



Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Kare DC5
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	19 May 2026
Centre ID:	OSV-0001995
Fieldwork ID:	MON-0045207

About the designated centre

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

This designated centre provides residential services to three adults with an intellectual disability. The centre comprises of three houses in different locations in Co. Kildare; two bungalows and one two-storey house. One bungalow consists of a living room, kitchen, lobby, bedroom with en-suite, a store room, staff bathroom, staff office/bedroom and a bathroom. There is a garden space out the front of this house. The other bungalow consists of a living room, kitchen-dining room, a bedroom, staff office/bedroom and a bathroom. The two-storey house consists of a living room, kitchen-dining room, utility room, sensory room, staff bathroom, three bedrooms (two are staff bedrooms), a recreation room, a bathroom and a garden space out the back of the house. The person in charge in this centre divides their working hours between the three houses within this designated centre, and another designated centre. Social care workers and care assistants are employed to work in this centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3
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How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 19 May 2026	09:00hrs to 16:30hrs	Linda Dowling	Lead

What residents told us and what inspectors observed

This inspection was unannounced. The purpose of the inspection was to monitor the compliance of the designated centre with the regulations and associated standards. The inspection was completed over one day by one inspector. Overall, the findings of the inspection were that a person-centered, individualised service was being provided to the residents that lived there. The designated centre was meeting good levels of compliance across the regulations reviewed, with some improvements required in relation to safeguarding resident's finances and improvements to the premises in one of the three properties that make up the designated centre.

As mentioned the centre comprises three individual properties with each property home to one resident. The first property was a bungalow that contained a resident's bedroom, two staff bedrooms, a sitting room, a sensory space and kitchen-dining area. When the inspector arrived, they were greeted by two staff members and the resident living there. The resident did not use verbal communication although the inspector observed their movements and noted they were familiar with all spaces within the house, they were able to move freely through the house and outside in the garden where they had their own shed. The shed which was observed to be visited frequently by the resident only contained an old sofa. The inspector noted the resident's clothes were stored in a room beside their bedroom and their bedding was also stored there. The staff reported this was due to the risk of the resident ripping their bedding if left in their room throughout the day. The resident had free access to this room at all times. The property was in need of maintenance in almost all areas, this is discussed further under regulation 17: premises.

The inspector did not get to meet the other two residents as they were out and engaged in community activities at the time the inspector arrived at their home. The second property had just been renovated and was found to be clean, bright and spacious, the resident had a bedroom upstairs and a sensory / art room downstairs they had lots of art supplies and a sensory tent. As part of the renovation the resident now had a specific space in the garden for them to engage in water play as this was something they enjoyed doing daily. The third property was a two bed bungalow, one bedroom was assigned as a staff sleepover / office. The resident had their own bedroom, a spacious kitchen, sitting room and bathroom facilities. This property was found to be in good condition. The resident living in the centre requested notice on further inspections and choose to be out of the house when the inspector came to visit.

Throughout the inspection the inspector spoke with the person in charge, the centre senior manager and three members of the staffing team alongside a review of documentation.

As each property was an individualised service the residents therefore had autonomy over how their day was directed. Two out of the three residents had

busy, active lives where meaningful opportunities for community participation and access were provided. The third resident engaged in some community based activities although many activities were based on drives and short visits to woodlands and beaches. On review of documentation residents were seen to participate in film club, social disco, art and exercise classes, visits to the library, paid employment in a garden centre and hotel and voting in general and local elections.

Overall the inspector found the residents were involved in the day-to-day running of their home and had opportunities to participate in activities they enjoyed. In the next two sections of the report, the findings of this inspection will be presented in relation to the governance and management arrangements and how they impacted on the quality and safety of service being delivered.

Capacity and capability

The provider's systems to monitor the quality and safety of service provided for the residents included, unannounced provider audits every six-months, and an annual review. Through the review of documentation and discussion with staff the inspector found that provider's systems for the day-to-day management and oversight of the centre were effective on the day of inspection.

Audits being completed were leading the provider to take action and bring about identified improvements. The person in charge was full-time and had responsibility for one other designated centre. The person in charge was knowledgeable in relation to the centre and the resident. From the information provided to the inspector it was evident that the person in charge was spending time in the centre to ensure sufficient oversight was in place.

Regulation 14: Persons in charge

The provider had appointed a full-time person in charge of the designated centre who was suitably qualified and experienced. The person in charge was responsible for one other designated centres operated by the same provider. The person in charge reported to and received support from the operations manager. They demonstrated a good knowledge of the resident including their support needs, wishes and preferences on the day of inspection. One resident was observed to be comfortable in the presence of the person in charge.

