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 DC2
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-0001992
Fieldwork ID:	MON-0034135

About the designated centre

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

This designated centre provides a full-time residential service to three adults over the age of eighteen years with an intellectual disability. The house is a bungalow is on the outskirts of a large town in Co. Kildare. The designated centre consists of four bedrooms, one bathroom (wet-room), a kitchen, a sitting room, a personal computer room, a toilet and a utility room. There is a small patio area out the back of the house and to the front a small garden area. A bus is made available to this centre in the evenings and during the day if required. The person in charge divides their time between this centre and one other. There are social care workers and social care assistants employed in this centre. The staff provide support to the residents during the day and night.

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
Tuesday 14 May 2024	09:30hrs to 17:20hrs	Erin Clarke	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. The inspector also found good compliance with the regulations in this centre. Some improvements were required in relation to residents' finances and the provision of positive behavioural support for their emotional well-being. However, the overarching area of concern was individual compatibility between residents, which was negatively impacting their ability to live together without conflict.

This centre consisted of a single bungalow in a quiet housing estate on the edge of a large town in Co.Kildare. Each resident had their own bedroom. The house provided residents with a combined kitchen and dining area, a sitting room and a second communal room, which also contained a computer. The centre included two separate bathing and toilet facilities, a staff office space and sleepover room and an enclosed garden area to the rear. Laundry facilities were provided in a large shed located in the rear garden area.

One resident proudly gave the inspector a tour of their bedroom. They explained they had been living in the centre for a year and had enjoyed decorating their room. The inspector observed the room reflected the resident's likes, interests and preferences. For example, the resident's craft work and favourite singers were featured in their room.

Due to the needs of some previous residents living in the centre, the premises was also equipped with mobility appliances and had been adapted to support manual handling and physical needs. Overhead tracking was available in one bedroom, and an emergency exit was available from the bedroom to the rear garden to support an emergency education. A large, accessible wetroom also supported the use of mobility aids. At the time of the inspection, the residents living in the centre did not require these supports.

Four inspections have been conducted at this centre since 2019, revealing that one resident expressed a desire to live alone and was not happy sharing living space with other residents. The resident chose not to set up their bedroom and kept all their belongings in suitcases. During the last inspection in August 2023, it was reported that a new apartment was planned to be built as an extension to another designated centre, with construction expected to commence in November 2023.

During this inspection, the inspector was informed that work had commenced on the apartment building, and the resident was very happy with the development. The resident's keyworker told the inspector that the resident was visiting homeware and electrical shops to plan how they would like to decorate their new home.

In advance of the inspection, residents had been supported by staff and family to complete a Health Information and Quality Authority (HIQA) survey. The three questionnaires relayed both positive and negative feedback regarding the quality of care and support provided to residents living in the centre. Surveys relayed that residents were happy with staff, that they knew their likes and dislikes, and that they were available to assist them when needed. Surveys did note, however, that two residents expressed varying dissatisfaction with whether the house was a nice place to live in due to personal preferences and the actions of others. In addition, some of these impacts on residents were brought personally to the inspector's attention during the inspection, which were discussed directly with the management team.

On the day of the inspection, the inspector had the opportunity to engage with all three residents living in the centre. The inspector met one resident briefly before they left for work and spent time with two residents while they were having breakfast and at various times throughout the day. Residents led busy and active lives. When they were not working, one resident took guitar lessons and was a member of local social groups. They also played basketball and supported their county's football team.

Residents were supported by a team of social care workers and assistants who were managed by the person in charge. On speaking with staff, the inspector found that they were familiar with the residents' different personalities and were mindful of each resident's uniqueness and different abilities. Another resident spoke to the inspector about a holiday they had planned for the summertime, which they were very excited about as it would be their first time on an aeroplane. They also attended dance classes and social groups and aimed to gain paid employment.

Overall, the inspector found that the person in charge and staff were striving to ensure that residents living in the designated centre were being supported to live a life of their choosing. The inspector observed that the residents, and where appropriate, their families, were consulted in the running of the centre and played an active role in the decision-making within the centre. One resident's long-desired wish to live by themselves was being progressed, and the resident was looking forward to moving to their new home at the end of the year.

