Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Issued by the Chief Inspector

Name of designated centre:	Kare DC13
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	09 April 2026
Centre ID:	OSV-0005750
Fieldwork ID:	MON-0048503

About the designated centre

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

Kare DC13 comprises a detached bungalow located in a large town in Co. Kildare. The house is close to many local amenities. There is a kitchen come dining room and a sitting room. There is a garage with storage and laundry facilities. Each person residing in the home has their own private bedroom with an en-suite bathroom. There is also a staff sleepover room/office. There is a garden to the front of the property with spaces for parking a small back garden. Full time residential care is provided to a maximum of adults with an intellectual disability. Residents are supported by a person in charge, social care workers and social care assistants.

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 9 April 2026	12:30hrs to 20:30hrs	Marie Byrne	Lead
Friday 10 April 2026	07:50hrs to 12:40hrs	Marie Byrne	Lead

What residents told us and what inspectors observed

This inspection was unannounced and completed to review the arrangements the provider had to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities 2013 and the National Standards for Adult Safeguarding (Health Information and Quality Authority and the Mental Health Commission, 2019). The inspection was completed by an inspector of social services over the course of two days. The findings of this inspection were that the provider's systems for safeguarding residents were not proving effective in this designated centre. High levels of non-compliance were identified on this inspection.

The provider was aware of the difficulties two residents were experiencing with sharing their home and had taken action and implemented a number of additional control measures. However, these actions and control measures had not proven effective at removing the presenting risks relating to safeguarding in this centre. There was an absence of a specific time-bound plan to address this. In response to the high levels of non-compliance found during this inspection, the Chief Inspector of Social Services invited the provider to an escalation meeting requiring them to bring the centre back into compliance.

KARE DC13 provides full-time residential services for up to three adult residents with intellectual disabilities. The centre comprises one bungalow in a housing estate in a large town in County Kildare. There are three resident bedrooms all of which have an en-suite. There is also a staff sleepover room/office. Shared spaces include a living room and a kitchen-dining room. There are laundry facilities and storage space available in the garage at the side of the house. There is a front garden with space to park vehicles and a small back garden. A vehicle is shared with the local day service and this will be discussed further under Regulation 23: Governance and Management.

The inspector found that the house was homely and well-maintained. However, there were limited communal spaces and this impacted residents' freedom to move around their home and to spend time in their preferred spaces. For example, one resident was heard asking staff if they could use the sitting room as their peer was also at home. Staff were heard telling the resident that this was their home and everybody had the right to use communal spaces. This will be discussed further under Regulation 17: Premises.

The inspector had an opportunity to meet and speak with each of the three residents living in this centre over the course of the two days. The inspector also had an opportunity to meet and speak with the six staff on duty (two of which were agency staff), the person in charge and one of the provider's persons participating in the management of a designated centre (PPIM). In addition, the inspector used

observations, a review of documentation and discussions with staff to capture the lived experience of people using this service.

During the inspection, residents spoke with the inspector about how important their independence was to them and described how staff supported and encouraged their independence. The inspector observed that space in the kitchen-dining room was limited, particularly when a number of residents and staff were present. In addition, records reviewed indicated that a recent simulated fire drill when one sleepover staff was on duty had demonstrated that one resident could not be supported to safely evacuate the centre in a timely manner. These concerns had been highlighted to the provider by the staff team and person in charge. The inspector was informed the provider's facilities and management team had visited and reviewed the premises in relation to accessibility and fire safety. At the time of this inspection, no clear timeline or decisive plan had been put in place to rectify this issue and mitigate any potential risks. Therefore, a provider assurance report was issued to the provider by the Chief Inspector after the inspection to seek assurances in relation to fire precautions in this centre.

Residents spoke about how they like to spend their time both in the house and in their local community. In response to residents' changing needs and safeguarding concerns in the centre, the provider had implemented additional staffing supports. This supported residents to engage in activities separately and outside their home. Over the course of the inspection, residents were observed to leave the house with staff to attend appointments, to visit their family and friends, to go swimming and to go shopping.

Residents spoke with the inspector about visiting and being visited by their family and friends. One resident went to visit an important person in their life during the inspection. Prior to this, they spoke about how important their relationship with this person is to them and showed the inspector pictures of them spending time together.

