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:	Ailesbury
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	31 August 2023
Centre ID:	OSV-0001992
Fieldwork ID:	MON-0034151

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
Thursday 31 August 2023	12:10hrs to 19:30hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

During this inspection, the inspector spoke with all three residents and their support staff team, observed routines and interactions in their home, and reviewed records related to their support structures, goals and wishes, and commentary on their experiences living in this designated centre.

The residents lived in a suburban bungalow in which each resident had a single bedroom and shared access to a kitchen and sitting room. The house required some minor repainting but was overall clean, comfortable and personalised. The house was within walking distance to some of the residents' preferred community amenities including the local town, parks, pubs, churches, shops, and areas for walks.

One resident had been vocal with the provider for a number of years that they did not see this designated centre as their home and did not want to live here. This resident did not wish to share a living space with other service users and chose not to set up their bedroom, keeping all their clothes and belongings in suitcases. This resident and their wish to not live in this house had been discussed on previous inspections in 2019, 2021 and 2022. In that time multiple other residents had moved in and out of this house for different reasons, and the resident was not happy with their current living arrangements, asking staff daily when they were going to be moving out. The provider management advised the inspector that a new apartment space was being built as an extension to another designated centre, with construction anticipated to start in November 2023. This had been discussed with the resident in a key-working session in August 2023 in which it was clarified to them that it would still be a long time before their new home is ready for them and that they would still be living in a residential care and support service after the move.

The inspector spoke with two residents who had moved into this house in the past year. They commented that they liked the house and felt supported by the staff. One resident told the inspector they were looking forward to travelling to Dublin at the weekend. None of the residents attended a day service but a social club was restarting for one resident. There was a large whiteboard reminding staff what plans residents had, including salon appointments, medical appointments and social and hobby opportunities. The residents were seen using this board as well. One resident was taking lessons in playing the guitar. Another resident had tickets to an ABBA show at Christmas. During the day residents were supported to spend their day in the house and the local area based on their preference. One resident was supported by a volunteer with whom they had worked for years. One resident was risk assessed as safe to come and go from the house and into the town without staff accompaniment, and was observed staying in contact with staff by phone.

One resident told the inspector that while they loved their home and were fond of the staff, they did not like how one of their peers spoke to them and make them feel

upset and scared in their home. The provider had notified the Chief Inspector of more than twenty instances in 2023 in which this resident was subject to verbal abuse, rude hand gestures, swearing and name-calling by their peer causing them to become upset and distressed. The inspector observed records of more incidents in which the resident alleged these same interactions but which were not witnessed by staff. During the inspection one such instance of verbal abuse occurred, with the affected resident telling the inspector that "this is what I have to put up with all the time" and "I shouldn't have to live like this, I'm sick of it". The staff were observed firmly encouraging their peer to apologise. Evidence observed during the day through speaking with staff and residents and reading documented notes indicated that staff were trying their best to have everyone get along and follow the rules of shared house, but that the safeguarding plans and risk control measures had not been effective in improving the impact or frequency of these interactions.

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.

Capacity and capability

The designated centre was resourced with an experienced and well-established staff team who demonstrated a good knowledge of the residents and their interests, wishes and personalities. The staff and local management had been proactive through audits and ongoing team engagement in identifying areas for development and ensuring the service was appropriately resourced, with a staffing complement and requisite skills and training as required, following changes in residents and their assessed support needs. The management had means of ensuring that staff were alerted to mandatory training or refresher courses in which they were outstanding.

As the person in charge was on statutory leave on the day of this visit, the inspection was primarily facilitated by the front-line staff team with a senior manager available by phone in later in the day. While the staff team provided valuable information from their knowledge and experience with the residents, they did not have ready access to documents and evidence required for their own duties as well as required as part of the lines of enquiry for this inspection. This resulted in some evidence taking a long time to retrieve or being unavailable for review on this inspection. For example, the inspector could not make any judgment on regulations related to how complaints were managed as the records of these could not be retrieved for the entire inspection.

In response to concerns related to the compatibility of residents due to a pattern of incidents reported to the Chief Inspector, the inspector requested written assurance from the provider in February 2023 regarding the risk assessments and safeguarding measure related to this risk. From the response to this request and what was

observed during this inspection, there were identified gaps in provider assurances that these risk had been identified and the associated risk controls kept under review. There was a lack of evidence that a comprehensive compatibility review took place in relation to new and existing residents, and contrary to the assurance report, safeguarding controls created in January 2023 not been revised as the relevant incident trend continued through the year.

