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:	Kare DC1
Name of provider:	Kare DC1
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	13 & 14 May 2024
Centre ID:	OSV-0003422
Fieldwork ID:	MON-0043553

About the designated centre

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

KARE DC1 comprises two homes located in the same housing estate within walking distance to a town in Co. Kildare. One home is a six bedroom bungalow that can accommodate five residents. The other is also a bungalow that can accommodate two residents. All residents have their own bedroom, access to bathrooms, living areas, kitchens and gardens. The homes provide full time residential support to a maximum of seven residents over the age of 18 with a diagnosis of an intellectual disability. Person centred supports are provided to meet the physical, emotional, social and psychological needs of each person living in the house. Residents are supported by a social care leader, social care workers and care assistants. Staff provides support as required during day, evening and at weekends, including a sleep over each night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	7

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 13 May 2024	14:30hrs to 18:30hrs	Michael Keating	Lead
Tuesday 14 May 2024	09:30hrs to 14:00hrs	Michael Keating	Lead
Monday 13 May 2024	15:00hrs to 18:30hrs	Carmel Glynn	Support

What residents told us and what inspectors observed

This inspection was carried out to assess the provider's regulatory compliance, to inform a recommendation to renew the registration of the designated centre. The provider KARE, Promoting Inclusion for People with Intellectual Disabilities operates 20 designated centres and has demonstrated a good regulatory history. Inspectors of Social Services completed inspections in nine designated centres over two days, including visiting the provider's head office to discuss oversight and progress with quality improvement initiatives with members of senior management. Overall the inspections found high levels of compliance with the regulations, and effective governance and oversight systems which were identifying and acting upon issues in response to the needs of residents. In this centre, the inspector also found good levels of compliance with improvements required in relation to the compatibility of residents with the assessed needs of their peers.

From what residents told us and from what inspectors observed, it was clear that residents were enjoying a good quality of life and that the care and support provided to the residents was person-centred. Residents were treated with dignity and respect. The provider and person in charge were endeavouring to promote an environment where each of the residents' needs and wishes were considered and taken into account. However, in one of the two houses comprising the designated centre, residents clearly described their dissatisfaction with the current living arrangements.

Residents were very respectful of one another when describing their experiences living in the centre, and were highly complimentary of all of the staff members. The inspectors met and spoke with all seven residents in the centre and also reviewed the questionnaires which had been completed by all residents. Some residents had differing communication styles and staff were clearly able to assist residents to communicate with the inspectors where required. Residents spoke about leading really active and busy lifestyles, such as being in paid employment, accessing the community independently, attending evening classes and using the centres' electric cars for social, personal and other uses. Many of the residents spoke about how their independence was promoted and enhanced such as being able to stay in the house without staff support for periods of time, in the self-administration of medication, in food preparation and in managing their financial affairs. Other residents required one-to-one support from staff with activities of daily living and for accessing community activity. However, it was clear that all residents led interesting and active lives.

Some residents also spoke of the challenge of group living in one of the two houses comprising the designated centre. While being so respectful of their fellow residents, they articulated clearly how they were impacted by peer to peer incidents. The provider was aware of this and residents had been supported to use the complaints process and incidents were being appropriately recorded and reported. Notifications have also been submitted to the Office of the Chief Inspector as required by the

regulations. This is further discussed under Regulation 8 Protection, later in this report.

All residents had their own bedrooms and ample communal space. The centre was extremely homely and designed and laid out to meet the specific needs of residents. For example, one of the two bungalows was divided into apartment style living, where the two residents could choose when to avail of communal space or when to retreat to their space. Both properties were very well maintained and personalised. Families were also encouraged to visit and residents were also supported to visit family members. There was a clearly defined management structure in place and staff were aware of their roles and responsibilities in relation to the day-to-day running of the centre. The service was led by a capable person in charge, supported by a staff team, who was knowledgeable about the support needs of the residents living in the centre.

There were effective management arrangements in place that ensured the safety and quality of the service was consistently monitored. The provider had strong oversight systems in place to monitor and review the quality of services provided. This included clear and effective reporting arrangements at all levels of the organisation. There were comprehensive audits taking place including the six-monthly unannounced visits and the completion of an annual review. The annual review was completed in consultation with residents, resident's representatives and staff.

There was a high level of mandatory and refresher training maintained for staff in the designated centre. The inspector found that all staff in the designated centre had completed training in Human Rights. One outcome from this training was that staff had considered how restrictive practices in one part of the centre were impacting upon other residents sharing that space. As a result, some restrictions has been reduced (such as access to the kettle) while others were under review by the restrictive practice committee (such as the locked presses in the kitchen).