Throughout the inspection staff on duty were observed to be very familiar with residents' assessed needs and communication preferences. Residents appeared comfortable and content in their presence. The three residents who spoke with the inspector were very complimentary towards the staff supporting them. They described them as “good”, “nice”, and “very good”. Two residents spoke about what they would do if they had any worries or concerns. One resident spoke about difficulties they were encountering sharing their home with one of their peers. In addition the inspector observed two residents experiencing difficulties using the communal spaces during the first day of the inspection. As the inspector and the day staff were leaving on the first day, they observed an incident of a safeguarding nature. Both residents were immediately supported by staff members. This will be discussed further under Regulation 8: Safeguarding.

There were a large number of documents in an easy-read format on a variety of topics. These topics included information on rights, safeguarding pathways and how to access independent advocacy services and the confidential recipient. A sample of minutes of residents' meetings were reviewed. Residents' rights and safeguarding

were discussed at each of these meetings. This will be discussed further under Regulation 9: Residents Rights.

In summary, the provider was failing to ensure residents were effectively and appropriately safeguarded. Staff had completed training and were aware of their responsibilities relating to safeguarding. In addition, residents were being supported to make choices and decisions, and to be aware of the safeguarding and complaints procedures in the centre. However, there was a lack of a specific time bound plan by the provider to reduce risks relating to resident compatibility and safeguarding in this centre.

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

Overall the findings of this inspection were that the provider had failed to ensure their management systems were providing a service that was safe and appropriate to residents' needs. Strategies to support residents were not effective and there remained an ongoing risk to residents' well-being and safety.

In June 2024, the Chief Inspector issued a request for the provider to complete a Provider Assurance Report relating to an increase in the notification of incidents of a safeguarding nature. The provider's response detailed numerous assurances regarding actions that were being taken to safeguard residents in their home and these were reviewed during an inspection in the centre in July 2024. Following this a compliance plan was submitted and an update to this compliance plan was requested from the provider in March 2025. This indicated that a number of actions had been completed to bring about the some improvements.

During this inspection the inspector found that while actions had progressed and the provider had implemented a number of further control measures to reduce presenting risks, this was not proving effective. They had not completed robust assessments to determine the root cause, or to determine if residents were compatible to share their home. As previously mentioned, due to the level of concern relating to safeguarding, resident compatibility and fire precautions, after the inspection the Chief Inspector issued a provider assurance report requesting assurances relating to fire precautions and invited the provider to an escalation meeting.

The centre was not fully staff and residents' assessments were not sufficiently detailed in relation to the staffing supports required. Overall, it was not

demonstrated that the current staffing arrangements were meeting residents' needs or effective at reducing risks relating to safeguarding.

Regulation 15: Staffing

The inspector found that the provider had not ensured that the number of staff was appropriate to meet the safeguarding needs of residents.

The inspector was informed that there were two whole time equivalent staff vacancies at the time of this inspection. Based on discussions with staff and a review of a sample of rosters, it was evident that efforts were being made to ensure continuity through the use of regular relief and agency staff, but this was not always proving possible. For example, over a four week period in March 2026, 19 shifts were covered by eight different staff.

Overall the inspector found that it was not demonstrated during the inspection that staffing arrangements were effectively planned, organised or managed to meet residents' needs or to implement the control measures in safeguarding plans. The provider had increased staffing support for residents in line with residents' changing needs and presenting risks relating to safeguarding. However, residents' assessments did not clearly identify the required staffing supports.

Based on a review of documentation and discussions with staff, it could not be demonstrated that residents could safely evacuate in a timely manner with minimum staff levels on duty while also providing the required supervision of residents. For example, staff told the inspector that two residents could not be left alone at the external evacuation point due to safeguarding concerns. It was also documented in one resident's' assessment of need that they should not be left alone due to a risk of leaving without staff supervision. In addition, a control measure listed in a recent interim safeguarding plan for this resident states that they have been assigned 1:1 staffing during the day (08:00 - 20:00) to respond to their changing needs. However, the inspector reviewed another preliminary screening report which highlighted the requirement for staff to leave this resident unsupervised and the increased risk of incidents occurring during this time. This was due to the fact that another resident requires the support of two staff for transfers and with personal and intimate care, as detailed in their risk assessments and plans. The inspector reviewed daily notes to indicate a number of occasions when 1:1 support was not in place for one resident as staff were providing support to another resident. For example, on two occasions over a two week period in February 2026, it was noted that they were left unsupervised while staff supported another resident. On one occasion it was noted they were unsupervised for 45 minutes and on the other occasion for one hour. The inspector also reviewed records to demonstrate that the resident who requires 1:1 support during the day regularly wakes early in the mornings before sleepover staff are due to report for duty. For example, in January 2026 they were awake 26 times before 07:00 and in February they were awake on 22 occasions before 07:00.

