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 DC6
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	14 May 2024
Centre ID:	OSV-0001983
Fieldwork ID:	MON-0035158

About the designated centre

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

Kare DC6 is registered to provide respite support for up to four adults over the age of eighteen years with an intellectual disability. The centre is located in Co. Kildare and is a dormer bungalow located in a rural setting. There are four bedrooms for the use by service users and two bedrooms for the use of staff. There are also two sitting rooms and a kitchen dining area for use by residents. There is ample external grounds for residents to access throughout the year. Residents are supported by direct support staff during the day and night. Individuals staying in DC6 may have a broad spectrum of support needs which range from requiring minimum support with daily activities/personal care to those requiring a high level of support with daily activities and personal care.

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
Tuesday 14 May 2024	08:20hrs to 15:00hrs	Marie Byrne	Lead

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 residents' assessments of need and personal plans, and the systems in place to ensure that the Chief Inspector of Social Services is notified of certain events in line with regulatory requirements.

From what residents told them and from what the inspector observed, it was clear that respite users were enjoying their time in respite. There were four people using respite services at the time of the inspection and the inspector had an opportunity to meet and spend some time with three of them on the morning of the inspection, and to briefly meet one of them as they left to go to day services.

Kare DC6 is a six bedroom house close to a village in County Kildare. Upstairs is used as a staff sleepover/office/storage space. There are four resident bedrooms downstairs, two of which have ensuite bathrooms. There is also a staff sleepover room come office, a main bathroom, two sitting rooms and a kitchen. There is a large garden and driveway to the front of the house and a large mature garden at the back of the house. Some premises works had been completed since last inspection and more were planned such as, works to improve parking facilities and the replacement of kitchen cabinet doors. These had been reported and were due to be completed. The centre is within driving distance of a number of towns and villages and when respite users are in the centre there is a vehicle to support them to take part in activities they enjoy.

One resident opened the front door and greeted the inspector on their arrival. They looked at the inspector's identification and invited them in. They were aware the inspector was coming and had seen their picture in the "nice to meet you" document which was sent in advance of the inspection. They introduced the inspector to two other respite users and two staff who were in the sitting room. They were all relaxing after breakfast and waiting for transport from day services to pick them up. They chatted about what it was like to use respite services in this centre and each of them showed the inspector the bedroom they liked to stay in while they were in respite.

Residents chatted with the inspector and staff about the weather, some of the

activities they like to take part in while in respite, where they live, and what day service they attend. They were very positive about their time in respite and said things like, "I love coming in here", "the food is good here and so are the staff", "the staff are good" and "I like coming to respite". One resident spoke about their family and how many more nights they were staying in respite.

The provider had introduced a "short break feedback form". Some of these forms had been completed and some were due to be completed when the person was next availing of respite services. These forms were in an easy-to-read format and overall residents were complimentary towards care and support in the centre. They indicated they had enjoyed their stay in respite, were treated with dignity and respect, that staff listened to their choices for menu and activity planning, and that they felt safe during their respite stay. They included comments such as "very happy with everything", "quite happy", and "staff help me with everything I need". A small number of respite users indicated some areas where they would like to see change. For example, one resident discussed an area where they may require more support and one resident said "I would like to share my visit with different people next time".

During the morning of the inspection respite users appeared very comfortable and content in the centre, and in the presence of staff. They sat chatting with staff and were observed to seek them out when they needed support. Staff were observed to be very familiar with residents' communication preferences. They spoke fondly about residents and discussed some of their goals and talents.

There was information available in posters, easy-to-read documents and social stories for respite users in relation to areas such as their rights, safeguarding, advocacy, and infection prevention and control (IPC). There were also picture rosters on display. Resident meetings were held for each respite break and presented in an easy-to-read format.

In summary, respite users appeared happy and content in the designated centre. They were busy and had things to look forward to. The staff team were motivated to ensure they were happy, safe and taking part in activities they found meaningful during their respite stay. The provider was completing audits and reviews and identifying areas of good practice and areas where improvements may be required.

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

Capacity and capability

Overall, the findings of this announced inspection were that respite users were well supported during their respite breaks. The inspector found that the provider was aware of areas where improvements were required. In line with the findings of this

inspection, their own audits and reviews had identified the improvements were required in relation to residents' plans and prior to the inspection they had retrospectively submitted a number of notifications after identifying that they were not submitted in line with regulatory requirements and timeframes.