Regulation 15: Staffing

The provider had revised the assessed staffing needs for this designated centre in June 2023 in advance of the most recent resident admission to be assured that the house was appropriately staffed during the day and night. The provider was in the process of interviewing to fill one vacant post, and in the interim period, the use of regular relief staff mitigated the impact on staffing continuity of the residents.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had identified the mandatory training for this designated centre based on the assessed needs of residents. In the main staff had been facilitated to keep up to date in this training, however some examples were observed of staff who had not yet completed training or were overdue to attend a refresher session. This included subjects such as fire safety and safe administration of medicine. The inspector found examples of future training which was identified as required to support residents' needs, including supporting residents to manage their finances or to participate in decision making, and providing guidance to staff in supporting residents with sensitive personal support needs.

Judgment: Substantially compliant

Regulation 21: Records

Records were maintained, but were not easily retrievable during the course of this inspection. Some of the records required on this inspection were not available for review in the designated centre in accordance with Schedule 4 of the regulations and relevant provider policies.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had resourced this service appropriate to the residents' assessed needs in relation to premises, staff and vehicles. Support was provided by an established front-line staff team who spoke positively on the formal and informal support and supervision provided by their line manager.

Following the regulatory findings of previous inspections, the inspector observed evidence of progress made by the provider in addressing some long-term projects including enhancing the fire safety of the premises, and acquiring suitable accommodation for a resident who has been clear for years that they do not want to live in this house.

The provider had conducted a six-monthly unannounced inspection of the quality and safety of the service in May 2023. From the findings of this the provider had developed a detailed and time bound plan of works to address deficits in compliance with regulations or policies and continuously improve elements of the service. These works included providing staff with training in supporting residents' rights and autonomy, and establishing effective tools to plan and track the progress of residents' personal goals and wishes.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

All residents had a signed contract of services in place which outlined the terms associated with living in this designated centre.

The provider had facilitated residents admitted in the past year to visit the centre prior to admission and to ensure the house was suitable for their needs. While it was the choice of an existing resident not to meet their new peers on these visits, the provider had not conducted a formal assessment of compatibility to be assured that housemates would be safe from potential abuse.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector observed examples of incidents and practices in this designated centre which had not been notified to the Chief Inspector.

Judgment: Not compliant

Quality and safety

In the main, the residents' health and personal support needs were being delivered and residents were supported to be busy and active in the community. Some areas were identified for development to ensure that residents' autonomy, independence and support with long-term life enhancement objectives were being supported in accordance with their capacities and wishes. Some areas for improvement were identified related to fire safety, including ensuring that equipment and staff practices were kept under review.

The provider had suitable policies and procedures in place related to maximising resident autonomy and safety, collecting data related to alleged abuse, and keeping track of progress with support objectives. However the inspector observed instances during the day in which these had not been implemented in practice. Residents who did not have their own access to their finances did not have an associated risk or restrictive practice assessment in place per policy, and where finances were managed by a third party the provider did not have their systems implemented to be assured all monies were accounted for. The provider had not established a risk and evidence based assessments of the residents' capacity regarding medicines, and opportunities to support residents have have greater understanding and autonomy of their medicines. Following a recent audit the provider had developed a tool for guiding staff and keeping track of the steps towards life enhancement objectives such as planning holidays and learning to cook, however these were not consistently utilised.

The inspector observed good examples of the provider ensuring the premises was suitable and safe in design and layout for the service and its residents. Following two service users moving out in the past year, the inspector observed that bedrooms were painted and redecorated to reflect the preferences of their new occupants. The house was overall in a good state of repair with outstanding items listed for the attention of the facilities team, including staff commenting that a longstanding drainage issue causing a smell in one bathroom on previous visits had been rectified. Upgrades had been made to ensure emergency evacuation routes were protected in the event of fire.

As referenced in other sections of this report, a pattern of incidents of concern related to the compatibility of peer residents had had a negative impact on the lived experience of residents in their home. The provider had a safeguarding plan and risk controls in effect in the interim period before one person was due to transition to a new service. However in the seven months since this plan was set out, there had been no revision of risk controls despite the inspector being told by residents and staff, as well as reading the review notes of these risk assessments, that the plan was not effective in achieving the intended outcome. Despite this ongoing issue, the

front-line team were observed encouraging mutual respect between peers and de-escalating incidents of concern as they occurred.

