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:	Priory Village
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Announced
Date of inspection:	06 October 2023
Centre ID:	OSV-0008185
Fieldwork ID:	MON-0041650

About the designated centre

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

Priory Village is a designated centre registered to provide full-time residential support for up to three adults with an intellectual disability. The centre consists of a two-storey house on the outskirts of a town in Co. Kildare. Each resident has a private bedroom, one of which has an en-suite bathroom. Downstairs is an accessible bathroom, large living room and kitchen, and a sun room with dining space. The premises has a large garden space and the use of a vehicle in the evenings for community access. Residents are supported by a team of social care workers, with access to nursing support as required.

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
Friday 6 October 2023	10:20hrs to 17:50hrs	Karen Leen	Lead
Friday 6 October 2023	10:20hrs to 17:50hrs	Erin Clarke	Support

What residents told us and what inspectors observed

This report outlines the findings of a short-notice announced risk-inspection of this designated centre. This inspection was carried out following the receipt of solicited information from the provider to the Chief Inspector of Social Services. The information received set out an ongoing incompatibility concern and conflicting needs of residents, resulting in peer-to-peer safeguarding incidents which were having a negative impact on residents.

The inspection was facilitated by the person in charge for a period of the morning and the operations manager, who was appointed by the provider as a person participating in the management of the centre (PPIM) throughout. The inspectors of social services used observations and discussions with residents in addition to a review of documentation and conversations with key staff to form judgments on the residents' quality of life. Overall, the inspectors found high levels of non-compliance with the regulations and standards, with inspectors not assured that there were appropriate management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. Furthermore, formal safeguarding plans submitted and in place in the centre could not be implemented by staff as intended due to lack of resources, therefore impacting negatively on the lived experience of the residents. In addition, safeguarding plans in place that were endeavouring to keep residents safe were, at times, resulting in an environment that was restricting residents from free movement in their home.

The designated centre consisted of a two-storey house in which each resident had their own bedroom (one with en-suite), which was furnished to their own individual style and tastes. The centre had a combined sitting room and kitchen area, sun room and large external garden, which were equipped for activities that residents liked to participate in, such as rugby. On the second floor of the property, there was a small sitting room that support staff informed inspectors that one resident liked to use. The designated centre had a maximum capacity of three residents, and at the time of the inspection, there were no vacancies in the centre.

On arrival to the centre, two residents were attending day service, and one resident was being assisted with their morning routine by staff. Inspectors had the opportunity to meet with all residents during the course of the inspection. One resident spoke briefly with the inspectors, showing the inspector some of their artwork and also accessories that they liked to wear. The inspectors observed the resident speaking and joking with staff. During these interactions, there was an atmosphere of warmth and understanding of the resident's needs.

Inspectors had the opportunity to speak with one resident on return from their day service. The resident receives an individualised day programme from the centre, with staff informing inspectors that the resident had not enjoyed previous day service placements and this service was more tailored to the individual's interests. The individualised day service programme also included options for the resident to

attend identified classes which they enjoyed within a day service run locally by the provider. The inspectors had the opportunity to speak to the resident on return from one activity. The resident told the inspectors that they enjoyed their day service. The resident spoke to the inspector about their great interest in sports; being a rugby fan, they were enjoying the games in the Rugby World Cup. The resident had also taken part in a number of mini marathons and walking groups in the local community. The resident then showed one of the inspectors their bedroom and gym equipment in the centre.

Inspectors spoke to another resident on return from their day service; however, inspectors observed that the resident was very anxious and required staff support. Inspectors spoke briefly to the resident with the support of staff and the PPIM; however, as the resident was experiencing such high levels of distress, the inspectors adhered to staff guidance and gave the resident time to be supported by staff. Inspectors found that the resident was seeking support from staff to access external environments; however, staff or the provider did not have suitable arrangements in place to support the resident in these requests. These supports will be discussed further under regulations 15: Staffing and 23: Governance and Management.

While the inspectors recognised that the increase and change in needs of residents had occurred within a relatively short period of time, the inspectors found on the day of the inspection that the service was not safe, adequately resourced, monitored, or tailored to meet the needs of the residents. As a result, the service offered did not represent a human rights-based and person-centred approach to the care and support of residents.