Over the course of the inspection, the inspector had an opportunity meet the four residents. They also had the opportunity to meet and speak with four staff members, the newly identified person in charge, and the person participating in the management of the designated centre (PPIM).

There were clearly defined management structures and staff were aware of the lines of authority and accountability. The person in charge reported to the PPIM. There was an on-call manager available to respite users and staff out-of-hours. The provider had systems to monitor the quality and safety of service provided for residents. These included area specific audits, unannounced provider audits every six months, and annual reviews of care and support in the centre. Through a review of documentation and discussions with staff the inspector found that provider's systems to monitor the quality and safety of care and support were being utilised to identify areas of good practice and areas where improvements may be required. The provider had developed policies, procedures and guidelines to guide staff practice.

There was one staff vacancy at the time of the inspection and this was as a result of a social care worker taking on the person in charge role. Staff were completing additional hours and regular relief were covering shifts to ensure continuity of care and support for respite users. Staff who spoke with the inspector were motivated to ensure respite users were happy and safe during their respite break. They spoke about the supports in place to ensure that the staff team were carrying out their roles and responsibilities to the best of their abilities. These included supervision with their managers, training, and opportunities to discuss issues and share learning at team meetings.

Regulation 15: Staffing

The inspector reviewed a sample of four months of planned and actual rosters in the centre and found that they were well maintained. As previously mentioned, there was one staff vacancy at the time of the inspection and regular staff were completing additional shifts and regular relief staff for completing a small number of shifts to ensure continuity of care and support for respite users.

A review of staff files was completed the day before this inspection in the provider's head office. They were found to contain the information and documents specified in schedule 2 of the regulations.

Judgment: Compliant

Regulation 16: Training and staff development

From a review of the staff training matrix and a sample of nine certificates of training for staff members, the inspector found that each staff had access to and had completed training listed as mandatory in the provider's policy.

From a review of staff training records, four staff working in the centre had completed training on applying a human rights based approach in health and social care. The inspector spoke with two members of the local management team about this training. They spoke about a shift in staff thinking following the completion of this training. For example, they said that the training had brought about debate in relation to supporting residents to manage their own finances, to make choices around the activities they would like to engage in, and in relation to supporting residents' to develop and maintain their independence.

The inspector reviewed a sample of probation or supervision records for six staff. Detailed records were maintained and agendas were found to be resident focused and varied. Discussions were held in relation to staff's roles and responsibilities for respite user's care and support. Each staff who spoke with the inspector stated they were well supported and aware of who to raise any concerns they may have in relation to the residents' care and support, or the day-to-day running of the centre.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured that the required records were available for review during the inspection. There were systems to ensure that records were a good quality, accurate and up-to-date. There were a number of online systems which were easy to navigate and audits were completed regularly to identify if any changes or updates were required. Audits were proving effective and leading to improvements. Some actions were in progress at the time of the inspection such as the review and update of residents' plans. This is discussed further under Regulation 5.

Judgment: Compliant

Regulation 23: Governance and management

There was a clearly defined management structure which was detailed in the provider's statement of purpose. Staff who spoke with the inspector were aware of the reporting structures, and of their roles and responsibilities. The provider had

systems for oversight and monitoring including a number of audits, six-monthly reviews and an annual review.

The inspector reviewed the latest annual review which was detailed and identifying areas for improvement; however the action plan at the end of this report did not fully reflect the findings or actions detailed in the main body of the report. However, there was a quality improvement plan in the centre which was detailed in nature and captured the actions from audits, the six-monthly reviews and those listed in the annual review. There was limited detail in the residents and their representatives section of the annual review, but the inspector viewed a number of resident feedback forms and a number of compliments in the centre which were due to be captured in the next annual review.

Judgment: Compliant

Regulation 31: Notification of incidents

Through a review of documentation in the centre the person in charge had ensured that the Chief Inspector of Social Services was notified of the required incidents in the centre in line with regulatory requirements. However, three notifications had not been notified in line with the timeframes identified in the regulations. Two of these notifications related to allegations or suspicions of abuse and the other related to non-serious injuries.

Judgment: Not compliant

Regulation 34: Complaints procedure

The provider had developed a complaints policy which was available and reviewed in the centre. The complaints procedures were also outlined in the statement of purpose and there was an a easy-to-read document on managing complaints available and on display in the centre. There was a nominated complaints officer and their picture was available in the easy-to-read document.

