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:	Clannad
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:	22 January 2025
Centre ID:	OSV-0005633
Fieldwork ID:	MON-0045612

About the designated centre

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

Clannad is a residential centre located in Co. Kilkenny. The centre affords a service to four adults, both male and female over the age of 18 years with an intellectual disability. The service operates on a 24 hour 7 day a week basis ensuring residents are supported by care workers at all times. The day to day operations of the service are provided by a clear governance structure. Supports are afforded in a person centred manner as reflected within individualised personal plans. The residence is a detached bungalow house which promotes a safe homely environment decorated in tasteful manner.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 22 January 2025	09:15hrs to 17:00hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This inspection was unannounced and was carried out with a specific focus on safeguarding, to ensure that residents felt safe in the centre they were living in and they were supported in line with their specific assessed needs.

Overall, it was found that although safeguarding incidents had decreased in the centre over the last three months there was a number of improvements required to ensure that residents' safety was paramount and that they lived in an environment that optimised safe care and support at all times. Although, residents appeared reasonably comfortable in their home on the day of inspection, the provider had identified that the group of residents were not compatible to live in the same house at all times. On the day of inspection there were 13 interim or formal safeguarding plans in place.

The inspection occurred over a one day period and was completed by one inspector. The designated centre had capacity to accommodate four residents for full-time residential care. There were no vacancies on the day of inspection.

On arrival at the centre, three residents were up and about for the day and the fourth resident was being assisted with personal care. Two residents were in the sitting room and there was a television program playing in the back ground. One resident was in the hall and was eager to show the inspector some of their preferred items in their bedroom.

All four residents had specific communication requirements. Some residents used adapted sign language, gestures and vocalisations to communicate where-by other residents would use repetitive questions and statements and answer some direct questions with support. The inspector had the opportunity to meet with all four residents across the day of inspection and observe aspects of their daily routines.

The inspector spent some time with one resident while they showed them preferred items in their bedroom. A staff member was present to support the resident's communication needs at this time. The staff member readily understood the resident's specific communication methods and reassured the resident when they asked about questions about going home for a family visit. The resident had recently been introduced to a new mobility device within the home and was seen to use this independently. The resident had plans to attend day service and later left with a staff member.

The inspector met the other two residents in the sitting room. They were sitting on the couch. While one resident did not communicate directly with the inspector they would nod or use a thumbs-up sign to indicate they were ok. The other resident used repetitive questions and statements to communicate. Staff were heard answering the resident in a consistent and patient manner to ease any anxieties the resident had. The resident seemed very comfortable in their environment and would

often revert questions to their peer.

The fourth resident was in the kitchen when the inspector met them. They primarily used gestures to communicate. They were enjoying their breakfast and nodded and give a thumbs-up when asked some direct questions. For most of the day they sat in their preferred seat watching television. Staff explained that the resident often made a choice to remain at home, however, activities were offered both in house and community based , on a frequent basis. On the day of inspection a member from the multi-disciplinary team was coming to visit the centre to review the resident's needs in relation to activities outside the home and determine if further supports were needed in this area.

Across the day of inspection the two staff present were seen to interact and involve all residents in activities of daily living and offer in house activities. Residents were seen painting, engaging in household tasks such as sweeping, preparing meals as well as been offered activities out of the home. Three residents left the home on the day of inspection. Residents went to day service, out for coffee, and out for walks. Overall, it was found that residents were actively involved in their home life and given opportunities to go out and about in the community. However, access to resources was, at times, a barrier to community access. There was only one vehicle associated with the centre. Due to the location of the centre access to vehicles was essential as the centre was in a rural location. The need for an additional vehicle had been identified by the provider. However, on the day of inspection this had not been addressed.

As part of the inspection process the inspector completed a walk around of the premises. The residents each had an individual bedroom, one bedroom had en-suite facilities, and the other three residents shared access to a main bathroom. There was a sitting room, living room and kitchen area. The laundry facility was kept in the garage. For the most part, the designated centre was meeting the assessed needs of residents. Storage space was limited and the staff had to complete any office based work in the residents' sitting room. The provider had identified that the long term suitability of the premises was not adequate and had plans to address this over the next 18 months.