The inspector reviewed a sample of three staff files and found they each contained the information required under Schedule 2, including Garda vetting, a full employment history and references.

Throughout the inspection, staff were observed to read situations and residents' mood and form and react accordingly. As previously mentioned, residents were very complimentary towards the staff team. The safeguarding concern observed during the inspection and referred to under Regulation 8 occurred at a time when one staff was reporting for duty.

Judgment: Not compliant

Regulation 16: Training and staff development

The provider had suitable arrangements in place to ensure that staff had access to induction, probation, training, supervision and support to enable them to promote residents' rights, health and wellbeing.

A review of the staff training matrix demonstrated that 100% of staff had completed safeguarding and Children's First training. Each staff who spoke with the inspector were aware of their roles and responsibilities should there be an allegation or suspicion of abuse. They were also knowledgeable in relation to the control measures in place in residents' safeguarding plans. Over the course of the inspection they spoke about difficulties implementing some control measures in risk assessments and safeguarding plans and this is discussed further under Regulation 15: Staffing and Regulation 8: Protection.

The new person in charge had a supervision schedule in place to ensure staff were in receipt of quarterly formal supervision. As they had just commenced in the centre they had not completed any formal staff supervisions at the time of this inspection. However, staff told the inspector that they were very supportive and available to them by phone or in person if they required their support.

A sample of staff meeting minutes held in 2025 and 2026 were reviewed. Safeguarding and protection was a standing agenda item as was restrictive practices and learning as a result of incident review and trending. Staff has an opportunity to raise any concerns they many have in relation to residents' care and support at staff meetings. The inspector reviewed a number of minutes including those from August 2025 which referred to safeguarding concerns, particularly relating to compatibility and difficulties residents were experiencing sharing their home.

The inspector reviewed minutes if meetings where it was noted that staffing resources, particularly in the evening/at night were highlighted by the staff team. It was also documented in minutes reviewed that the new to the centre, person in charge had raised it to the person participating in management of the centre (PPIM) with a view to determining if additional staffing was required, at times.

Judgment: Compliant

Regulation 23: Governance and management

Overall, the inspector found that the provider had not ensured that adequate arrangements in place to safeguard residents. Given the concerns relating to incompatibility and safeguarding risks in the designated centre, a comprehensive review was required by the provider. In addition, the inspector found that the centre was not adequately resourced to meet residents' needs. This particularly related to staffing, transport and the availability of computers for documenting residents' care and support.

The inspector found that while the provider was self-identifying that improvements were required in relation to safeguarding and resident compatibility, the actions they had taken to date had not proven effective. The inspector reviewed minutes of the provider's senior management team which showed that safeguarding and residents compatibility was discussed on a number of occasions in 2025. The provider's annual review, six-monthly reviews and risk register demonstrated that concerns relating to safeguarding and protection were highlighted and discussed. For example, the 2025 annual review stated "due to ongoing disputes between two residents there has been a large rise in the number of safeguarding submitted". However, it was not demonstrated during the inspection that the provider had assessed resident compatibility or recently reviewed the impact for residents of ongoing safeguarding concerns. There was an absence of a specific, timebound plan to bring about the required improvements.

The person in charge had commenced in the centre in February 2026. Based on discussions with them and a review of documentation including the risk register, risk assessments and the minutes of meetings, it was demonstrated that they were aware of, and escalating their concerns relating to safeguarding, fire safety, staffing and transport in the centre. They reported to and received supervision and support from a person participating in the management of the designated centre. It was clearly documented in the minutes of meeting between the person in charge and PPIM that they had discussed these issues. For example, they had escalated risks relating to fire safety to the provider's risk escalation forum which resulted in a review the property which was ongoing at the time of the inspection.

As previously mentioned, a vehicle was not assigned for the sole use of this centre. One of the control measures relating to safeguarding described by staff, was to ensure two residents travelled separately. Another was to bring one resident for a drive when they were tense or anxious. The inspector also reviewed a recent complaint made by a resident that they could not access wheelchair transport when they wanted to go somewhere. The inspector acknowledges that an action in the provider's annual review for 2025 was to source a full-time bus for this centre.