However, the inspector found that similar to previous inspections in the centre there remained safeguarding concerns and residents expressed that they did not enjoy who they were living with which was impacting on the quality of the service being provided to them. In addition, improvements were also needed to the provision of behavioural supports due to the change of interpersonal dynamics in the centre.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how

these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

On the day of the inspection, a clearly defined management structure was in place. The service was led by a capable person in charge who facilitated the inspection. The person in charge was supported by a person participating in management (PPIM) and a staff team knowledgeable about each resident's support needs. The PPIM, who held the role of operations manager, was also met with during the inspection and demonstrated good oversight and knowledge of the service being provided, including the challenges in the centre. It was clear that residents knew the person in charge and operations manager well as they greeted them in their home, joked and spoke about various topics going on in their lives.

The provider and local management team had implemented management systems to ensure that the centre was effectively monitored. Annual reviews, six-monthly reports, and a suite of audits had been carried out, with actions identified to drive quality improvement. The local management team monitored quality improvement actions and addressed those within their control. However, some actions repeatedly highlighted in reviews in the centre were dependent on one resident moving to their new home, which had been delayed for many external reasons. The inspector was informed that the building of this new property was on track for completion at the end of the year.

The registered provider was striving to ensure that the number, qualification, and skill mix of staff were appropriate to the number and assessed needs of residents, the statement of purpose, and the size and layout of the designated centre. Residents benefited from a consistent staff team, and the inspector found that the staff team knew the residents well. There were arrangements for the support and supervision of staff working in the centre, such as management presence and formal appraisal meetings. Staff could also contact an on-call service for support outside of normal working hours.

Staff also attended monthly team meetings, which provided an opportunity for them to raise any concerns regarding the quality and safety of care provided to residents. The inspector viewed a sample of the recent staff team meeting minutes, reflecting discussions on complaints, resident safeguarding, goal planning, audit findings and policy reviews.

The provider and person in charge were aware of their roles and responsibilities regarding the management of records. The person in charge was aware that record keeping was a fundamental part of practice which was essential to the provision of safe and effective care. Records, including records relating to schedules 2, 3 and 4, were made available for review. It was found that records in the centre were up-to-

date and included all of the required information.

Incidents were appropriately managed and reviewed as part of continuous quality improvement to enable effective learning and reduce recurrence. Overall, effective information governance arrangements were in place to ensure that the designated centre complied with notification requirements. The person in charge ensured that incidents were notified in the required format and within the specified timeframes.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider submitted an application to renew the registration of the centre. The application contained the required information set out under this regulation and the related schedules.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. They were found to be suitably skilled and experienced for the role, and possessed relevant qualifications in social care and management.

The person in charge demonstrated effective governance, operational management and administration of the centre. Staff informed the inspector that they felt supported by the person in charge and that they could approach them at any time in relation to concerns or matters that arose.

Judgment: Compliant

Regulation 15: Staffing

The person in charge maintained an accurate rota, which indicated that the service was staffed according to the assessed needs of residents. There was a consistent staff team who were known to the residents. There were no staff vacancies at the time of the inspection. The person in charge had also recently amended the staff complement in the centre in the morning time as part of a safeguarding response.

The provider also maintained all required information for staff who were employed, including vetting disclosures and employment histories as required by the regulations.

The inspector spoke to two staff members and found that they were knowledgeable about the support needs of residents and about their responsibilities in the care and support of residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had a mandatory and supplementary training programme in place, which assisted in ensuring that staff had the knowledge and skill sets to provide care for residents in this service. There was a training matrix in place that supported the person in charge to monitor, review and address the training needs of staff to ensure the delivery of quality, safe and effective service for the residents.

A review of training records indicated that all staff were up to date with their training needs. All staff who worked in the centre received mandatory training in areas such as fire safety, manual handling, medicine administration, and safeguarding. Training in various aspects of infection prevention and control, epilepsy care, human rights, and positive behavioural support was also provided to staff to meet the specific support needs of residents.

The person in charge facilitated one-to-one supervision sessions and regular team meetings, which promoted consistency of care and provided staff with operational and service updates.

