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:	Country Lodge
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:	18 July 2024
Centre ID:	OSV-0005827
Fieldwork ID:	MON-0035233

About the designated centre

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

Country Lodge is a designated centre operated by Saint Patrick's Centre (Kilkenny). It provides a community residential service for up to four adults with a disability and complex needs. The designated centre is a detached bungalow which comprises of four individual resident bedrooms, an office, a visitors room, a large open planned kitchen/dining/living room and a number of shared bathrooms. The designated centre is located close to an urban area in County Kilkenny near to local amenities and facilities. The staff team consists of staff nurses, social care workers and health care assistants. The core staff team is supported by the 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
Thursday 18 July 2024	09:30hrs to 19:00hrs	Sarah Mockler	Lead

What residents told us and what inspectors observed

This announced inspection was completed to inform a decision regarding the renewal of registration for the designated centre. The inspection took place over one day. A total of four announced inspections (which included an inspection this centre) occurred in centres operated by the registered provider over a two day period. This report will outline the findings against this centre.

Overall, the findings of the inspection indicated that residents were receiving care in line with their assessed needs. There had been a number of changes to the management and local staff team in recent months and staff were still in the process of learning about residents' needs, likes and dislikes. Improvements were required in the management of personal possessions, healthcare plans, managing safeguarding incidents and ensuring residents' rights were upheld at all times.

Some overarching findings in relation to the provider's oversight and governance and management arrangements were identified in all four centres inspected. Inspectors noted an improved level of oversight from a governance and management perspective both at local and provider level. Overall, this was resulting better levels of care and support being provided to residents. However, improvements were required in the management of residents' possessions and finances across a number of the centres reviewed. This finding also related to the inspection of this centre.

The centre was registered to provide a residential community service for four individuals.The inspector had the opportunity to meet with three residents that lived in the designated centre. At the time of the inspection there was one vacancy.

The residents in this centre used non-verbal means to communicate, such as vocalisations, facial expressions and some gestures or movements. All residents were assessed to need full support with all aspects of their care and support needs. In order to gather an impression of what it was like to live in the centre, the inspector observed care practices, spoke with staff and completed a review of documentation in relation to residents' care and support needs.

On the inspector's arrival at the centre in the morning all residents were in bed. There were three staff present and the person in charge. It was explained to the inspector that residents choose to get up when they wanted too and staff were available to start their routine when the residents were ready.

The inspector completed a walk around of the designated centre. The designated centre is a detached bungalow which comprises of four individual resident bedrooms (one bedroom was vacant on the day of inspection), an office, a sitting room, a large open planned kitchen/dining/living room and a number of shared bathrooms. Storage within the centre had improved as an additional outdoor shed had been

purchased and installed to allow storage of larger accessibility equipment.

The inspector met with all three residents across the course of the day. The first resident was up and showered and was in the kitchen. The resident was observed to independently mobilise in their wheelchair around the centre and in and out of the garden area. They particularly enjoyed spending time outdoors in the garden space. A second resident was being supported with their breakfast. A staff member was sitting with the resident at this time.

The inspector met the third resident in their bedroom. They were listening and watching preferred music on their own television. They were up and dressed and were eager to show the inspector a hat they had picked out. The staff member supporting the resident at this time was very familiar with the residents individual communication means and supported the resident when the inspector was present. The resident was comfortable and well presented.

Two of the residents in the centre had plans to leave the centre for part of the day. Plans included attending a stable area to help with horses and going out for a coffee. These two residents enjoyed a good level of activity in line with their specific assessed needs. The third resident had no plans for the day and spent the majority of the day in the garden or in the centre. Improvements were required in relation to this resident's access to activities in the community and in the home which is further explained under Regulation 13.

Later in the afternoon all residents returned to the centre. Staff were preparing meals and supporting residents with their routines. For example, one resident was seen relaxing in the sitting room watching a preferred television show. A staff member was sitting with the resident at this time. The resident appeared very comfortable and the staff member was seen interacting with the resident in a very kind, caring manner.

As this inspection was announced, questionnaires about aspects of care and support in the centre were sent out in advance of inspection and four completed questionnaires were received by the inspector. All residents were supported by staff to answer relevant questions. All answers indicated that the residents were happy with the care and support provided, the premises and how staff interacted with them.