Overall, the findings of this inspection were that this was a well run centre which was identifying and responding to issues as they arose in the centre. The provider had clear and effective monitoring arrangements in place and was supporting staff and residents to contribute to the operation of the centre.

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

Capacity and capability

There were management systems in place to ensure that the service provided to residents was safe, consistent and in the main, appropriate to residents' needs. However, as detailed within the report, compatibility issues in one of the two

bungalows were impacting upon the quality of service provision for some residents.

The provider's oversight arrangements had ensured that senior management were aware of this issue and were now trying to improve this situation. The provider had a programme of auditing and reporting in place which ensured that all issues such as accidents and incidents, safeguarding concerns and complaints were being escalated through all levels of management up to and including board level. Minutes of meetings between the Chief Executive and the Board were reviewed which showed detailed trending and oversight of issues and measures that were being taken as a result. For example, compatibility issues in a small number of centres, were a recurring agenda item and were being prioritised.

In this centre, there was evidence that staffing resources were kept under review and there was flexibility shown in relation to responding to the needs of residents. A review of the roster demonstrated that staffing levels and skill mix were appropriate to meet the assessed needs of the residents. The whole time equivalent as set out in the statement of purpose (10.21 WTE) was maintained and also accounted for the annual leave requirements of the staff team. In the main unplanned leave was covered by the core staff team and a small number of relief staff. This ensured that continuity of care was provided to all residents.

There was a person in charge employed in a full-time capacity, who had the necessary experience and qualifications to effectively manage the service. The person in charge was present in the centre Monday to Friday and there was management cover available out of hours and at weekends. The person in charge was providing high quality supervision and support to the staff members and residents also spoke positively about the person in charge. In turn, the person in charge was also meeting with their manager in a formal manner on a monthly basis. These meetings were informed by regular audits of the centre and were identifying actions to be taken. The residents were always to the fore of these meetings and how they could bring about changes to the centre for the benefit of residents. For example, bringing about improvements to the premises of the centre to provide more accessible bathing and shower options in the centre.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted a complete application for the renewal of the registration of this designated centre.

Judgment: Compliant

Regulation 15: Staffing

There were sufficient numbers of staff members employed in the centre to meet the

assessed needs of residents. The resident group were observed to receive assistance, care and support in a respectful, timely and safe manner. Residents received continuity of care and support from a well resourced staff team with increased staffing support provided to residents at specified times.

From a small sample of files viewed, the person in charge also maintained relevant information and documents as specified in Schedule 2 of the Regulations.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had ensured that all mandatory training was complete and up to date for all staff. This included training in safeguarding and protection and the safe administration of medication. In addition all staff received training in response to the specific needs of residents, such as in relation to epilepsy, communication and positive behaviour support. This meant that residents were supported by staff who were appropriately trained to meet their needs. Staff had also completed training in human rights and were applying this training to review practices in the centre such as considering the impact of, and actively reducing the restrictive practices within the centre.

All staff were appropriately supervised on a day-to-day basis as well as through the provision of formal supervision.

Judgment: Compliant

Regulation 23: Governance and management

There were clearly defined lines of authority and accountability in the designated centre. The centre was run by a person in charge who was supported in their role by a person participating in management (PPIM), an operations manager for the provider. The person in charge and PPIM were well informed regarding the residents' needs and the issues of concern in the centre.

As detailed earlier in the report, issues were being escalated through all levels of management within the service. It was clear that there was an extremely transparent and honest approach to the reporting and oversight of service provision. Senior management were well aware of issues and where improvement was required. There was also evidence of regular engagement between senior management and residents directly.

There was a quality team in place which supported the person in charge and PPIM in overseeing key areas of service delivery, such as safeguarding issues and

complaints. There were a series of audits in place in the centre which were robust and were identifying risks in the centre. A six monthly audit had been completed for the centre. These audits reflected the stakeholders' views on the quality of service and set out clear action plans to address risks where required. Staff in this centre were performance managed and facilitated to raise concerns about the quality and safety of care provided to residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose was reviewed by the inspector and found to meet the requirements of the Regulations.

It detailed the aims and objectives of the service and the facilities to be provided to the residents.

The person in charge was aware of their legal remit to review and update the statement of purpose as required by the regulations. The provider has also developed an accessible, easy read, version of the statement of purpose to make it more accessible to residents.

Judgment: Compliant

Regulation 34: Complaints procedure

There was evidence that all complaints were being reviewed at the highest level of the organisation and that residents and their families were being supported to make complaints as well as providing plenty of compliments. There was currently one open complaint made by a resident in relation to compatibility concerns, which have been well documented. Any complaints not resolved locally were forwarded to the complaints officer. The complaints officer who was spoken with, was aware of the open complaint and had meetings planned in relation to this. Information in relation to how to make a complaint was available in the centre.