Judgment: Compliant

Regulation 21: Records

The registered provider had ensured that records in relation to each resident as specified in Schedule 3; and the additional records specified in Schedule 4 were maintained and available for inspection by the chief inspector.

On the day of the inspection, records required and requested were made available to the inspector.

Judgment: Compliant

Regulation 23: Governance and management

The centre was resourced to ensure the effective delivery of care and support in

accordance with the statement of purpose. The provider had a management structure in place which assisted in the oversight of care. The provider had appointed a full time person in charge and they were also supported by a senior manager. Both managers had a good understanding of the service and also of the residents' care needs.

Management presence in the centre provided all staff with opportunities for management supervision and support. Arrangements in place, such as staff team and one-to-one support and supervision meetings, facilitated staff to raise any concerns they may have about the quality and safety of the care and support provided in the centre.

Notwithstanding the current safeguarding concerns at the centre, the inspector found a notable improvement in the escalation and response to related concerns at an organisational level. Regular meetings were held with board members of the registered provider to diligently monitor, oversee, and respond to safeguarding concerns in high-risk centres. Additionally, the inspector was informed that substantial additional funding had been allocated to implement an interim safeguarding plan for the centre while a new designated centre was being constructed.

Judgment: Compliant

Regulation 3: Statement of purpose

The provider submitted a statement of purpose with the application to renew registration that accurately outlined the service provided and met the requirements of the regulations.

The inspector reviewed the statement of purpose and found that it described the model of care and support delivered to residents in the service and the day-to-day operation of the designated centre. The statement of purpose was available to residents and their representatives.
In addition, a walkabout of the property confirmed that the statement of purpose accurately described the facilities available, including room function.

Judgment: Compliant

Regulation 31: Notification of incidents

There were effective information governance arrangements in place to ensure that the designated centre complied with notification requirements.

The person in charge had ensured that incidents, as detailed under this regulation,

which had occurred in the centre were notified to the Chief Inspector. For example, the inspector reviewed a sample of the records of incidents that had occurred in the centre in the previous six months, such as minor injuries and allegations of abuse and found that they had been notified in accordance with the requirements of this regulation.

Judgment: Compliant

Regulation 4: Written policies and procedures

Relevant policies and procedures were in place in the centre, an important part of the governance and management systems to ensure safe and effective care was provided to residents, including guiding staff in delivering safe and appropriate care. A review of the centre's Schedule 5 policies found that all policies and procedures had been reviewed in line with the regulatory requirement.

As such, the provider ensured that all policies and procedures were consistent with relevant legislation, professional guidance, and international best practices regarding delivering a safe and quality service.

Judgment: Compliant

Quality and safety

The management team and staff were striving to ensure that residents received an individualised service based on their needs, preferences and abilities. The provider had resources in place to ensure that residents were integrated members of their community and engaged in activities that they enjoyed regularly. However, as discussed in the opening section of this report, personal differences between residents had created, at times, an unpleasant living environment, resulting in safeguarding concerns.

The house was found to be suitable to meet residents' individual and collective needs in a comfortable and homely way. This enabled the promotion of independence, recreation and leisure in the house. The inspector observed the physical environment of the house to be clean and tidy and in good decorative repair. Residents had free access to all areas in their home, bar other resident bedrooms and no restrictive practices were used in this centre. One area for improvement identified by the inspector was actioned by the person in charge during the inspection.

The inspector observed that each resident was provided with the opportunity for personal development through keyworking sessions and goal planning. Residents

were supported and encouraged to engage in the community in a way that was meaningful and enjoyable to them. Residents attended or were planning to attend various musicals and concerts. Residents had also made plans to go on overnight holidays with staff or their families. Independence skills teaching in travelling and money management was also encouraged and promoted.

The inspector reviewed two residents' personal plans that were maintained through a computer software system. The person in charge ensured that there was a comprehensive assessment for each resident, taking into account their changing needs. The assessment informed residents' personal plans which guided the staff team in supporting residents with identified needs and supports. Plans were reviewed annually, in consultation with each resident, and more regularly if required. There was an accessible version of plans available to residents.