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

Capacity and capability

The inspector found that there was a clearly defined management structure in the centre. There was a full-time person in charge in place. At the time of inspection they had remit over three designated centres. A team leader had been appointed to aid the person in charge in their managerial and operational responsibilities. However, due to a number of changes in management structure with the designated

centre, gaps in oversight, specifically in relation to safeguarding incidents had occurred. In addition improvements were required in supervision of staff, risk management and access to information in relation to positive behaviour support plans was required.

There was a consistent staff team employed and the numbers and skill mix of staff was appropriate to meet the needs of residents. Although there were some vacancies at the time of inspection a core relief staff team was utilised as well as regular agency to ensure continuity of care as much as possible.

The provider's policy in relation to supervision of staff stated that four one- to -one supervision sessions were to occur in a calendar year. This had not occurred for all the staff team, therefore effective supervision of staff was not being implemented on a continuous basis. As the skill set of staff team was essential part of some safeguarding plans this required review to ensure staff were being effectively supported.

Regulation 15: Staffing

The inspector reviewed the rosters in place for a six week period between December 2024 and January 2025. There were six core staff represented on the roster with roles delegated as social care worker, staff nurse or health care assistant. In addition the team lead and person in charge, who were supernumerary to staff team, were also present in the centre. There were a number of shifts covered by agency or relief staff. The inspector noted that the shifts covered by agency were not frequent, for example between 8th December 2024 and 21st of December 2024 four agency staff cover four separate shifts. This ensured that continuity of care was available to residents as much as possible.

In addition, the provider had identified the whole time vacancy requirements of the centre and were in the process of recruitment of these posts. There were also systems in place to track and review the use of agency, relief and overtime shifts within the centre to ensure that residents were afforded continuity of care.

Staff present on the day of inspection were knowledgeable around the residents' specific needs, likes and dislikes. They were seen to understand each person's individual communication needs and support residents in a kind and caring manner.

Judgment: Compliant

Regulation 16: Training and staff development

The inspector reviewed the training matrix in place that tracked the training requirements of all staff. It was found that all staff had completed training in the

safeguarding. This course was deemed mandatory by the provider. In addition, staff completed training in areas such as fire safety, safe administration of medicines and managing behaviour that is challenging. There were gaps in safe administration of medication training with two staff due to complete the assessment piece in relation to this training in the coming weeks. The provider assured the inspector that staff did not administer medicines until all aspects of training was completed.

Staff supervision records were reviewed as part of the inspection process. The provider's policy stated that a minimum of four supervision sessions were to occur across a calendar year. From a review of three staff records, none of the staff had received supervision in line with the requirements of the policy. For example, one staff had received one supervision in 2024 and one supervision in early 2025. This gap in supervision had been identified in the provider's audits and there was a schedule of supervision in place for 2025.

Judgment: Substantially compliant

Regulation 23: Governance and management

There were clear lines of authority and accountability in this service. The centre had a clearly defined management structure in place which was led by a person in charge who reported directly to the Wellness and Culture Integration Officer. A team leader was in place to support the person in charge in their role. However, due to a number management changes within the designated centre there had been gaps in oversight across a number of areas of care and support.

Since April 2023 there had been four appointments of a person in charge to the role. The person in charge currently appointed was in their role since November 2024.

There were gaps in oversight systems such as supervision as discussed under Regulation 16, team meetings and handover systems when a new person in charge had been appointed. This had been identified by the provider and there was a plan in place to ensure a system was in place to induct the person in charge to their role in a systematic manner.

In relation to Regulation 8: Safeguarding, the gaps in oversight had resulted in a lack of information being available to the local staff team. The systems in place to ensure sufficient information was available to staff and was kept up -to -date was inadequate. This is discussed in further detail under the relevant regulation.

Judgment: Substantially compliant

Quality and safety

Overall, the inspector found that the centre presented as a comfortable home and care was provided in line with each resident's assessed needs. A number of key areas were reviewed to determine if the care and support provided to residents was safe and effective. These included meeting residents and staff, a review residents key documentation in relation to safeguarding and risk management. Significant improvement was required in relation to they systems of oversight around safeguarding procedures in the centre.