The inspector spoke with one resident who told them what they would do if they had any worries or concerns. They said they would speak to an member of the staff team. The complaints process was also discussed at resident's meetings.

Eight complaints submitted between 2022 and April 2024 were reviewed. These had been reviewed by the relevant parties and followed up on. Where possible, they were closed in a timely manner and to the satisfaction of the complainants. Some complaints related to times when respite services were suspended due to the COVID-19 pandemic or emergency placements. These complaints were fully

resolved once respite service began operating again.

Judgment: Compliant

Regulation 4: Written policies and procedures

An inspector reviewed the Schedule 5 policies and found that the 21 required policies were available. They had been reviewed in line with the timeframe identified in the regulations.

Judgment: Compliant

Quality and safety

Overall, the inspector found that respite users appeared comfortable and content in the centre. They had opportunities to take part in activities and were making decisions about how they wished to spend their time during their respite break.

The inspector reviewed a sample of four respite users' assessments and personal plans and found that these documents positively described their needs, likes, dislikes and preferences. Some of these documents required review to ensure they were fully reflective of their care and support needs and guiding staff practice to support them. This will be discussed further under Regulation 5.

Respite users, staff and visitors were protected by the risk management and fire safety policies, procedures and practices in the centre. There were detailed risk management, and fire safety policies in place. The risk management systems were ensuring that risks were identified, assessed, managed and reviewed. There was a system for responding to emergencies. Staff had completed training in fire prevention and emergency procedures and residents were supported to become aware of fire safety procedures. Fire equipment was serviced and maintained and fire safety checks were completed regularly and this was recorded.

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

Residents' rights were discussed at resident meetings and their daily routine was led by them. There was a bus available in the centre to support them to take part in activities they enjoyed in the local community. When respite users were in the centre, the inspector observed them indicating their choices to staff around what they wanted to do, and when they required their support. The inspector observed

their right to privacy being upheld by staff ensuring that they were given time and space to be alone, if they wished to.

Regulation 12: Personal possessions

The provider had developed a policy relating to residents' personal property, personal finances and possessions. The inspector reviewed a sample of four respite users' money support plans. These plans clearly outlined the level of support they required, if any, to manage their finances while using respite. Those who required them had a property inventory list completed to log the possessions they brought with them to respite. For those respite users who require support, a log is maintained of the money they bring in, when they tap their card for purchases and the receipts for any purchase they make during their respite stay.

Judgment: Compliant

Regulation 13: General welfare and development

The registered provider was ensuring that respite users were supported to take part in activities they enjoyed. Two residents spoke with the inspector about things they liked to do while using respite services such as, bowling, going for meals or a drink, shopping, arts and crafts, and cooking and baking.

Respite users were supported to attend their day services placements during their respite breaks. They had goals in place and in the sample reviewed for four residents, the steps to achieve goals were detailed in nature and there was a section to show any steps taken to achieve them, or any follow ups required.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider's risk management policy was available and reviewed by the inspector. It contained the required information as detailed in the regulations.

Records were maintained to show the vehicle was being serviced and maintained. There were documents to demonstrate that staff were completing regular car checks which involved internal and external checks of the vehicle. These were reviewed for January to April 2024.

The registered provider had systems in place for the assessment, management and

ongoing review of risk including a system for responding to emergencies. The inspector reviewed the online risk register and the risk assessments for four respite users and found they were detailed in nature and reflective of the presenting risks.

There had been a small number of incidents in 2024 and these were reviewed by the inspector. There was evidence that these had been reviewed and followed up on. Learning as a result of this review of incidents was shared with the team and documented in the minutes of team meetings. For example, following a recent audit in the centre which found that some unexplained bruising or marks had not been reported in line with the provider's policy, this was added to the agenda of the next staff meeting. The designated officer was due to attend and the safeguarding policy and body marks reporting process was due to be discussed.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector reviewed a sample of four respite users personal emergency evacuation plans which clearly outlined the support they may require to safely evacuate in the event of an emergency. Fire evacuation and the emergency plan were discussed at residents meetings. The evacuation points and emergency exits were discussed and residents' understanding of fire evacuation were captured in the minutes of meetings reviewed for February and April 2024. The inspector observed emergency evacuation procedures on display in the centre.