Regulation 12: Personal possessions

Residents had access to and control over their personal items and clothing, however some residents had not been provided with support to manage their financial affairs in a manner which empowered their independence and autonomy. Examples were observed of two of the three residents not in possession of their debits cards or personal income or did not have access to their bank accounts. Residents who did not have access to their money and cards did not have a restrictive practice assessment completed as required by provider policy. Finances were managed by family members and other people outside of the centre who provided some cash into the house for the resident, with additional funds if requested for specific purposes.

Other requirements of the provider policy on resident monies were not implemented in practice. The provider did not have any active plans in place to support the residents to have enhanced access to their finances, or to provide training, advice or assistance to enable individuals to manage their own money. As monthly bank statements were not readily available to the provider for their review, nor did the resident or provider have sight of accounts online, there was no evidence of how these statements were being reconciled. As such, the provider could not demonstrate how they were assured that all resident monies and savings were appropriately accounted for.

Judgment: Not compliant

Regulation 17: Premises

The provider had ensured that where residents had been discharged and new residents moved in, bedroom had had new paint, decoration and furniture based on their preferences. The house overall was clean and in a good state of repair. Where cosmetic work was required to walls and flooring, this had been raised to the facilities team and were scheduled for repair or painting.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had recently upgraded doors and door frames along fire evacuation corridors to protect escape routes and contain the spread of fire or smoke. These doors were equipped with devices which would allow them to be held open by preference or necessity without propping or wedging them open. The provider advised that a full fire engineer risk assessment was scheduled to confirm fire compliance of the building following the completion of these works.

Reports of fire drills were not available for review on inspection and staff could not comment on procedures followed and time taken during any practice evacuations in this house. All practice evacuations took place during the day with multiple support staff, and as such there was no evidence to indicate how the provider was assured that a safe and efficient evacuation could also take place during sleepover shifts when all residents and the sole staff member would be asleep. The inspector observed a smoke alarm in an ancillary building with laundry appliances was not working, and staff confirmed this area was not included in routine fire alarm checks.

Judgment: Substantially compliant

Regulation 29: Medicines and pharmaceutical services

The inspector reviewed the prescription and medication records of residents and found them to contain sufficient information to guide staff on times, doses and rationale for administration. Prescriptions were clear on the start and end dates of new or discontinued medicines. Some medicine was stored in a refrigerator however the required temperature was not identified or recorded as required by provider policy.

Some improvement was required to demonstrate how residents were encouraged to develop independence and skills to manage their medicines in line with assessed needs and capacities. Of the three residents, one resident was supported to retain supervised control over their medicine. A risk and capacity assessment had been conducted for a second resident which determined they understood their medicines, their times and their doses, however medicines were locked in an office and fully controlled by staff. There had been no assessment of capacity to determine the support level required for the third resident.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed a sample of the assessed personal, health and social care needs of residents and, in the main, there were clear and person-centred support plans in place to deliver on these assessed needs. In the sample reviewed, some

support objectives set out for residents had not been progressed or started by their intended deadline and it was unclear whether these unsuccessful plans would be revisited or revised going forward.

Judgment: Substantially compliant

Regulation 8: Protection

There was an ongoing safeguarding concern in this designated centre related to the compatibility of service users in the shared living space. Between January and August of 2023 there had been 22 notified incidents of peer interactions causing residents to become distressed or upset. The front-line staff demonstrated how they were supporting the residents during these incidents and encouraging apologies and adherence to house rules. However these risk controls had not resulted in any reduction in the level of risk or the effect on residents. The provider had a long-term plan for one person to transition to new accommodation within the next year, and had developed a safeguarding plan in January 2023 to mitigate the risk in the interim period. However despite review notes highlighting that this plan was not effective in reducing the risks or frequency of incidents, there had been no revision to these interim risk controls.

In a review of daily notes recorded in the centre, the inspector observed a number of allegations of abuse which had not been reported internally in accordance with provider policy. Evidence observed indicated that front-line staff were advised to determine grounds for concern themselves instead of reporting allegations for preliminary screening.

Judgment: Not compliant

Regulation 9: Residents' rights

Practices related to residents' access to their finances did not promote resident autonomy and independence. Some residents did not have access their cards or accounts with financial institutions or a plan in place to enhance their autonomy or access.