Judgment: Compliant

Regulation 4: Written policies and procedures

All Schedule 5 policies were reviewed and were up to date. A number of easy read policies (12) had been developed, including safeguarding and protection, managing

complaints and managing service users monies. These policies were written in plain English with shorter sentences and used images to support understanding.

Staff were aware of the policies and there was evidence that they were being implemented such as in escalating safeguarding concerns and in managing complaints.

Judgment: Compliant

Quality and safety

Resident's wellbeing and welfare was maintained by a good standard of evidenced based care and support. People were encouraged and supported to live full and active lives and there was a culture embedded in the centre which supports a rights based approach to care where promoting independence was to the forefront of service provision.

In the main, residents were safe and their concerns were well responded to. Residents' support needs were assessed on an ongoing basis and there were measures in place to ensure that residents' needs were identified and adequately met. The premises was found to be designed and laid out in a manner which met residents' needs. There was adequate private and communal spaces for residents to avail of. Each resident had their own bedroom which was decorated in line with individual tastes with family photographs and pictures of residents involved in their hobbies and enjoying holidays away.

There was a risk management policy and associated procedures in place. There was an accurate risk register in place that reflected the risks identified in the centre. The processes in place ensured that risk was identified promptly, comprehensively assessed and that appropriate control measures were in place. The risks reviewed really considered the rights of residents to make choices and considered the concept of positive risk taking. For example, a number of residents had risk assessments in place in relation to staying home alone (without staff), these had been very well considered with consideration given to emergency situations and safety. Other residents freely accessed the community and explained to inspectors how important this was to them. The provider had ensured that residents retained control of their personal property, residents had their own items in their homes and these were recorded in a log of personal possessions. Residents were supported to manage their finances as independently as possible with many residents managing their finances independently. Support was in place for each resident who required assistance with financial management on an individual basis.

The individual choices and preferences of the residents were promoted and supported by management and staff and there was evidence that residents were supported to choose their daily routines and engage in activities they liked and enjoyed. Residents had access to advocacy services if required, and were listened to

with care and respect by staff. Residents were also involved in the running of their home and participated in resident house meetings. The inspector found these meetings to be of high quality and were lead by the residents.

Regulation 17: Premises

The premises were laid out to meet the assessed needs of the residents. Each resident had their own bedroom (some en-suite) which were decorated to their individual style and preference.

Both houses were of an adequate size with room available for residents to relax in. Private garden areas were also available to the residents to avail of in times of good weather.

The houses appeared well maintained, clean, warm and homely on the day of this inspection. There was an effective system in place to ensure the maintenance requests were prioritised. There has been upgrades to bathrooms and kitchens to enhance accessibility for residents.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had committed to a programme of works in relation to enhance the fire containment measures in this centre which has been completed. There were adequate fire management systems in place to include a fire alarm system, fire doors, fire extinguishers and emergency lighting. Equipment was being serviced as required by the regulations. The provider was also in the process of commissioning a fire assessment report for all properties, including this designated centre.

Staff also completed required checks on all fire equipment in the centre and evidence was provided that all staff had training in fire safety and participate in a drill at least once per year.

Fire drills were being conducted at a minimum of once per quarter and included times when there was minimal staff on duty. Each resident had an up-to-date personal emergency evacuation plan in place. Two residents spoken with described the emergency evacuation procedures to the inspector.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

There were comprehensive assessments of need in place for all residents in the centre. These assessments were then used to develop personal plans for each resident which considered each residents health, personal and social care needs. Plans were tailored for each resident in areas such as staying home alone and money support plans which had associated social stories developed. There were strong goal setting plans for each resident with a focus on specific interests and independent living skills. For example, two residents spoken with discussed their goals related to food preparation, of following new recipes and of using a new air fryer. Other plans reviewed and discussed with residents included a support plan for medical appointments and in preparing for a new job.

Support plans had also been adapted into easy read formats and social stories to assist understanding and communication.

Judgment: Compliant

Regulation 7: Positive behavioural support

Inspectors viewed three residents' positive behaviour support plans and individual risk management plans. Residents who required this support had access to behaviour support (Clinical Nurse Manager Specialist) and psychiatry as needed. Support plans which had been developed provided detailed guidance on how best to identify and alleviate the cause of behaviour and detailed communication support requirements.