The person in charge and staff were aware of residents' needs and knowledgeable in the care practices to meet those needs. Care and support provided to residents were of good quality, respected residents' right to privacy, and promoted their independence. However, improvements were needed to the timeliness of the provision of behavioural support as well as oversight of the same. This was to ensure that residents changing support needs were addressed in a timely manner so the risk of further escalation was effectively mitigated.

The organisation's risk management policy met the requirements as set out in regulation 26. For the most part, there were systems in place to manage and mitigate risks and keep residents and staff members safe. The inspector found that individual and location risk assessments were in place and were endeavouring to ensure safe care and support was provided to residents in their home and in the community. The risk register was reviewed regularly, and risks relating to the centre and residents were addressed.The inspector reviewed a potential risk related to the oversight of the residents' finances. It was noted that in the absence of access or receipt of bank statements, this is not a risk that could be effectively managed at a local level and required review by the provider.

Staff were provided with appropriate training relating to keeping residents safeguarded. The provider, person in charge and staff demonstrated a high level of understanding of the need to ensure each resident's safety. However, residents who lived in this service were not happily living together, and relationships had deteriorated, leading to safeguarding concerns. On the day of the inspection, there was one active, long-standing safeguarding concern.

Regulation 13: General welfare and development

Through discussions with residents and staff and a review of documentation it was evident that residents had opportunities for occupation and recreation. They were attending day services, taking part in their local community, working in a local business, and going to the local social groups.

Residents were also supported to maintain their independent living skills, maintain links with their family and friends and maintain links with their community in accordance with their wishes.

Judgment: Compliant

Regulation 17: Premises

Overall, the premises were observed to be comfortable, warm, bright, and generally well-maintained. The inspector observed the premises to provide a homely environment that promoted activities of daily living and encouraged residents to undertake everyday tasks. The premises was located with good access to local amenities and services that supported residents' autonomy to engage and connect with their local community.

For the most part, the physical environment of the house was clean and in good decorative and structural repair. The provider had identified that the exterior of the house required painting, but internal painting had occurred.
The inspector noted a piece of equipment with rust in the bathroom and a surface wrapping around grab-rails that did not allow for effective cleaning. These were actioned by the person in charge and removed with evidence of completion submitted post-inspection.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector found that incidents were managed and reviewed as part of the continuous quality improvement to enable effective learning and reduce recurrence. Where there had been incidents of concern, the incident and learning from the incident, had been discussed at staff team meetings.

However, some improvement was required in the assessment of organisational risks. For example, the provider for this centre maintained a risk register, and although it contained a range of risks, a review of these was required to ensure this system of review fully supported the provider and person in charge in their ongoing oversight of key aspects of this service, to include oversight of finances. The provider did not have oversight of some residents' finances. Due to the nature of the concern, this presented a safeguarding risk.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The person in charge had ensured that a comprehensive assessment of each residents' health, personal, and social care needs had been carried out. The inspector reviewed a sample of the assessments and found that they were reviewed on an annual basis or more frequently if required.

The person in charge had ensured that personal plans were developed for residents. The plans were informed by the assessments and reflected the supports required to meet the resident's needs. The plans viewed by the inspector were up-to-date and readily available to guide staff in the appropriate delivery of care and support interventions. The requirement for improvement in positive behavioural support plans are actioned under Regulation 7: Positive behavioural support.

Judgment: Compliant

Regulation 6: Health care

Where a resident refused recommendations by allied health professionals, the refusal was discussed with the resident to determine the resident's understanding of the decision and recorded. The inspector observed one such refusal that did not present a high risk to the resident. Healthcare was well managed, and both long-term conditions and changing needs were responded to appropriately.

There were detailed healthcare plans in place that included appropriate guidance for staff; for example, a care plan for the management of epilepsy gave guidance for the long-term management of the condition and also for the management of the resident in the event of a seizure. Three was evidence that these care plans were implemented, and the interventions were recorded daily where appropriate.