The next two sections of this report will 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 provided.

Capacity and capability

This inspection was a risk-based inspection carried out in response to an increased pattern of solicited notifications from June 2023 to the day of the inspection relating to peer-to-peer safeguarding incidents submitted to the Chief Inspector. The inspectors were not assured on the day of inspection that there were appropriate governance systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. The provider's own audits failed to identify areas of non-compliance within the regulations and, therefore, did not have a quality improvement plan to address these issues. These concerns had been escalated to the provider by the person in charge and the person participating in management and highlighted by the inspectors throughout the course of the inspection.

The provider had recently increased the whole-time equivalent staffing levels in the designated centre in an attempt to support residents. The provider had formal safeguarding plans for residents, which documented the requirement for additional day support hours to provide two residents with one-to-one support. However, the provider had failed to implement the additional staffing to provide one-to-one support to residents, meaning that when incidents of concerns occurred, staff did not have the resources to assist all residents in the centre, which often led to residents being redirected to their bedrooms or away from communal areas within the centre. Under the regulations, the provider must ensure appropriate staffing numbers and skill mix are in place to support residents. Based on the overall findings of this inspection, inspectors were not satisfied that the provider was discharging these requirements.

The provider had a complaints procedure in place in the designated centre; however, inspectors found no evidence during the inspection that this procedure had been offered to residents or their family members. Inspectors found evidence that residents and family members had detailed their current dissatisfaction with their lived experiences in the centre but were not offered the complaints process or a referral to an external advocate. Inspectors found evidence of one resident's level of dissatisfaction with the service provided in the centre, that they requested to leave the centre for a number of days and be supported by family members. Furthermore, inspectors found that resident meetings taking place in the centre on a weekly basis focused mainly on meal options and did not discuss topics on the running of the centre or how to make a complaint if the resident wished to do so. Inspectors noted that on three occasions, two residents had refused to attend the weekly meeting.

While the statement of purpose contained the information required by Schedule 1 of the regulations, some of this information was found to be inaccurate. For example, the statement of purpose did not accurately reflect the whole-time equivalent staffing required in the designated centre and was not reviewed at regular intervals by the provider incorporating changes in the designated centre, such as staffing complements.

Regulation 15: Staffing

The inspectors found that the centre was not staffed to meet the current assessed needs of the residents. Furthermore, the provider had identified safeguarding plans for residents in the designated centre, which incorporated additional staffing to support during daytime hours in order to protect residents from abuse. The provider had implemented additional staffing in the centre, but inspectors found that this did not meet the needs of each resident and did not ensure continuity of care for each resident in the designated centre.

Judgment: Substantially compliant

Regulation 23: Governance and management

The findings of this inspection indicated that oversight in the centre required improvement to identify and address areas where improvement was required. The provider carried out a legally mandated six-monthly unannounced visit and review of the quality of care and support provided in the centre in August 2023. The purpose of the visit is to monitor the safety and quality of care and support provided in the designated centre and, as required, to put a plan in place to address any concerns identified during the visit.

However, the audit did not identify many of the issues discovered on the day of the inspection. In some areas, full compliance was awarded despite the fact that the inspectors had identified issues with the processes. For instance, in the audit, it was determined that the staff handover procedure was "100% effective." As concise daily progress notes of residents were not routinely written, inspectors requested the notes from the handover, but these were not easily accessible because they were only stored in staff members' emails. To analyse the requested information, the inspectors took the unusual step of asking for access to staff emails.

On review of the emails, the handover procedure was determined to be unsuitable for its intended use. It was unclear when residents were present at the centre, community, or at home, and information regarding significant incidents in the centre was absent. Additionally, the provider did not exercise any oversight over the reports writing quality to ensure legal and professional obligations in creating and maintaining accurate records.