Although it was found that there were systems in place to report and manage safeguarding concerns in the centre, it was found that these were not effective. 13 safeguarding plans were in place in the centre. The majority of these plans were not available to the staff team as they were kept on a computer system that the staff did not have access too. Correspondence reviewed by the inspector indicated that requests of updates on formal safeguarding plans were not submitted to the Safeguarding and Protection Team within specified time lines. Overall, the handover of information to the person in charge was found to be lacking detail and therefore it was not clear what safeguarding plans were being implemented in the centre on the day of inspection. Although incidents had decreased this was due to a resident spending a large proportion of the day out of the centre. A full review of safeguarding measures and plans was required to ensure they were effective and that residents' safety was central to service provision.

Regulation 10: Communication

Residents were assisted to communicate in accordance with their assessed needs and wishes. Observations on the day of inspection indicated that both staff present readily understood each residents' unique communication style.

The inspector reviewed three residents' files and found that a communication toolbox was in place describing each resident's specific needs in terms of their preferences around communication. Easy read information on safeguarding was also in place to help support residents understand the different aspects of keeping safe.

Residents also had access to telephones and other such media as Internet, televisions, radios and personal tablet devices.

Judgment: Compliant

Regulation 17: Premises

The centre was located in a rural setting in Co. Kilkenny. It comprised a detached bungalow building surrounded by a very large garden area.

Internally the home had two sitting rooms, a small kitchen, four separate bedrooms, one bedroom was en suite, and a main bathroom. These areas of the home were clean and presented as homely with pictures on display. Each bedroom was clean and well presented, and residents had personal items on display.

The house was small in size and would not be suitable if changing needs such as needs in mobility were to change in the resident cohort. The long terms suitability and accessibility of the home was in consideration by the provider and there were ongoing plans to address this in the coming 18 months.

Judgment: Compliant

Regulation 26: Risk management procedures

It was found that although aspects of risk management had improved in the centre since the last inspection, this was an area that required additional attention to detail and timeliness of action to ensure that risks were managed in a robust manner.

On review of two residents' individual risk assessments it was found that not all risk assessments were in place. A safeguarding incident occurred in July 2024. An action deemed necessary was the development of a risk assessment to mitigate the identified safeguarding risk. This risk assessment was not in place on the day of inspection. It was unclear what control measures were in place around this. Staff spoken with were unaware of this risk assessment.

The provider had a system in place to record accidents, incidents and near misses. The provider utilised the National Management System (NIMS). Overall, the majority of incidents were recorded. However, it was found that not all incidents were being recorded through this system. For example, the inspector reviewed an incident where-by a resident had attempted to open a product with chemicals contained in it. This was recorded in daily notes and not in the incident management system. Therefore this incident was not reviewed as in line with the provider's risk management policy, there was no system in place to manage this risk and there limited information available to staff.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Two residents had positive behaviour support plans in place on the day of inspection. The inspector reviewed both of these plans and found that they had been updated by the behaviour support specialist in September of this year. All staff were required to sign off that they had read these plans to ensure they were clear

on the information provided. On one resident's plan the sign in sheet was signed off by staff a few days prior to the inspection. It was unclear if this information had been made available to staff prior to this date despite being updated four months ago.

In addition, not all staff had received training in positive behaviour support and de-escalation techniques. There were 10 staff represented on the training matrix and only five of these staff had up -to -date training in this area.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector found that, while safeguarding concerns were being identified, reported to the relevant authorities and managed to some degree in the centre, there was no comprehensive review of safeguarding plans in the centre to ensure they were effective. There was no review of actions and it was unclear if all actions had been implemented as required. In addition, updates as requested by the Safeguarding and Protection Team had failed to be provided in the relevant time lines. Therefore the effective management of safeguarding concerns within the centre was not evident.

As stated previously there were 13 open safeguarding plans at the time of inspection. The person in charge was not aware of all safeguarding plans. The plans were not readily available in the centre. For example, on review of two residents' folders, one safeguarding plan was in place in each folder. There had been further incidents in relation to safeguarding with no corresponding information available in residents' files. It was unclear on what information was guiding staff practice.