Judgment: Compliant

Regulation 15: Staffing

The provider had ensured there were sufficient staff on duty to meet the assessed needs of the residents. There was currently no requirement to use agency staff and while they did use relief staff these were consistent.

The inspector reviewed four weeks of rosters. It was found that the rosters in place were up-to-date and staff were identified by their full name and grade. This roster was reflective of the staff on duty on the day of inspection. All training and approved leave was identified on the roster in advance to ensure adequate cover was arranged.

The person in charge was utilising the probation process effectively when new staff members joined the team. From review of probation meeting minutes detailed discussions were held in relation to the staff members roles and responsibilities.

Team meetings were held regularly in the centre, the inspector reviewed the last four months of meeting minutes and seen evidence of discussion on topics including, adverse events, risk management, health and safety and organisational updates.

Judgment: Compliant

Regulation 16: Training and staff development

There were systems in place for the training and development of the staff team. The inspector reviewed the staff training matrix that was present in the centre. It identified that the staff team in the centre had up-to-date training in areas including safeguarding, medication management, fire safety and manual handling. Any refresher training due was scheduled. Staff members were also provided with centre specific training including inclusive communication, positive behaviour support and report writing.

The inspector reviewed the provider's new annual review and reflection system, all staff had engaged in an initial meeting and details were captured in relation to wellbeing, your roles, workload and professional development. This system was still in its infancy and would need time to become more established. Staff and management had been supported with a short training video on the process prior to it commencing.

Judgment: Compliant

Regulation 23: Governance and management

The management structure defined in the statement of purpose was in line with that in place in the centre during the inspection. The person in was employed full-time position with responsibility for one other centre operated by the provider. The person in charge was present in the centre regularly and they were available by phone on the days where they not based in the centre.

The provider had the required oversight systems in place, as required by the regulations. This included an annual service review and unannounced visits every six months along followed by corresponding reports. These reviews led to the development of quality improvement plans, with actions monitored and reviewed on an ongoing basis.

The person in charge and operations manager had monthly meetings in place, these meetings included review of the operations of the centre, staffing and resources and professional development. Minutes were keep of each meeting and actions were set where necessary.

Judgment: Compliant

Regulation 31: Notification of incidents

A record was maintained of all incidents occurring in the centre, and the person in charge was aware of the requirement to notify specific incidents to the Chief Inspector of Social Services, in line with the regulatory requirement.

The inspector reviewed the incident, accident and near miss records and found that all incidents requiring notification had been duly reported.

Judgment: Compliant

Quality and safety

For the most part the inspector found that residents were provided with person centred care.

A number of key areas were reviewed to determine if the care and support provided to the residents was safe and effective. These included meeting the residents and staff, a review of, risk documentation, fire safety documentation, and a review of

residents' finance records. The inspector found good evidence of the residents being well supported in the majority of areas of care and support with overall positive outcomes noted for the residents. However, some improvements were required in relation to one of the premises and the oversight of residents' finances.

Regulation 10: Communication

Residents were assisted to communicate in accordance with their assessed needs and wishes.

Easy to read information was available on topics such as tenancy agreements, advocacy and complaints. Residents were supported to understand these topics and their rights through residents meetings and discussion with staff.

Other supports in place included, for one resident, photos of their staff on duty on display and an activity board showing their planned activities for the week ahead. One resident likes to take the display strip of daily activities with them when going out, they also like to partake in developing the visual schedule with activities of their choosing.

From review of residents' communication passports they were noted to contain good detail that guided staff practice. When speaking with a staff member in relation to residents' communication passports and the supports in place they identified one resident is more at ease and speaks more freely about issues when out walking rather than a face to face conversation. The residents' communication passport also documented strengths, routine, things I like and dislike, and how I communicate best.

Judgment: Compliant

Regulation 12: Personal possessions

The inspector reviewed the systems in place regarding the management of residents' finances and found that appropriate measures were in place for cash reconciliation and ensuring receipts were available for evidence of purchases. Although, two residents living in the centre did not have full and direct access to their own personal finances.

For two residents a family member had access and control of their monies and gave them cash when and if required. One resident also has to seek consent from their family member prior to spending in excess of fifty euro. While the provider is supporting the residents to manage their cash and maintain an accurate cash balance, they have not supported the residents to seek support and advice in relation to the overall management of their finances. In addition, financial

statements were not available for all accounts where one resident's money was held therefore the provider was failing to maintain oversight of the resident's full financial affairs.