Over the course of the two days of the inspection, the inspector observed staff experiencing difficulties when more than one person needed to review or complete electronic records. There was one laptop in the centre and this was under/attached to the computer monitor in the office.

Judgment: Not compliant

Quality and safety

Overall, the inspector found that efforts were being made to keep residents' safe and protect them from abuse. However, due to ongoing concerns relating to difficulties experienced by residents sharing their home this was not proving effective.

Residents had opportunities to take part in activities they enjoy, and to spend time with their family and friends. They were supported and encouraged to develop and maintain their independence and to make choices and decisions in their everyday life. The premises was found to be warm, clean and well-maintained during this unannounced inspection. However, communal spaces were limited and the provider was in the process of reviewing accessibility and fire safety measures in the centre.

The inspector reviewed a sample of residents' assessments and plans and found that these documents positively described their needs, likes, dislikes and preferences. This also detailed how they communicate. Residents were in receipt of support of health and social care needs in line with their assessed needs. However, as previously mentioned residents' assessments did not clearly outline the staffing supports required to meet their needs and there was an absence of a robust assessment relating to residents' compatibility to share their home.

Staff had completed safeguarding training and those who spoke with the inspector were found to be knowledgeable in relation to their roles and responsibilities.

Regulation 10: Communication

Residents were supported to make decisions about their care and support and to promote their rights, health and wellbeing.

From a review of the each residents' plans they each had their communication needs assessed. They had a communication section in their care plan which described how staff should present information to them in a way that best suits their communication needs, styles and preferences.

Safeguarding and complaints were being regularly discussed at residents' meetings and keyworker sessions. There was a folder with easy-read documentation available in the sitting room and the minutes of resident meetings showed these were used with residents during their meetings to ensure they were aware of and understood the contents.

Based on observations and a review of documentation, the inspector found that residents were being supported to understand their rights, to communicate their choices and to understand how to raise and concerns they may have about their care and support in the centre.

Judgment: Compliant

Regulation 17: Premises

Based on observations during the inspection, the inspector found that the premises was not meeting the number and needs of residents.

The two main communal spaces in the house were the kitchen-dining room and the sitting room. Space in the kitchen was limited and this was particularly evident when there were a number of residents and staff using this space. The dining room table was large and the inspector observed one resident experiencing difficulties negotiating their way around and accessing the things that they needed. It was clear that their independence was important to them but due to the layout of the room, they had to ask staff to support them to get some things they needed.

The inspector reviewed one resident's risk assessments that a low stimulus approach and environment was required and that they find it hard when their is a noisy environment. On a number of occasions during the inspection, the inspector observed the environment to be noisy and very busy. They observed this resident to pace and appear tense and anxious, at times on the first day of the inspection. The inspector was informed by the person in charge that members of the management team and facilities team had recently visited the house to review the premises in terms of meeting the number and needs of residents, accessibility and fire safety.

On the first day of the inspection, the inspector observed two residents wishing to spend time in the sitting room. However, they did not wish to spend time together. This was observed to cause distress for both residents. The resident who was using the sitting room was observed to look out into the hall and check where their peer and staff were every couple of minutes. The other resident was observed pacing and moving in and out of their bedroom to see if the other person had moved out of the sitting room. As previously mentioned, the other resident was heard asking permission to use the sitting room before they did as they were aware that their peer liked to watch their favourite television programmes there. Over the course of the evening, staff were observed to be available to them both on every occasion they required support. However, as the day staff and inspector left the centre one

resident entered the sitting room and a negative verbal interaction occurred between two residents. This will be discussed further under Regulation 8: Protection.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The provider had not put effective arrangements in place to meet residents' safeguarding needs. Plans and risk assessments were developed relating to safeguarding and protection; however, these were not proving effective at the time of this inspection.

The inspector reviewed each residents' assessments and plans. As previously mentioned, the staffing supports required were not fully detailed in residents' assessments and plans. In addition, there were discrepancies noted across two resident's assessments, plans and risk assessments in relation to the staffing supports they require. For one resident, additional supports were in place some evenings (until 23:00) to support them to attend a class and socialise. They had risk assessments in place that stated they require 2:1 support for personal care. On the other evenings they were supported to get ready for bed before the day staff finished their shift at 20:00. Staff reported this was their preference, however, there were not enough staff after 20:00 to support them to get ready for bed.