Whilst having a perspective on quality, safety and compliance with regulations and standards, the provider should ensure that any report of their unannounced visit explicitly reflects how systems, practices and procedures impact on outcomes for residents. While 10 incidents of a significant safeguarding nature had occurred since June 2023, resulting in negative outcomes for residents, complaints, the deployment of additional staff and further requests for information from the office of the Chief Inspector, these were not referenced in the six-month report. This was partly due to the prescriptive nature of the audit tool that did not allow for edits to be made by the auditors.

Furthermore, it was not clearly identified on the report the time and duration of the visit, the progress made on actions identified during previous visits and consultation with residents and staff.

As a result, the provider had failed to ensure that the oversight of the service was robust, appropriate to residents' needs, consistent and effectively monitored.

Judgment: Not compliant

Regulation 3: Statement of purpose

There was a statement of purpose in place in the centre, however inspectors found that the statement of purpose had not been reviewed since March 2023. While the statement of purpose contained the information required by Schedule 1 of the regulations, some of this information was found to be inaccurate.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The person in charge was submitting notifications regarding adverse incidents within the three working days as set out in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

Residents living in the designated centre were not facilitated to exercise their right to make a complaint by the provider. The inspectors found evidence in residents' support documentation highlighting residents and their family members' current dissatisfaction with the designated centre. However, when these concerns raised by residents and their families were discussed during the course of the inspection, management within the designated centre had not identified them as a complaint. Residents were not offered access to advocacy services in order to assist and support them in making a complaint to the provider.

Judgment: Not compliant

Quality and safety

Overall, inspectors were not satisfied with the standard and quality of care and support observed on the day of the inspection. The inspectors found that the centre was not operating in line with the aims and objectives of the centre's statement of purpose. The aim of Priory Village was to provide person-centred supports to meet the physical, emotional, social and psychological needs of each resident. Despite a clear management team in place and a team of staff who presented as dedicated and committed to the residents, significant improvements were required in order to

bring this centre into compliance and to ensure that residents' safety and rights were upheld.

A number of residents in the centre presented with support needs in the areas of behaviour and mental health. Inspectors reviewed residents' behavioural guidelines and found that they were not adequately detailed or reviewed in order to guide staff practice, particularly with the use of prescribed therapeutic interventions. Inspectors found that where a resident was prescribed a therapeutic intervention for behavioural management, there was no clear guidance in place that instructed staff at what point to administer the intervention.

A review of incidents of a safeguarding nature by the inspectors found that safeguarding plans put in place were ineffective in ensuring that residents were appropriately protected from experiencing abuse. The inspectors found that these incidents were reoccurring and negatively impacted the individuals involved and their emotional wellbeing.

Overall, the provider had not taken sufficient or effective steps to ensure that residents lived in a suitable environment that was free from distress and failed to ensure their wellbeing was maintained. The inspectors found that supports identified by the provider to maintain residents' safety and to ensure a safe and effective service for residents, such as up-to-date behavioural guidelines, transport, and additional staff arrangements, were not being met, which in turn was impacting on residents' rights to exercise choice and control over their daily lives.

Regulation 7: Positive behavioural support

Positive behaviour support plans were in place for a number of residents in the centre. On the day of the inspection, positive behaviour plans had not been reviewed in line with residents' changing needs or in line with changes identified by the provider as inputted through residents safeguarding plans. Therefore, the plans in place were not reflective of residents' needs in the area and could not guide staff appropriately on how to best support residents during times when their behaviour could negatively impact themselves or others.

Positive behaviour support plans in place included a number of strategies and de-escalation techniques to guide staff on how to best support residents during times when their behaviour could negatively impact themselves or others. However, the inspectors found that the centre did not have access to interventions identified in the positive behaviour support plan that would be offered to residents during the proactive support phase of their support plan; for example, one resident's behavioural guidelines identified a coping strategy to go for a drive with staff if they are available however the centre does not have access to transport that could facilitate each resident at all times over a 24 hour period.