Overall, the inspector noted that all residents appeared content in their home. A new staff team had commenced supporting the residents and they were adequately meeting their assessed needs. However, improvements were required in a number of areas to ensure that the centre met compliance with the regulations.

In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

Overall, the findings of the inspection were that the residents were in receipt of a safe service that was meeting their needs. However, changes in the staff team had meant that some areas that required improvements remained outstanding. For example, a number of areas required further input to ensure compliance with the regulations. This included areas such as healthcare planning, general welfare and development, oversight of safeguarding incidents and reporting and management of personal possessions. In addition, there were a number of vacancies in the staff team that required recruitment to ensure a full compleiment of staff were available to residents.

The person in charge was full-time and had a large managerial remit. They were responsible for two designated centres and was also appointed as the Wellness and Cultural Integration Manager across the service. In this post they were required to be on call for a number of centre's operated by the provider. They had been in the person in charge post in this designated centre since April 2024. The person in charge facilitated the inspection process.

The person in charge and local management team had systems in place for the day-to-day management and oversight of the centre. This included the six monthly provider audits, annual reviews of the quality of care and local medication, finance and infection prevention and control (IPC) audits.

As previously stated, there was a relatively new staff team in place in the centre.The staff team had been given the required training needed to complete their role and it as evident that they were embedding the theory of their training into everyday practice. A large part of this was getting to know the residents, and what they liked and disliked. Not all staffing posts had been filled at the time of inspection. Therefore a consistent staff team was in the early stages of being established.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted the required information with the application to renew the registration of this designated centre. The inspector reviewed all the relevant information and found it was in line with the requirements of the regulation. Information submitted included the statement of purpose, floor plans, and application forms and fees.

Judgment: Compliant

Regulation 15: Staffing

The staff team consisted of staff nurses and healthcare assistants. There were approximately four whole-time equivalent vacancies and a staff member that had been re-deployed. In order to fill the vacant posts relief and agency staff were being used on a regular basis. Of the staff team that was present including relief staff, four of the posts had only been filled in recent months. As the staff team were being established and vacant posts still required recruitment, consistent and continuity of care for residents was in the early stages of being embedded. Although the staff team was meeting the residents' immediate needs, further skill development of the staff team was required to ensure all residents needs were equally met. For example, having an equal emphasis on meeting all residents' health and social care needs.

There was a staff roster in place which was well maintained. The inspector reviewed a four-week period of rosters and noted that the required number of staff were present in the centre to support residents. On discussion with the person in charge and from a review of rosters it was noted that one resident was not in full receipt of their personal assistance hours. The resident was currently in receipt of 18 hours per week with a further six hours funded and not filled. At the time of inspection it was unclear what measures were being put in place to address this.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had ensured that the majority of staff had up-to-date training across both mandatory requirements and relevant training in line with residents' specific assessed needs. On review of the training matix it was found that staff had completed training in areas such as fire safety, safeguarding, manual handling, safe administration of medicines. In addition, training requirements to meet specific resident needs such as training in oxygen administration and epilepsy management were also completed by the staff team.

The provider had policies and procedures in place in terms of probation and supervision of staff. This included one-to-one supervision sessions with a line manager and on the job mentoring. It was found that overall staff were in receipt of supervision in line with the provider's policy. Newly hired staff had all completed an induction and were in the process of completing their probation periods.

Judgment: Compliant

Regulation 23: Governance and management

Over approximately the last 18 months the provider had introduced and/or improved the systems of oversight within the designated centre. This included a re-structuring of the management team, re-structuring of reporting structures, and introduction of new audit systems to review the level of quality of care. For example, the provider was completing six monthly unannounced audits in line with the requirements of the regulations. The inspector reviewed the most recent six monthly audit that had been completed in May 2024. 52 actions out of a total of 116 actions remained open on the day of inspection. For example, the audit report had identified that residents required more access to the community and activities, and this was in line with the findings of this inspection. Overall, the audit tools were identifying areas of improvement and demonstrating a more robust approach to oversight.

There were clear lines of accountability within the centre, with a full-time person in charge that reported directly to the Director of Services. As previously mentioned the person in charge had a large managerial remit. In order to support the person in charge in their role a team leader had been appointed to the centre. The team leader provided direct support to residents but also had 10 hours a week protected time to completed delegated managerial duties.