The inspector acknowledges the remaining resident in the centre had access to all their own finances and they are supported to save for trips abroad, check bank balance on a regular bases and pay their utility bills in the post office when required.

Judgment: Not compliant

Regulation 17: Premises

As mentioned previously the centre comprises three properties. Each property is located near local amenities and facilities. One property required review in relation to maintenance works and infection prevention and control risks.

The two story property had been renovated recently and was bright, clean and spacious. This property was seen to be suitable to the resident's needs, it was decorated in a homely manner and individualised to the residents taste and interests.

One of the bungalows was located a short walk to a town and the resident enjoyed the independence of accessing facilities on their own, they utilised a mobile phone to keep in contact with staff members. Their home was personalised and had a homely feel. This property was in good condition and was suitable to the residents needs.

The third property was an older bungalow and was in need of maintenance throughout. On entering the property the inspector observed a smell possibly due to poor ventilation, this had also been highlighted in the previous inspection report. The inspector also observed worn and chipped skirting boards, painting required internally and externally. The property showed wear and tear in all areas. The resident's steel shed was also in poor condition, it was not insulated therefore not appropriate for use in the winter, the door was removed and it only contained an old sofa, while the inspector was informed the resident had had different items of interest in the shed, over time they had removed or taken them apart. On the day of inspection the resident was observed to go out to the shed on several occasions and they appeared to want to spend time there, they sat on the sofa for brief periods and came back out again.

While there was an assigned area within the house for sensory items and new items had been purchased for the resident this room was also the only direct access to the kitchen. The inspector observed it was also used for storage of items such as a vacuum, wet floor signs and an additional fridge therefore the space was not functioning as a sensory room.

The inspector also observed the resident had no en-suite door, this posed a risk to the residents privacy and dignity while using the en-suite. It was reported the resident had taken down the door although there was no evidence the provider had considered or trailed any other alternatives to protect the resident's privacy and dignity. The en-suite was also noted to be be unclean with a build up of dirt on the flooring, around sanitary wear and in corners.

From review of the providers audits it was seen that property works were identified and actions set, these actions had however, no time frame for commencement of works or completion dates set. When the inspector requested additional information on the outstanding works they were informed it could be 12-18 months time frame. This required review.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had detailed risk assessments and management plans in place which promoted the safety of the residents and were subject to regular review. There was an up-to-date risk register for the centre and individualised risk assessments in place which were also updated regularly to ensure risks were identified and assessed. For example, the inspector reviewed risk assessments in place for fire, financial abuse, behaviour of concern, lone working and transport.

There was an effective system in place for recording adverse incidents and accidents. On review of the system there had been a reduction in the number of incidents recorded. For one resident they had a total of eight incidents so far in 2026 the other two residents had none yet recorded for 2026 and only two in 2025.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had implemented systems to ensure the centre was appropriately monitored for fire risk and to ensure the residents could be safely evacuated in the event of an emergency.

There were records to demonstrate regular visual inspections by staff of escape routes, fire doors, emergency lighting and fire-fighting equipment and these were reviewed by the inspector. The fire safety systems in the centre such as the alarm, emergency lighting and fire fighting equipment had all been serviced and maintained in line with regulatory requirements.

Each resident had personal emergency evacuation plan (PEEP) in place which detailed individual preferences as to how they like to be prompted to leave the house.

Regular fire drills were taking place at each property and the person in charge had scheduled these drills to ensure all staff had taken part in a drill at least once throughout the year.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The provider had policies, procedures and systems in place for the receipt, storage, return and administration of medications. The inspector observed that there were suitable storage facilities in each property for medicines. The keys for the medication storage units were kept securely when not in use. All staff had completed training in the safe administration of medicines.

On reviewing two of the three residents' prescriptions (Kardex), it was noted they had up-to-date records in place. All administration of medication had been appropriately signed and each 'as required medication' (PRN) had clear guidance of staff on when to administer it, the maximum daily dosage allowed, and the minimum gap between dosages.