Improvements were required to ensure that where residents required therapeutic interventions, there was inadequate guidance in place for staff that clearly

demonstrated at what stage in the support plan the intervention should be implemented. Inspectors found that positive behaviour support plans did not identify the use of therapeutic interventions. Furthermore, inspectors found that where a therapeutic intervention was identified as necessary, there was no support documentation to demonstrate that other interventions or strategies had been completed prior to the administration of a therapeutic intervention. One resident had an identified assessed need of requiring the support of a behaviour support plan; however, the resident's behaviour support plan remained in a draft format with no clear guidance for staff in managing behaviours of concern for the resident.

Judgment: Not compliant

Regulation 8: Protection

On reviewing residents' safeguarding plans, the inspectors found that safeguarding plans in place were not reflective of the resources available in the designated centre, meaning that plans in place were ineffective in protecting residents from all forms of abuse. For instance, one formal safeguarding plan devised and in place within the designated centre outlined an ongoing response to managing behavioural incidents with an increase in staffing resources for additional day support hours so that two residents would have one-to-one staffing during the day. Inspectors found no evidence of one-to-one support available to all residents in the centre during behavioural incidents and furthermore found that, as a result, staff could not safely protect all residents within the designated centre from the negative impact of such incidents. This lack of staffing resources to support residents often resulted in staff being required to supervise residents in communal areas and, when required, to move residents from one communal area of the house to their room or out of the centre. However, as discussed within the report, the centre does not have transport readily available to all residents in the house should it be required.

In addition, formal safeguarding forms highlighted that behavioural guidelines were in place for residents and were regularly reviewed. Reviewing behavioural guidelines, inspectors found that one plan had been last reviewed on the 09th of May 2023 despite the resident experiencing a decline in their mental health with increased behavioural incidences occurring in the centre from June 2023 to the day of the inspection. Another resident's behavioural support guidelines was devised on the 22nd of July, 2023. However, these guidelines were not complete despite an increase in behavioural incidents due to compatibility issues within the centre and the provider's assurance that an ongoing review of behaviour guidelines was occurring in line with their response to ensure the protection of each resident in the designated centre.

Overall, the inspectors found that while the current resources and living arrangements were in place, residents would continue to be impacted in a negative way. The risk of continued safeguarding incidents occurring in communal areas while residents had meals, returned from outings, remained in the centre.

Furthermore, strategies designed to keep residents safe resulted in a more restrictive living environment for residents and negatively impacted their quality of life.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspectors found the service was not safe, effective, adequately resourced, monitored, or tailored to meet the needs of the residents. As a result, the service offered did not represent a human rights-based and person-centred approach to the care and support of residents.

Safeguarding plans in place detailed ongoing responses in place endeavouring to ensure residents' safety however, a number of the supports identified by the provider to maintain residents' safety were not in place. This lack of additional support for residents resulted in an environment that was restrictive in nature, whereby residents were required to leave the centre for bus drives if available or redirected to their rooms.

Inspectors found gaps in residents' documentation in relation to incidents of challenging behaviour. Behavioural incidents occurring in the centre that noted an impact on other residents were not being reported by the designated centre in incident reports, staff handover or in residents support documentation. Inspectors reviewed a sample of handover documentation between staff highlighting significant behaviour incidents within the centre, one incident documenting an occasion where staff had to lock themselves into an office to maintain their safety. Inspectors found no documentation in the centre that noted or detailed the support being provided to other residents during this time or during additional incidents were one-to-one support was required for residents for behavioural support management. Furthermore, on discussion with management and support staff, they could not inform inspectors as to who was supporting the remaining residents in the centre during times of significant challenging behaviour incidents.

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	
Regulation 15: Staffing	Substantially compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Substantially compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Not compliant
Quality and safety	
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Priory Village OSV-0008185

Inspection ID: MON-0041650

Date of inspection: 06/10/2023

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: The provider implemented additional staffing in the centre, which meets the needs of each resident and ensures continuity of care. There are extra staff on each shift when required to ensure safeguarding plans can be implemeneted correctly. There are currently two sleepovers and a day staff when all three residents are in the house. When one person is not staying in the house, the staffing rates are reduced to one staff on sleep over and one day staff. New transport approved and sourced and available for use as of the 20th of October 2023. The statement of purpose was update on the 10th of October to reflect the changes.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: An audit was conducted in February 2023 and August 2023 by members of the quality team. Restrictive practice and positive behavior support formed part of the audit in Feb 2023. Kare acknowledge that based on the risks present in this location a different type of audit should have occurred for the unannounced inspection conducted in August 2023. Kare's audit policy will be amended to include risk based audits with input from relevant stakeholders across Kare. Auditors have been informed to make the audit tool flexible and relevant to the issues in	

the location at the time where required. Time of unannounced visit and duration of visit will be captured in the template going forward. This was communicated on the 8th of November 2023.