Judgment: Compliant

Regulation 3: Statement of purpose

This document outlines the model of care and support to be delivered to residents within the service. The inspector reviewed the statement of purpose and it was found to reflect the facilities and service provided. All the required information set out in Schedule 2 of the regulations were in place.

Judgment: 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. The following 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 of residents' finances, risk documentation, fire safety documentation, safeguarding documentation and documentation in relation to healthcare needs. Some improvement was required in a number of areas but for the most part this had been

identified by the provider through their own auditing systems. Improvements are detailed in the regulations below.

Some changes to the management of residents' finances had been implemented over the last year. This included the introduction of a specific debit card that allowed residents immediate access to some of their funds. As this system was new, staff were in the early stages of learning the relevant systems. Further, improvements were also needed in the management of residents' possessions.

Although some residents were afforded the opportunity to access activities and other events in the community on a regular basis, this was not the case for all residents within the home. Further, development of residents' goals and access to social activities were required.

Regulation 12: Personal possessions

All residents in this centre had Health Service Executive (HSE) Private Patient Property Accounts (PPPA). In order to access money from these accounts, the residents all had a debit card where money from their account could be transferred to this card. The card could be used to directly purchase items or take money out of a bank machine. This system allowed easier access to residents' finances. The expenditure form this debit card was audited by the person in charge on a monthly basis.

The introduction of the debit care allowed better auditing of residents finances. However gaps remained in this system. For example, there were no up-to-date bank statements present in the centre. This meant that expenditure was not cross referenced with bank statements to ensure that residents spending was reviewed and managed appropriately.

Although asset lists were in place, the inspector found they were inaccurate at times, and there was no clear system in place to outline what should be on an asset list or how it should be recorded. For example, clothing was present on all asset lists but there was no record of residents' personal phones or tablet devices. It was unclear how the provider was managing residents' property in an effective manner.

Judgment: Substantially compliant

Regulation 13: General welfare and development

The inspector reviewed daily notes, spoke with staff and residents and observed the routines and activities offered to residents on the day of inspection. Two residents left the centre on the day of inspection and one resident remained in the home. The resident that remained at home spent the day between the house and going out to

the garden. On review of their daily notes over the last six week period the activities logged were drives or spending time in the garden. The resident was brought swimming once during this six week period. The inspector also reviewed their 'Visioning Meeting Notes'. This meeting occurred on an annual basis to review the resident's personal plan and develop goals for the upcoming year. There were no goals set for 2024 and this section was blank on the relevant form. This gap in residents' care had been identified by the provider and required further review.

Judgment: Substantially compliant

Regulation 17: Premises

Overall, the premises was well kept both internally and externally. The inspector completed a walk around and reviewed all aspects of the property. The centre was a detached bungalow building adjacent to a busy road in Co. Kilkenny. To enter the front garden you had to pass through a double gate. Parking was allocated to the side of the building. To the rear of the property there was a garden area and two sheds that were allocated for storage of items. The laundry room was also located in a separate small room to the rear of the property.

Internally, the designated centre was well maintained, clean and presented in a homely manner. All residents' bedrooms had been tastefully decorated with family photographs and personal items on display. There was an accessible bathroom available for residents to use. Overhead hoists were in place in a number of rooms. Rooms were organised in a manner to allow easy access to accessible equipment. For example, in the living room to the rear of the building the main part of the room was kept clear to allow residents use their support bed in this area.

Judgment: Compliant

Regulation 20: Information for residents

The inspector reviewed the residents guide that was submitted as part of the renewal process. This document contained all the required information as set out by the Regulations. For example, this document highlighted that visitors were welcome at any time.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed incidents and accidents, centre specific risk assessments and individual risk assessments as part of the inspection process. Overall, it was found that risk was managed in an appropriate manner. All incidents, accidents and near misses were recorded on the National Incident Management System (NIMS). There was evidence that incidents were reviewed. Of note there was a low rate of incidents in the centre.