In addition, the Safeguarding and Protection Team had specifically requested updates in relation to specific safeguarding plans. The inspector reviewed correspondence indicating requests for information to be submitted in November 2024 and January 2025 for four separate plans. This information had not been submitted as requested. For example, the Safeguarding and Protection Team had requested details on the skill set and experience of the staff team, as this was an action stated in a safeguarding plan. The information was required to be submitted by the 30 November 2024. This remained outstanding on the day of inspection and had not been submitted.

It was unclear how actions were being monitored for effectiveness as there was limited oversight in relation to the implementation of plans. For example, in a safeguarding plan dated March 2024 an action stated was that a second vehicle was to be allocated to the designated centre. On the day of inspection this action remained outstanding.

Overall, although incidents had reduced in the centre, this was primarily due to residents spend large amounts of time apart from each other. Safeguarding plans

required review to ensure they were effective and informing staff practice.
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	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Clannad OSV-0005633

Inspection ID: MON-0045612

Date of inspection: 22/01/2025

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • There were training gaps identified during the inspection for safe administration of medication training. All team members that had outstanding assessments have completed same by 31.01.2025. All team members are now fully trained in medication management. • The training matrix for Clannad is now being reviewed on a fortnightly basis by the PIC going forward to ensure each team members training is in date. This will be discussed at team meetings and addressed in individual Quality Conversations. • A Quality conversations schedule is in place in Clannad for 2025, printed and located in the Quality Conversation folder. Each staff member has been scheduled for Quality Conversation as per Aurora policy, same have commenced in line with the schedule since 25.01.2025.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Since the inspection took place a new PIC from within the service has been assigned to Clannad with no other remit of a designated centre. Handover has been completed between previous PIC and TL and the new PIC and actions from this compliance plan and inspection been discussed to ensure full implementation. • A full review of current safeguarding plans for Clannad has been conducted by Aurora's Human Rights & Equality Lead, Social Worker, Safeguarding Designated officer and Person in Charge and any outstanding actions will be completed by 28.2.25. • The provider has commenced a review of all designated centre Safeguarding folders and documentation on Safeguarding drive to ensure that all safeguarding plans and	

records are up to date and reflected in the designated centre house folders, person's file and on the Sharepoint System.
• A Quality Initiative on Safeguarding has commenced in Aurora in January 2025 to implement necessary developments and in line with HIQA Safeguarding assessment framework, this includes a review of provider audit oversight and pathways for supporting PICs and Team Leaders in implementing safeguarding plans.
• The team meeting on the 13/03/2025 will have a specific focus on current/open safeguarding plans to be discussed with the Clannad team, to ensure that all team members are aware of open FSPs and actions required.
• PIC & SCW are attending Safeguarding workshop on 4th or 24th March'25 delivered by Aurora Social Worker, Human Rights & Equality Manager and they will be joined by Clinical Nurse Manager 2, South East Safeguarding & Protection Team. This will ensure further learning and development/capacity building in understanding and implementing Safeguarding practices.
• PIC will deliver learning to the Clannad team at the March team meeting from above workshop.
• PIC has emailed safeguarding policy to all team members to ensure team members attend prepared to discuss safeguarding at the team meeting on 13.03.2025. Safeguarding Easy Read has also been added to person supported Focus on Future Planning meeting.
• Safeguarding is on standard agenda of all team meetings and will be discussed at all meetings going forward.
• Quality Conversations schedule is in place for 2025, printed and located in the QC folder. Each staff member has been schedules for QC as per policy, same have commenced since 25.012025.
• A Team meeting schedule is in place for 2025 for Clannad.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