The provider had restrictive practice committee to monitor and oversee restrictive practices at provider level. There were a number of restrictive practices in place in the centre, primarily in one of the bungalows, which were as a result of clinical assessment such as locked kitchen presses, locked wardrobe at specific times of the day and access to toiletries. However, there was evidence that they are being kept under constant review and with some practices being reduced or removed. For example, the access to the kettle was no longer limited for residents and a locked door had been reviewed.

The provider and person in charge had considered the impact of some of these restrictive practices on those residents who do not require them, and the impact of this is discussed and actioned under Regulation 9 Residents rights, below.

Judgment: Compliant

Regulation 8: Protection

The impact of compatibility issues has been well documented within this report. It has been acknowledged that the providers oversight systems have self-identified this issue however, at the time of the inspection, it was unclear what measures were being taken to alleviate the impact on residents. There were recent peer-to-peer verbal altercations in the centre in the days just prior to the inspection, these were part of a pattern of incidents which had occurred in the centre in recent months. As a result there were now four residents with active safeguarding plans in place and due to the high level of risk relating to safeguarding incidents an enhanced safeguarding audit had been completed by the provider.

Two residents spoken with clearly outlined how these incidents were upsetting them and expressed a wish to move from the centre if this level of upset continued for them.

Judgment: Not compliant

Regulation 9: Residents' rights

There was evidence that the centre was operated in a manner which was respectful of residents' rights. Residents attended weekly meetings, the inspector found these meetings to be of high quality discussing an abundance of topics relevant to each individual and to the centre. Topics discussed at residents meetings included updates from the providers Chief Executive and Senior Management team, residents understanding of the providers strategic plan, human rights and advocacy. Residents rights were further supported by staff who advocated for services on behalf of the residents. For example, one resident had expressed a wish to make a will. Staff made appointments with a number of solicitors in this regard who refused to assist the resident on the basis of perceived capacity. This is still being actively pursued and the residents rights under the Assisted Decision Making (Capacity) Act 2023 are now being pursued.

However, the impact of the compatibility issues and the levels of restrictive practice in one of the two bungalows comprising this designated centre mean that elements of residents daily life are being negatively impacted upon. For example, residents need to carry a key to access food storage and are being subject to behaviour which is causing upset.

Judgment: Substantially compliant

Regulation 6: Health care

Residents were receiving a high level of care and support to assist them with all of their identified heathcare needs. Residents accessed healthcare professionals in the local area such as their General Practitioner (GP), Dentist, Chiropodist and Optician. Other heath related supports were provided by the organisation directly such as nursing support, psychology and speech and language therapy. Of note a resident spoken with had required significant health related support over the past 12 months following a number of health concerns which included hospital stays where she received significant support from the staff in the centre.

Residents were also encouraged to take an active role in the management and treatment of health related conditions - for example, one resident had been supported to administer her own weekly injection which meant she could self-administer while on a family holiday.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant
Regulation 6: Health care	Compliant

Compliance Plan for Kare DC1 OSV-0003422

Inspection ID: MON-0043553

Date of inspection: 13/05/2024 & 14/05/2024

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 8: Protection	Not Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: The risk register for this location has been reviewed and the location has been escalated to the Internal risk oversight group on the 18th of June 2024. It will be brought to the attention of the Board of Directors on the 28th of June 2024. The organisation risk register has been updated to reflect the change in circumstances in this loctaion which impact the safeguarding on the 18th of June 2024. The provider escalation meeting will discuss this case detail on the 25th of June 2024. Actions will be noted as part of this meeting. A medication review has been requested following a recent change for one individual. This will be completed prior to the end of July 2024. The HSE will be notified of the current circumstances in this location. This will be completed through the IMR meeting by the end of August 2024. There is an active safeguarding plan in place to aleviate the impact of the incidents on other people living in this accommodation.All staff have been made aware of the plan by the leader in May 2024. Any updates are communicated to the team on a regurlar basis by the leader. Staff support in this location has changed to provide 1-1 support to one individual.	
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
The staff will continue to pursue the development of a will for one person through a solicitior. The aim is that this will be completed by the end of September 2024.
As part of this process a referral to the social work department in Kare will be completed by the end of June 2024.
A clinical referral will be completed to conduct a capacity assessment by the end of June 2024.
Kare will follow up with The National Federation of Voluntary service providers who are advocationg on the challenge of making a will, Nationally to address this impact. This will be pursued by the 21st of June 2024.
As part of an overall safeguarding review the restrictive practice cases in this location will be reviewed with the aim of reducing the restrictions further. This will be completed by the end of October 2024.

Each person has been asked if they would like the support of an independent advocate and where requested they are in the process of being supported to refer to an advocate. This referral will be completed by the end of June 2024.

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 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/08/2024
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/10/2024