Risks assessments were all recently reviewed and reflective of the current risks within the centre. The inspector reviewed all risk assessments in place for two residents. It was found from a review of the these documents all relevant control measures were in place as stated. For example, for residents with compromised abilities around eating, drinking and swallowing a risk assessment was in place. Control measures included close supervision when eating, staff training and modified diets. The inspector reviewed the training matrix and found that all staff were trained in the area.The inspector observed a resident eating their breakfast, and saw the food was prepared in line with the relevant guidance and staff were supervising and supporting the resident as required.

Judgment: Compliant

Regulation 27: Protection against infection

On a walk around of the premises it was found that all aspects of the premises were clean and well maintained indicating that good infection and prevention control measures were adhered to. Similarly residents' equipment was clean. A review of the cleaning schedules showed that resident equipment was included and cleaned on a regular basis.

There was sufficient personal protective equipment was available at all times and staff had adequate access to hand-washing facilities and or hand sanitising gels. All staff received training in relation to IPC requirements and this training was represented on the training matrix.

Judgment: Compliant

Regulation 28: Fire precautions

There were suitable arrangements to detect, contain and extinguish fires in the centre. On the walk around of the premises the inspector noted suitable fire doors in place, emergency lighting, fire alarm and fire extinguishers in place. The records reviewed indicated that equipment was maintained by a suitably qualified person on

a regular basis.

The residents had a detailed personal emergency evacuation plan which clearly outlined the support they may require to safely evacuate in the event of an emergency. In addition to this, there was a centre specific evacuation plan in place to guide staff in the event of an emergency. All staff had completed fire safety training.

The inspector reviewed five fire drills records that had occurred in 2024. The drills demonstrated that all residents could be evacuated. Recently, due to new staff the times of evacuation had increased. This had been identified as an area that required improvement and the person in charge outlined that further drills would occur with the newer members of the team over the next few weeks.

Judgment: Compliant

Regulation 6: Health care

The inspector reviewed two residents' assessments and personal plans and found that overall their healthcare needs were assessed and healthcare plans were developed and reviewed as required.

Residents were accessing health and social care professionals in line with their assessed needs such as an occupational therapist, physiotherapist, GP, dentist and psychiatry. All appointments were recorded and healthcare plans were updated as required. Nursing care was also available to residents on a daily basis

However, one healthcare plan, in relation to end of life care planning was not aligned with the resident's hospital passport or associated risk assessment. These documents required review to ensure all information was up to date and in line with relevant recommendations.

Judgment: Substantially compliant

Regulation 8: Protection

From a review of the staff training matrix, all staff had completed safeguarding and protection training. The inspector spoke with the person in charge and they were aware of 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. The inspector reviewed two intimate and personal care plans and they were sufficient in detail to guide staff practice in a safe manner.

However, oversight of safeguarding incidents, following reporting to relevant

agencies, required ongoing review. It was found that some safeguarding plans were in place since 2020 and the records had not been reviewed or closed off in a number of years. In addition, a formal request from the safeguarding and protection team in relation to specific information in October 2023 required follow up. These gaps in documentation posed no risk to residents, however, improvements were required in this area to ensure information present was accurate, up to date and investigated in line with relevant policies.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Overall, the service was striving to provide residents with choice and control across service provision. The changes made in relation to access to finances had allowed greater flexibility in residents accessing their own money.This was a positive step for all residents.

However, regular night checks were occurring for all residents in the centre. This was a historical practice and not aligned to any residents' assessed needs. Although this was in the process of being reviewed, it was still occurring at the time of inspection.

Not all residents in the home had access to natural supports and advocacy services outside of the staff team and provider. As some residents were required to make some important decisions around healthcare in the coming months, further exploration of residents rights in this area was required.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 13: General welfare and development	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 6: Health care	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Country Lodge OSV-0005827