The pattern of safeguarding incidents had a negative impact on the lived experience in the shared home. One resident expressed that they liked the house and the staff very much but did not always feel safe or comfortable in their home when sharing the living space.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Ailesbury OSV-0001992

Inspection ID: MON-0034151

Date of inspection: 31/08/2023

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

This document is divided into two sections:

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

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

A finding of:

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

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

Section 1

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

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: Training for staff in fire management was competed in June 2023 – The certificate was provided to the training department in June 2023. It was provided again in September 2023 and now records show as of the 15th of September that all staff have completed this training on site. One staff scheduled for SAMs medication management training on the 20th September which has been completed. All full time staff and relief staff on the rota were confirmed to be up to date with all mandatory training on the 20th September 2023.	
Regulation 21: Records	Not Compliant
Outline how you are going to come into compliance with Regulation 21: Records: Kare's electronic system for complaints recording was reviewed with the developer on Tuesday the 12th of September to ensure the system is capable of ensuring that all staff working in a location can access complaints for that location including the person in charge at any point, regardless of the department linked to the complaint or the timeline when the complaint was made. Any actions identified have been completed on Thursday the 14th of September. All leaders and services were informed of the improvement changes via email on the 14th of September 2023 via a communication from Kare's CID Database helpdesk.	

PIC to go through all complaints over the past three years as part of a staff team meeting to identify learning opportunities and ensure all staff are aware of the outcome of the complaints. Staff team meeting scheduled for 13th October 2023 and this is on the agenda.

All schedule 4 records are available to staff working in this location as of the 20th September 2023.

Regulation 24: Admissions and contract for the provision of services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:
Compatibility assessment tool will be developed for use in Kare services by December 2023.

Staff communicated to about the compatibility assessment and informed on how to complete by December 2023.

Kare acknowledge compatibility issues in this location. This is noted on the location risk register by an increase in the risk rating related to safeguarding and referred to the board for information in October 2023.

An informal compatibility assessment with significant psychology and social work clinical input was conducted prior to any new moves to the location. Kare made the assessment with the knowledge that one person would be moving to new accommodation in the coming months. Additional staffing levels were included since the new admission to this location to allow for increased support to each person in line with their wishes.

Delays in the planned move due to external factors have been an issue. These delays have been communicated to the individual and their family members. They are kept up to date on the updates on a regular basis.

Transition planning for moves for one individual to a new location will be finalized when the construction schedule is agreed. The construction is expected to be completed in full by September 2024.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents: All safeguarding incidents have been reviewed with the designated officer in Kare on the 29th of September 2023. A review of safeguarding records and the rationale for recording was conducted. A plan to change how safeguarding incidents are recorded was developed and the Designated Officer is linking with the HSE Safeguarding and protection team to review the plan in October 2023. The development of relationships for individuals living in this location has continued to improve with the number of incidents of a safeguarding nature significantly reduced. The addition of the third person to the accommodation has been a positive move for the person who wishes to move as they are expressing they are enjoying the company and spending large amount of time out of their room with both individuals. HIQA notifications will be completed for all allegations from the 1st of September 2023	
Regulation 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: One individual in this location has expressed a wish for the person who supports them to manage their finances to continue to manage their finances. They do not wish Kare to be involved with supporting their finances. This is clearly documented in the persons money management plan. Communication with the individual and their family has been documented in relation to this matter. Kare are supporting the person with their choice in line with their will and preference. One individual does not have a bank card as they withdraw money directly from the cashier in the bank, which is the way in which they choose to bank. They use ID and bank in the same location all the time. They have engaged in this practice since they were younger and when asked about a bank card they have chosen to continue to bank in the manner which they choose for the foreseeable future. Kare are supporting the person with their choice in line with their will and preference. The two individuals and their representatives were informed of the HIQA inspection and subsequent actions on the 5th of October 2023 and at this time they do not wish any changes to the current practice. These discussions were documented in their contact sheets. Kare will continue to work with the individual and their representatives in relation to financial management in line with the current agreed financial support plan.	

The money support plan was updated for both individuals earlier in 2023 and last updated in October 2023 based on reviewed information.

All service users in this location on the 6th of November 2023 have been provided with a new copy of the following accessible information policies for Kare:

- Managing service user finances easy read
- Keeping me safe poster
- Keeping me safe easy read policy
- Making a complaint easy read

Three residents will be supported by staff to watch the new Human Rights educational video on Kare's LEAP platform on the 10th of November 2023.

A referral has been made for both people to the social work department to support them in building knowledge and skills in relation to protecting themselves from financial abuse 10th of November 2023.