Judgment: Compliant

Regulation 7: Positive behavioural support

Improvements were required to ensure residents, where required, had documented, evidence-based and allied health professional informed behaviour support plans in place. This included functional behavioural analysis and input from appropriate professionals, to reduce the risk of behaviours of concern occurring by creating a supportive social environment capable of meeting residents' needs. The deficits in both these areas were, at times, impacting on the quality of care and support provided to residents.

The inspector reviewed one behavioural support plan dated August 2023. While it had clinical and professional input, it was not subject to regular review following adverse incidents in the centre. From reviewing these adverse incidents in the centre, it was also not evident that the plan was effective due to the impact that the incidents of behavioural concerns were having on others.

Due to the nature of the ongoing and increasing personal conflict between residents, there was a requirement for psychological and emotional support for residents and greater guidance to staff on managing these situations.

Judgment: Not compliant

Regulation 8: Protection

The provider was actively trying to resolve conflict in the centre, which involved one resident moving to their new home as they were deeply dissatisfied with the living arrangements. While this action would alleviate the active safeguarding concern, a complaint was disclosed during the inspection, which incited further compatibility concerns in the centre that would not be managed through this transaction.

Judgment: Not compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant

Compliance Plan for Kare DC2 OSV-0001992

Inspection ID: MON-0034135

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 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: The risk of financial abuse for service users has been added to the Organisation risk register as a stand alone risk. This was completed with the relevant stakeholders on the 4th of June 2024. The risk of financial abuse has been reviewed and additional controls added on the location risk register to acknowledge the potential risks by the staff team and leader in conjunction with the Operations manager on the 7th of June 2024. The individual risk assessments for each service user required is in place and was last reviewed on the 28th of May 2024/ 3rd of June 2024. Managing service user monies and property policy states: Supporting electronic accounts – Bank/ Post Office etc. 3.4.1 Where Kare are supporting an individual with their account(s), the account should be: • in the individual's own name • have a correspondence address which ensures that the individual and staff supporting them have access to statements and other relevant communication from the financial institution i.e. the residential house address • set up to issue monthly statements on the account • set up to access online banking 3.4.2 Where Kare staff support/carry out transactions on an individual's account provision must be made to ensure account statements are available to the individual and staff so that they can verify all transactions. 3.4.3 The Leader will ensure that only designated staff member/s have access to an individual's personal financial information such as account details and PIN numbers. This policy will be reviewed internally in Kare and advice sought from an external party to ensure the policy lies within the relevant legal framework. This will be completed prior to the end of September 2024.	
Regulation 7: Positive behavioural	Not Compliant

support	

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Behaviour support guidelines for one individual will be updated by the end of June 2024.

Referral for support has been sought and an appropriate referral will be completed by the end of June 2024 for one individual.

A referral for another individual will be made to provide support prior to the end of June 2024.

Improvements were required to ensure residents, where required, had documented, evidence-based and allied health professional informed behaviour support plans in place. This included functional behavioural analysis and input from appropriate professionals, to reduce the risk of behaviours of concern occurring by creating a supportive social environment capable of meeting residents' needs.

The behavioural support plan dated August 2023 will be subject to regular review following trends in adverse incidents in the centre as part of the staff team meeting.

From reviewing these adverse incidents in the centre, it was also not evident that the plan was effective due to the impact that the incidents of behavioural concerns were having on others.

Due to the nature of the ongoing and increasing personal conflict between residents, there was a requirement for psychological and emotional support for residents and greater guidance to staff on managing these situations. This will be conducted by offering the staff team support.

Any further issues which occur in this location will be reported and esclated accordingly by the staff team as and from the 15th of May 2024.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
One individual is provided with regular updates in relation to the development of the new property they will be moving to by the end of 2024. This is progressing according to the plan as present.

An official complaint was logged on the internal CID database in Kare for one individual on the 6th of June 2024.

Bereavement counselling will be discussed and provided if required for one individual.

The provider escalation group in Kare have been provided with an update on the complaint and the request for alterntaive accommodation in the future. This is documente din the minutes of the meeting dated the 28th of May 2024.

The organization is in the process of sourcing holiday let accommodation for people in the location to access for time outside the home to reduce any issues. IT is envisaged that this will be completed by the end of October 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 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/09/2024
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Not Compliant	Orange	31/08/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	31/12/2024