Inspection ID: MON-0035233

Date of inspection: 18/07/2024

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. Person in Charge and Assistance Director of Services have discussed staffing standard since inspection. Due to further recruitment, three new HCAs have been assigned to Country Lodge team since 01.08.2024, this leaves a vacancy of 3.2 WTE's. Three relief staff have been identified for the designated centre to ensure consistency within the team and for the people supported. 2. The WCI Manager and Person in Charge have a meeting scheduled by latest 06.09.2024 to develop a plan in relation to Capacity Building for the new team and propose to DOS for resources to deliver. 3. Aurora SMT is successfully implementing a new recruitment strategy over the past weeks. An external recruitment agency is supporting the provider in implementing a robust system and process. FRS recruitment service will be launched on the 11.09.2024 and will further support the reduction of vacancies across the service as commenced over the past weeks. 4. Person in Charge is seeking further clarification on PA hours for a person supported in Country Lodge to ensure delivery of same and being reflective on the house roster.	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: 1. PIC ensured that The Residents Personal Property & Finance Policy is discussed at team meeting on 29.8.2024 and all team members will sign off on reading and adherence to same. 2. The PIC will ensure the Team Leader has full understanding of Aurora Finance Pathway to be able to guide and oversee implementation of same. 3. The PIC and Team Leader will request finance department to provide OJM to all staff team members as part of the capacity building plan for the team by 20.09.2024. 4. PIC & TL have printed financial statements for all people supported on the 20.08.2024 and all are filed accurately. The PIC and TL will ensure review of the statements by 13.9.2024.	

5. PIC/TL will review all three asset lists and will amend and update as required by 13.09.2024 6. PIC & TL will complete monthly finance audit by 31.08.2024.

Regulation 13: General welfare and development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 13: General welfare and development: 1. Personal Plan Policy was discussed at Team meeting on 28.08.2024. 2. New team members will complete the Personal Plan Training as identified by the Team Leader through their Individual Development Plan. 3. PIC & Team Leader will plan for a Circle of Support Facilitator to meet with Person Supported and key team to revisit Visioning Meeting held on 13.6.2024 to ensure roles are clearly identified with actions for the team to support the person going forward. This will be evident through the monthly reviews, which will be overseen by PIC and Team Leader. 4. PIC & Team Leader will review and update the annual review & visioning meeting minutes documentation and complete a full review of persons files by 30.9.2024. 5. Capacity building plan for the Country Lodge team will be developed by 13.09.2024 for approval and implementation.

Regulation 6: Health care	Substantially Compliant

Outline how you are going to come into compliance with Regulation 6: Health care: 1. PIC and Team Leader ensure the review of all documents relevant to healthcare to include hospital passport & risk assessments and amend to reflect Advanced Plan of Care by 11.09.2024 for the person supported.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: 1. PIC has met with Designated Officer on 31.7.2024 and working alongside the HSE Safeguarding team. Since 31.7.2024 three historical cases have been closed and remainder have been sent to safeguarding team requesting closure. 2. Aurora has a quarterly Safeguarding oversight Committee to review trend and concerns in relation to Safeguarding of people supported. Social Worker and DO report on a monthly basis do ADOS and DOS. 3. As per the new Governance and Management plan, that will be implemented on a phased basis commencing on the 16.09.2024 WCI managers will hold oversight in supporting PICs on local level in relation to Safeguarding plans, reviews and implementation of same.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: 1. PIC and Team Leader met on 31.7.2024 and have reviewed and addressed the night checks for one person supported and have amended documentation that this is no longer required. 2. PIC and Team Leader will meet and review the other two people supported restrictive practices and amend documents as required by 13.09.2024. 3. Restrictive Practice Policy was discussed at team meeting on 29.08.24 and all team members to sign off.

4. People Supported have access to advocacy services, this will be discussed at Focus on Future meeting on 01.09.2024 informing individuals using their preferred mode of communication.
5. The PIC and Team Leader are encouraging the understanding of when a referral needs to be made to Advocacy service for a person supported.
6. The PIC and Team Leader are encouraging the understanding and building capacity around Circle of Supports to support each person in decision making using a facilitator external to the designated centre.
7. The provider is onboarding a Human Rights & Equality Lead to further build understanding across the service and support for teams and managers.

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.	Substantially Compliant	Yellow	31/08/2024
Regulation 13(2)(a)	The registered provider shall provide the following for residents; access to facilities for occupation and recreation.	Substantially Compliant	Yellow	28/08/2024
Regulation 13(2)(b)	The registered provider shall provide the following for residents; opportunities to participate in activities in accordance with	Substantially Compliant	Yellow	13/09/2024

	their interests, capacities and developmental needs.			
Regulation 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	30/09/2024
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	11/09/2024
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Substantially Compliant	Yellow	30/09/2024
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or	Substantially Compliant	Yellow	13/09/2024

	her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			