A referral will be submitted to the lifelong learning team before the 10th of November 2023 for a bespoke training package delivered to the three people living in this location independently on money management and human rights to build knowledge and competence in the area of financial management. The training will be requested to be delivered by the end of December 2023.

The assessment of need for one individual was updated with input from a multi disciplinary element in Kare on the 17th of October 2023. The updated assessment of need ensures that it is reflective of the capacity of this individual to make decisions.

For the other individual, their Money support plan was updated and now reflects the assessment of need on the 5th of October 2023.

A referral to an independent advocate in relation to financial management was discussed with both people on the 6th of November 2023, this was documented in the daily contacts and key worker meeting notes. A referral form will be completed once the person has consented by the individual with support from the staff team by the 30th of November 2023.

A further review of each person's money support plan will be conducted in January 2024 when all additional support and training has been provided. The plan will be reviewed on a 6 monthly basis during 2024.

A restrictive practice risk assessment and if required a restrictive management plan will be completed for both individuals in this location in relation to their access to their own finances by the end of November 2023.

Policy on Managing Service Users Monies / Property will undergo a further review. The policy review will be completed and launched at the Heads of Unit meeting in January 2024.

Managing Service Users Monies Policy Easy Read will have a detailed review with representatives from across Kare that use the services. This will be updated and launched to service users by the end of March 2024.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Fire door certification was issued to the inspector via email on the 5th of September 2023 confirming all doors installed were registered fire doors.
A full fire engineer risk assessment has been identified as being required to confirm fire compliance of the building following the completion of the fire door installation works. This will be completed across the portfolio of Kare properties. Procurement is in progress and a schedule of works is expected to be drawn up once a consultant is appointed. This is expected to occur before the end of the first quarter of 2024.
Reports of fire drills have been made available for review by all staff in this location on the 5th of September 2023.

A night time evacuations is scheduled to take place on the 5th of October 2023. A fire drill record will be completed.

The smoke alarm in an ancillary building with laundry appliances has been replaced, and is now in routine fire alarm checks. This was replaced on the 3rd of September 2023.

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant

Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:
One service user self-assessment for medication will be reviewed in line with assessment of need indicators to ensure they are aligned. This will be completed by the nurse for this location with the planner and the individual. This will be completed by the end of November 2023.

Medicine stored in a refrigerator has the required temperature identified (not exceeding 25 degrees) and recorded as of the 10th of October 2023 in line with manafactures recommendations. A new temperature gauge was sourced for the location and recording template circulated to all staff for use, this commenced in operation on the 4th of November 2023.

Residents in this location are encouraged to develop independence and skills to manage their medicines in line with assessed needs and capacities. As part of the Individuals Support Plan new goals focusing on enhancing independent skills will be developed by the end of December 2023 as part of transition planning to a move to a more independent support package.
An assessment of capacity to determine the support level required for the third resident has been scheduled as part of the assessment of need review prior to the end of October 2023.

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 plans for three residents were reviewed by the staff team in September 2023. Support objectives set out for residents will be updated to show progression and where plans have since changed this will also be updated prior to the end of October 2023.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
Risk controls to reduce the level of risk or the effect on residents is reviewed on a regurlar basis in relation to safeguarding. Interim risk controls have been implemented and the provider has noticed as relationships in the location have developed in a positive manner the number of incidents has reduced as of the 5th of October 2023.
All allegations of a safeguarding nature have been reported for preliminary screening by the designated officer have been completed and will continue to be reported to HIQA through the portal on an ongoing basis as of 5th October 2023.
Staff team meeting includes adverse events on a monthly basis. Safeguarding incidents are discussed with the team. Actions may be noted. This will continue to occur for all meetings from October 2023.
The long-term plan for one person to transition to new accommodation within the next year remains in progress. The new accommodation has been approved by the planning department in Kildare County Council in April 2023. A formal reiew by the Kare Board of Directors was completed in February 2023.
The property has been out to tender for a contractor in August 2023.
As of the 6th of November 2023 Kare have completed the design stage of the new build. The project has been tendered and all tenders have been reviewed. The final

construction tenders were submitted to Kildare County Council and the Housing Department in September 2023 for final approval as part of the Capital Assistance Scheme stage 4 process (which is expected to be completed before the end of November).