Competency assessments had been completed for residents to determine the level of support they required to manage their daily and PRN medicines. The supports and practice in place was in line with the outcome of the assessment.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant

Compliance Plan for Kare DC5 OSV-0001995

Inspection ID: MON-0045207

Date of inspection: 19/05/2026

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 12: Personal possessions	Not Compliant
Outline how you are going to come into compliance with Regulation 12: Personal possessions: The PIC and staff team will complete a comprehensive review of the financial support arrangements for both residents, including current family involvement, consent arrangements, and decision-making supports prior to the end of August 2026. The keyworker has met with one family to discuss financial arrangements and a further meeting with the PIC will be scheduled prior to the end of August 2026 to finalise governance arrangements. The keyworker and leader will meet with each resident (and their chosen representative where appropriate) to review their wishes and preferences regarding the management of their finances and document these within their personal plans and financial support plans. This will be complete by the end of August 2026. The staff team will support each resident to be facilitated to access independent advocacy, financial information, or other appropriate supports to enable them to make informed decisions about the management of their finances, where required and in line with their will and preferences. The application for the advocacy support will be completed by the end of July if chosen to do so by the resident. The team with the support from the restrictive practice oversight group will review the existing arrangement whereby one resident requires family consent for expenditure over €50 to ensure that any restrictions are managed in line with Kare policy and acknowledged as restrictive. This will be completed by the end of August 2026. Keyworker has requested from family to obtain copies of all financial statements for every account where residents' funds are held, with the residents' consent to ensure these statements are available for provider oversight and regular review. The request has been completed and the family have said that they will provide the records every 6 months for review. This will commence at the next statement from the bank, The	

timeline of which will be identified by the family prior to the end of July 2026. The staff team and PIC will implement a bi annual financial oversight audit to review all resident financial accounts, records, balances, and supporting documentation to ensure complete oversight of residents' financial affairs. This will commence on receipt of the next financial statement and continue thereafter. The provider will provide refresher awareness and guidance to relevant staff on supporting residents with financial management, promoting autonomy, safeguarding finances, and maintaining appropriate financial oversight. This will occur at the staff team meeting prior to the end of September 2026. The quality team will conduct a financial audit of all records held during 2026 in each of the residential house. They will identify learning and provide recommendations. This will be completed by March 2027 in line with audit annual plan. The provider internal Risk escalation forum will discuss residents finances and associated risks in general at the next meeting in July 2026. The organisation risk register related to supporting finances for residents was reviewed and updated in June 2026	
Regulation 17: Premises	Not Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A track plan for frosted glass to further promote privacy was submitted to the facilities team in June 2026 and will be completed by the 7th of July 2026. The additional items stored in the sensory room have since been removed. This was completed in May 2026. The en-suite floors had been washed early on the morning of inspection and was walked upon while wet making the area appear unclean. This was rectified and staff team meeting discussion about reminder to maintain the cleaning checklist completed in June 2026. Additional areas of issue with the bathroom floors were added to trackplan for requested review by external contractor and will be scheduled to be addressed prior to the end of August 2026. The planned works for one property in this designated centre have been scheduled in line with information provided to the inspector. The facilities team have requested that the contractor provide a revised timeframe for these actions. This timeline has been reviewed following the inspection and rearrange to be completed in the first quarter of 2027.	

The air quality risk assessment was reviewed for this location. Reminder to staff to open windows to ensure proper ventilation has occurred. This was completed in July 2026.

The provider acknowledges that the resident's steel shed is currently in a poor state of repair. The resident has consistently chosen to create and maintain this environment in accordance with their preferences. Previous efforts to improve the shed, including the installation of a door and insulation, were not successful as the resident subsequently removed these modifications.

The resident regularly accesses the shed throughout the year, irrespective of weather conditions, and this forms part of their established daily routine. The resident's family have advised that the shed reflects the type of environment the resident prefers and that it continues to meet their individual needs.

The resident's behaviours, including moving furniture, removing items, and dismantling objects, are recognised as meaningful expressions of their preferences and how they choose to organise and interact with their environment. The provider remains committed to respecting the resident's rights, will and preferences while continuing to assess and manage any associated risks through ongoing review, engagement with the resident, their family, and the multidisciplinary team.

The staff team will undertake and document an updated environmental risk assessment of the shed, identifying any hazards and add any additional control measures that minimise risk while respecting the resident's autonomy and rights. This will be completed by the end of July 2026.

The PIC and staff team will engage with the resident, using their preferred communication methods, and with family and the multidisciplinary team to explore whether any environmental improvements can be introduced that the resident is likely to accept while maintaining the environment in accordance with their preferences. This will be completed by the end of September 2026.

The PIC will establish a schedule for routine inspection and maintenance of the shed to ensure it remains structurally safe and free from avoidable hazards, while recognising the resident's preferences regarding the environment. This will commence in July 2026.

The provider's audit actions have been reviewed and appropriate timelines included within. This was completed in July 2026.

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	30/09/2026
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/03/2027