There were records to demonstrate regular visual inspections by staff of escape routes, fire doors, emergency lighting and fire-fighting equipment. The fire alarm was activated and checked regularly and documentation relating to this was maintained and available for review. The inspector viewed service and maintenance records for emergency lighting, the alarm system and fire fighting equipment and found that they had all been serviced and maintained in line with regulatory requirements.

Detailed records of fire drills were maintained and ten of these were viewed by the inspector. Staff had access to fire safety training. Two staff spoke with the inspector about fire safety and evacuations procedures specific to this centre. Learning from drills was leading to the purchase of new equipment and repeat drills. The provider was in the process of reviewing the locking mechanism on two double doors out of resident bedrooms at the time of the inspection. These were locked with a key. Staff carried a key and and there was a key available in a break glass box beside both doors, due to a previously identified risk. Risk assessments were being completed to identify if thumb locks could be added to these doors.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of four respite users assessments and personal plans. These documents were available on an online system for which staff had completed training on how to navigate. Residents personal details, primary contacts, the services they avail of, the allied health professionals they access, their assessment of need, personal plan, care plans, their goals, risk assessments and incident reports were all available online. The system showed when documents were developed and reviewed. For the most part, documents were being regularly reviewed and updated. An annual review of three of the fours respite users assessment had been completed, and one was on progress.

In three respite users plans the inspector found areas where improvements were required. For example, there was a mismatch between their assessments of need and the plans in place. For some there were support needs identified in their assessment of need that did not have corresponding care plans, and for others there were care plans in place for support needs that were not identified in their assessments.

Judgment: Substantially compliant

Regulation 8: Protection

From a review of the staff training matrix 100% of staff had completed safeguarding and protection training. The inspector spoke with three staff, including a member of the local management team and they were each aware of their roles and responsibilities should there be an allegation or suspicion of abuse.

The provider had a safeguarding policy which was available for review in the centre. There was also an intimate care policy and respite users who required them had intimate care plans in place.

Judgment: Compliant

Regulation 9: Residents' rights

Through a review of documentation, and discussions with respite users and staff, it was evident that people were enjoying their respite breaks and they were empowered to make choice and decisions about how and where they spent their time. Their opinions were sought on a daily basis in relation to areas such as menu and activity planning.

From a review of resident meetings in February and April 2024 it was evident that they were provided with information on their rights. The minutes of the resident meetings were in an easy-to-read format and there were pictures of different menu and activities for people to choose from. There was information available on how to access independent advocacy services and this was regularly discussed at resident meetings.

Staff were observed to treat respite users with dignity and respect. Their privacy was maintained and they were observed to seek out staff support if and when the needed it.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 12: Personal possessions	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kare DC6 OSV-0001983

Inspection ID: MON-0035158

Date of inspection: 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 31: Notification of incidents	Not Compliant
Outline how you are going to come into compliance with Regulation 31: Notification of incidents: The leader is up to date with Mandatory in house Safeguarding training. The staff team have discussed the Safeguarding policy and notification requirements on the 22nd May 2024. The Designated officer is coming to the staff team meeting on the 20th of June to refresh reporting requirements for Safeguarding. An updated Bodymark guideline for staff has been reviewed with changes made to make it more user friendly. This will be launched at the HOU meeting on the 24th of June 2024 to leaders across Kare for sharing with staff teams. The staff team will discuss the updated changes at the team meeting in July 2024. One local Service has been provided with a cash control form to support the service user in relation to their finances. The PIC is meeting the staff in Local Service on the 12th of June 2024 to discuss further.	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: The Review of support needs and support plan for each person availing of respite service will be reviewed to ensure they align correctly. This will be facilitated by the relevant local service with input from the staff in the respite service. This will be completed for all 30 people by the end of March 2025. The individualized planning policy is under review which will update the responsibilities under the support plan and Review of support needs specific to respite services. This will be completed and launched to staff prior to November 2024.	

The clinical recommendations or guidelines will be clearly documented and communicated through CID database to the staff team supporting each individual. This revised process will be completed by the end of December 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 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	31/07/2024
Regulation 31(3)(d)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any injury to a resident not required to be notified under	Not Compliant	Orange	31/07/2024

	paragraph (1)(d).			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Substantially Compliant	Yellow	31/12/2024
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Substantially Compliant	Yellow	31/12/2024
Regulation 05(6)(a)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall be multidisciplinary.	Substantially Compliant	Yellow	31/12/2024