Kare's case review guidelines will be reviewed to ensure reflective of risk based audits with relevant input from stakeholders across Kare.

The risk management policy will be reviewed to ensure it is reflective of the required areas with input from the relevant stakeholders across Kare. The Board of directors subcommittee on Quality, Risk and Safety will be involved in the sign off of the policy as per Kares policy management framework.

These three policies and documents will be launched to the organization after approval at the Heads of Unit meeting in January 2024.

Two staff have been enrolled on Lead auditor training by The Irish Quality Centre (ISO 90001:2015) commencing on the 7th of March 2024.

One staff has been enrolled on Lead auditor training by The Irish Quality Centre (ISO 90001:2015) commencing on the 23rd of May 2024.

A new layer of auditing for risk based inspections will be introduced and additional auditors added to the panel to conduct the audits. They will have undergone Kare's internal audit training package on LEAP platform prior to commencing the auditing.

An enhanced audit is scheduled for this location to be completed by the end of November 2023.

The annual review for this location was conducted by the staff team and leader on the 20th of October at the staff team meeting. Further is work is scheduled to complete the annual review within input form the PPIM and quality department by the end of December 2023. The annual review will be reflective of the year that has been and inspections which have occurred both internally and externally.

Daily progress notes and handovers for each person living in this location have moved to Kare CID database. A written account of the day is captured. Staff have been infomred on how to access the contact records for the purposes of a handover on the 20th of October at the staff team meeting.
The individualised planning policy is under review and will be updated to include a new section on daily notes and handover. This will be completed in Quarter 1 2024.
Staff have been informed that they can not send handover information via email and this practice has ceased as of the 20th of October 2023.
Provider internal escalation meetings have occurred to discuss this location on the 25th of October and the 6th of November. Further meeting is scheduled for the 13th of November and will continue to be scheduled for the foreseeable future.

All social care leaders informed to notify PPIM and Quality department in relation to communication with HIQA which will improve governance and risk management as of the 8th of November 2023.

Kare will develop a crisis management plan which will be used in the event of a crisis which will highlight the actions required in Kare to appropriately respond where concerns are noted. The plan will be incorporated in to the Risk management policy. This will be launched by the end of January 2024.

Regulation 3: Statement of purpose	Substantially Compliant

Outline how you are going to come into compliance with Regulation 3: Statement of purpose:
The revised statement of purpose, which accurately reflected the staffing levels of the designated centre was submitted to the inspector by the PPIM via email on the 10th of October 2023.

An additional review of the statement of purpose was completed on the 6th of November 2023.

The revised statement of purpose was submitted to HIQA as part of a variance application for the designated centre on the 9th of November 2023.

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
Service users have been provided with the easy read document on making a complaint and accessing external advocacy on the 8th of November 2023.

Weekly meetings have been scheduled for service users which have been introduced while the location is experiencing difficulties as of the 20th of October 2023. People are provided with choice to attend, if they choose not to attend they are provided with an opportunity to meet with staff or leader on a 1-1 basis to discuss any issues or concerns.

Service users have been provided with the opportunity to watch the accessible version of making a complaint video on Kare LEAP training platform on the 8th of November 2023. One person choose to watch this and this was documented in their daily records.

Staff are actively asking and informing people and their representatives about the 'managing complaints' policy in Kare on a regular basis through the weekly meetings as and from the 20th of October 2023.

One family made a formal complaint on the 18th of October 2023 They met with the CEO on the 7th of November 2023 to discuss their concerns. CID database for managing complaints is updated with up to date information in relation to complaints on the 7th of November 2023.

