan for submission 07.11.2025
3. PIC has made a referral on 25.10.2025 to a national advocacy service for support. Awaiting feedback and contact.
4. Social worker continues to support persons family to obtain bank statement – this is

planned for completion prior to 20.11.2025.
5. Regular updates shared with person supported in an accessible way.

The finance audit will be reviewed and amended in line with updated policy in Q1 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	15/12/2025
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	19/12/2025
Regulation 23(1)(e)	The registered provider shall ensure that the	Substantially Compliant	Yellow	30/03/2026

	review referred to in subparagraph (d) shall provide for consultation with residents and their representatives.			
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall 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.	Substantially Compliant	Yellow	15/12/2025