Next steps:
1. Capital Assistance Scheme stage 4 approval - end November 2023
2. Kare Award contract - December 2023
3. Project planning and initiation meetings - January 2024
4. Construction commencement - site access and commence new build apartments to rear - February 2024
5. Complete new build construction of 2 new apartments - June 2024.
6. Register the variance of the registration of the designated centre Kare DC 10 June to September 2024.
A project manager was appointed to the project in September 2023 by Kare.
Regurlar project meetings in Kare are scheduled througout the build period with the project team, this will include regurlar and ongoing communications with the individuals and their family in relation to the build.
Planning for décor, finishes, furniture, garden space by the individual will be scheduled in to the project plan.
The risk rating in this location related to safeguarding has been increased and the board informed of the risk update in October 2023. The Commissioner of services in the CHO7 disability team are aware of the risks in the location, this was further discussed at the regular engagement meeting on the 19th of October 2023.

A meeting with the commissioner of services and the provider is scheduled for 9th of November 2023 and this issue will be flagged and discussed again.

An internal provider escalation meeting occurred to discuss this location on the 25th of October 2023, an additional meeting occurred on the 6th of November 2023.

The leader will link with families to continue to ensure that a coordinated approach to the home visits and overnight stays will limit the number of interactions possible between these two individuals.

Kare acknowledge that this delay to the full time move to alternative accommodation for one individual poses additional risks to both individuals. To minimize the risks the following additional controls will also be implemented:

- Staff team/leader provided with regular support from the Designated Officer for Safeguarding on a monthly basis from Nov 2023 onwards.
- Enhanced audit in this location in relation to protection, rights and positive behaviour support by a PPIM will be conducted in December 2023.
- Support from a named staff in the quality department and the PPIM will be given to the staff team to ensure actions are implemented from the audits in January 2024.
- Staff in this location will complete all 4 modules on Human rights available on HSELand by the end of December 2023.
- Provider escalation meetings will continue to occur each month until the issues are resolved in this location.

- Service users will be informed on a regular basis about the Complaints process and empowered to make a complaint if they choose to.
- Ongoing support to the individuals in this location to discuss and address any issues noted by the keyworker will be documented when they occur.
- People will be reminded of the house rules poster they created together on a regular basis, at least monthly.
- A referral to psychology for support for one individual to support development of positive relationships and appropriate conversations happened on the 5th of November 2023.

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
One individual in this location has expressed a wish for the person who supports them to manage their finances to continue to manage their finances. They do not wish Kare to be involved with supporting their finances. This is clearly documented in the persons money management plan. Communication with the individual and their family has been documented in relation to this matter. Kare are supporting the person with their choice in line with their will and preference.

One individual does not have a bank card as they withdraw money directly from the cashier in the bank, which is the way in which they choose to bank. They use ID and bank in the same location all the time. They have engaged in this practice since they were younger and when asked about a bank card they have chosen to continue to bank in the manner which they choose for the foreseeable future. Kare are supporting the person with their choice in line with their will and preference.

Risk controls to reduce the level of risk or the effect on residents is reviewed on a regurlar basis in relation to safeguarding. Interim risk controls have been implemented and the provider has noticed as relationships in the location have developed in a positive manner the number of incidents has reduced.
Transition planning for moves for one individual to a new location will be finalized when the construction schedule is agreed. This is expected to be completed in September 2024.

Additional risk controls as noted under regulation 8 will be applied to this regulation also.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	31/12/2023
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	20/09/2023
Regulation 21(1)(c)	The registered provider shall ensure that the additional records specified in	Not Compliant	Orange	13/10/2023

	Schedule 4 are maintained and are available for inspection by the chief inspector.			
Regulation 24(1)(b)	The registered provider shall ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.	Substantially Compliant	Yellow	31/12/2023
Regulation 28(2)(b)(iii)	The registered provider shall make adequate arrangements for testing fire equipment.	Substantially Compliant	Yellow	31/03/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/03/2024
Regulation 29(4)(a)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration	Substantially Compliant	Yellow	04/11/2023

	of medicines to ensure that any medicine that is kept in the designated centre is stored securely.			
Regulation 29(5)	The person in charge shall ensure that following a risk assessment and assessment of capacity, each resident is encouraged to take responsibility for his or her own medication, in accordance with his or her wishes and preferences and in line with his or her age and the nature of his or her disability.	Substantially Compliant	Yellow	30/11/2023
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	31/10/2023
Regulation 31(3)(a)	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	Not Compliant	Orange	31/10/2023

	relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.			
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	31/10/2023
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/09/2024
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.	Not Compliant	Orange	30/09/2024
Regulation 09(3)	The registered provider shall ensure that each	Substantially Compliant	Yellow	30/09/2024

	resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.			