• PIC has commenced full review of actions on current FSPs and to be finalised by 27.02.2025. As part of this review PIC is to identify and ensure the risk assessments are in place and reflective of the safeguarding plans/risks identified.
• PIC will review each persons supported individual risk assessments by 13.03.2025, ensure that risk assessment log is updated to reflect any potential risks and necessary additional control measures.
• As each risk assessment is updated the PIC and SCW will ensure all team members read and sign off on the documents. All risk assessments will be discussed at Team meeting on 13.03.25 and signed and by the team. Staff unable to attend meeting, PIC will ensure they follow up and keep then fully informed.
• On the job mentoring, using "Incident/Accident Pathway" will be completed with Clannad team around identifying incidents and accidents and the correct reporting procedures. This will address that all team members understand the identification and notification of incidents and reporting procedures of same. This will be completed at the March team meeting on 13.03.25.
• Aurora have now developed an Incident & Accident Committee, its primary purpose is

to establish a structured approach to managing, investigating, analysing, and mitigating all incidents and accidents within our organisation. The Committee is scheduled to meet next on 08.04.2025.
• Quality Conversation template and PIC monthly status reports have been updated to support PICs and WCI managers Quality Conversations and reporting in more detailed analysis of incidents and ensure actions are taken appropriately.
• DOS and WCI team have agreed on a monthly team review of incidents and notifications as part of the monthly team meeting to involve all team members in oversight of incidents, trends and necessary actions. This is to commence at the next team meeting 2nd week of March 2025.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• PIC to ensure all team members complete Introduction to Positive Behaviour Support training video by latest 28.02.2025.
• The remaining team members in Clannad outstanding their MAPA training are scheduled to attend same on 30.04.2025.
• Positive behaviour support Specialist is booked to attend April team meeting 17.04.2025 to further guide the team in Clannad on implementation of and adherence to support plans for each person living in Clannad.
• As part of induction process for any new PICs, Behaviour Support Specialist to meet to complete on the job mentoring around current Positive behaviour support plans for persons supported in Clannad. Scheduled for 12.03.25 at 2.00pm.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• Compatibility and other actions to safeguard people supported remain for Clannad and other designated centres and people supported on the agenda for the provider on Safeguarding Oversight Committee, Compatibility and Housing meetings.
The provider acknowledges that compatibility and vehicles were discussed in early 2024 for Clannad. As the provider and PIC at the time further reviewed actions of Safeguarding plans for the 4 people supported, more suitable actions were taken to support each person their daily planning. One lady was supported to return to Aurora Hub, which was prior to COVID outbreak in 2020 and important social weekly plan for her. Assigning of vehicles to designated centres occurs in line with resource management across the service and was not deemed a necessary action due to other actions implemented.
• PIC is completing a full review of current safeguarding plans with Human Rights & Equality Lead, Social Worker, Safeguarding Designated Officer, linking with CHO5 Safeguarding Protection team as required by 28.02.2025 to ensure all plans are closed and/or actioned as required.
• Following on from this meeting the PIC will bring the learning back to the team, in the March team meeting on 13.03.2025.

• PIC has invited the Social Worker to the team meeting on 13.03.2025 to discuss safeguarding with the Clannad team and build further capacity.
• PIC will attend Safeguarding Workshop on 24.03.2025. 2 team members will attend the Safeguarding workshop on 03.03.2025. Clinical Nurse Manager 2 and Social Worker from CHO5 will be assisting to facilitate these workshops on safeguarding practices.
• Safeguarding is now added to the agenda on all team meetings and also added to Focus on Future Planning meetings for people supported.
• PIC report on Safeguarding to WCI through PIC Monthly Status Report to ensure oversight and to be discussed at QCs between PIC and WCI manager.
• PIC will review each persons supported individual risk assessments by 27.03.2025, ensure that risk assessment log is updated to reflect any potential risks
• Director of Services met on 12.02.2025 with Safeguarding and Quality team to discuss further development of Safeguarding Audits to ensure monitoring and oversight. A further meeting is scheduled for 05.03.2025 to develop the current provider audit and implement next steps in overseeing
• The HIQA report will be added to the agenda at next Safeguarding oversight committee for discussion and considerations for Aurora. This committee meeting is scheduled to take place on 08.04.2025.

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 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.	Substantially Compliant	Yellow	31/01/2025
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	25/01/2025
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	04/03/2025
Regulation 26(2)	The registered	Substantially	Yellow	10/04/2025

	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.	Compliant		
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	30/04/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	25/03/2025