Kare Complaints officer scheduled to attend Staff team meeting agenda item about complaints the week of Friday the 15th of December 2023.

Complaints module for staff in development and will be available for staff to access on LEAP platform by the end of January 2024.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Positive behaviour support plans have scheduled for a comprehensive review has been for the 9th of November 2023. The plans will reflect the changing needs of the people living in this designated centre. Positive behaviour support plans in place included a number of strategies and de-escalation techniques to guide staff on how to best support residents during times when their behaviour could negatively impact themselves or others.

Psychiatry review occurred for one individual on the 17th of October 2023. PRN medication was discontinued for use at that review and PRN protocols were discarded as no longer relevant.

Safeguarding plans were updated and reviewed by the HSE safeguarding and protection team on the 6th of November 2023.

Behavioral guidelines identify a coping strategy to go for a drive with staff if they are available. The location now has increased access to transport and staff to allow this to happen as of the 20th of October 2023.

One individual behaviour support plan that was in draft remains in draft and has been reviewed by the behavioural support team on the 25th of October 2023. The full plan will be completed by the end of December 2023. This will discussed with the staff team at the staff team meeting in December 2023.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: Safeguarding plans in place are reflective of the resources available in the designated centre, as of the 20th of October 2023.

The HSE safeguarding and protection team approved the combined safeguarding plans on the 6th of November 2023.

Compatibility assessment tool will be developed for use in Kare services by December 2023.

Staff will be communicated to about the compatibility assessment and informed on how to complete it effectively by the end of December 2023.

The provider 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.

The provider Sourced alternative accommodation on the 26th of October 2023 and viewed the alternative accommodation on the 27th of October 2023 for one individual.

The provider Linked with the inspector for this designated centre to get advice on registration of the temporary accommodation on the 27th of November 2023.

Confirmation off landlord that fire doors are certified as meeting the regulatory requirements for community dwellings. Photographs showing fire stamps have been provided. Official Fire certs for each door to follow from the landlord to the facilities department by the end of November 2023.

The short term lease for the new property was signed on the 3rd of November 2023.

Keys to the new accommodation available from the 6th of November 2023. Transition planning commenced on the 13th of November 2023.

A Variance application for a change to the floor plan and statement of purpose for this designated centre will be submitted to HIQA on the 9th of November 2023 which will provide alternative accommodation for one person as an interim measure to protect the safety and welfare of all three residents.

Pending HIQA registration of the new property a transition plan will be implemented for one person to move to new accommodation with the support of the same staff team ensuring consistency and continuity for the individual.

Safeguarding plans will be updated after moves occur for one individual to new accommodation by the end of December 2023.

Regulation 9: Residents' rights	Not Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights: Behavioural incidents occurring in the centre that noted an impact on other residents are reported by the designated centre in incident reports as required, safeguarding incident report and daily contact records as of the 20th of October 2023. While incidents may occur, staff have been reminded to record the impact on other people as well as maintain records of who provided them support during the incident as of the 20th of October 2023. Restrictive practice review for this location has been scheduled to be completed prior to the end of November 2023. When accommodation changes occur a review will occur with one month of all plans to ensure they are reflective of the current environment.

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 15(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Substantially Compliant	Yellow	10/10/2023
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Substantially Compliant	Yellow	20/10/2023
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	31/01/2024

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	24/05/2023
Regulation 03(2)	The registered provider shall review and, where necessary, revise the statement of purpose at intervals of not less than one year.	Substantially Compliant	Yellow	09/11/2023
Regulation 34(1)(b)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall make each resident and their family aware of the complaints procedure as soon as is practicable after admission.	Not Compliant	Orange	15/12/2023

Regulation 34(1)(c)	The registered provider shall provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure, and shall ensure the resident has access to advocacy services for the purposes of making a complaint.	Not Compliant	Orange	31/01/2024
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Not Compliant	Orange	17/10/2023
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	31/12/2023
Regulation 08(2)	The registered provider shall	Not Compliant	Orange	31/12/2023

	protect residents from all forms of abuse.			
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Not Compliant	Orange	20/10/2023
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	30/11/2023