It was recorded in two residents' plans that they were experiencing difficulties sharing their home. This was also described by staff and observed by the inspector during the inspection. In addition, one resident told the inspector about the difficulties they were experiencing. As previously mentioned, the compatibility of residents to share their home had not been formally assessed.

Since the last inspection one resident had been supported to have a number of assessments. They were now accessing the support of a number of health and social care professionals. They were attending appointments regularly to support them with their changing needs. At time time of the last inspection the provider was engaged with the resident and their representative to review the suitability of the designated centre to meet their needs. They had offered the resident a move to another designated centre which they had declined. It remained the case that it was not clearly documented if their needs could be met in this designated centre. It was documented in their assessment of need that the provider was supporting them to look at alternative living accommodation.

Overall, the inspector found that residents' assessments and plans required review in relation to their accuracy and effectiveness. They also required review to demonstrate that residents' needs could be met in this centre, and to ascertain if residents were compatible to share their home.

Judgment: Not compliant

Regulation 7: Positive behavioural support

Residents who required it, had regular access to a psychiatrist, psychologist, mental health nurse or behaviour specialist. Significant efforts had been made to ensure that residents were accessing the supports and services they required since the last inspection. They now had risk assessments and plans which were being regularly reviewed.

The inspector reviewed a sample of residents' plans and risk assessments which outlined proactive and reactive strategies, and included consideration on safeguarding and protection and skills building for residents. These plans outlined steps staff should take to minimise safeguarding risks when residents were anxious or distressed. Staff had completed training and those who spoke with the inspector were aware of their roles and responsibilities and the steps to take if residents were experiencing increased anxiety or engaging in responsive behaviours.

The inspector observed and heard staff encouraging residents to express their feelings and supported them as best they could to manage situations. For example, throughout the first day of inspection staff were observed to implement the steps outlined in two residents' plans to support them during times when they were becoming anxious and overwhelmed. This included discussing how they were feeling, using distraction techniques such as discussing different topics or offering different activities. They were also observed to support them to leave the centre. Overall, the inspector found that the current guidance and controls were not proving effective at times. This is captured under Regulation 15: Staffing and Regulation 8: Protection.

It was reported that there were no restrictive practices in the centre at the time of the inspection. One resident had a restrictive practice management plan on file which showed that a restrictive practice reduction plan had been successfully implemented with the restriction then being removed. This demonstrated that the provider was focused on ensuring the least restrictive practice for the shortest duration.

Judgment: Compliant

Regulation 8: Protection

The findings of this inspection were that the provider was failing to ensure residents were effectively and appropriately safeguarded.

The inspector acknowledges that the provider had implemented a number of additional control measures since the last inspection. These included additional staffing supports at times, comprehensive assessments and input from health and for one resident, information sessions for residents on safeguarding and the changing needs of a peer and a review of restrictive practices. In addition, one resident was offered a move which they declined. Initially a waking staff was introduced but the inspector was informed that this was removed once a risk relating to a resident absconding reduced. However, there was a risk assessment in place for this resident which noted that should this resident leave the centre at night staff would be unable to follow and should contact emergency services.

It was noted in two residents' plans that they were experiencing difficulties sharing their home and that this may be impacting on the third resident in the house. In addition, the inspector reviewed the centre specific risk assessments and residents' individual risk assessments in relation to safeguarding. They had a moderate risk rating attached, indicating a high likelihood and moderate impact. The Chief Inspector was notified of 33 safeguarding concerns in 2024, 27 in 2025 and 8 to the date of the inspection in 2026. The majority of these related to allegations made by residents, negative verbal interactions between two residents and the impact of two residents actions on each other. For example, one resident had preferences in relation the environment. This included how the environment should be at a certain time in the evening. This was not in line with the preferences of their peer as observed on the first day of the inspection. One resident closed the curtains/blinds and turned on the lamps/lights. The other person was observed to then open the blinds/curtains and to turn off the lamps/lights. This was observed to cause upset for both residents and to contribute to a negative verbal interaction mentioned earlier. This was witnessed by the inspector and day staff when they were leaving the centre. Staff supported both residents and the sleepover staff documented and escalated the incident in line with the provider's and national policy.

From a review of the staff training matrix, 100% of staff had completed safeguarding and protection training. As previously mentioned, the staff who spoke with the inspector were aware of their roles and responsibilities and the control measures in open safeguarding plans. They were found to be very knowledgeable in relation to their roles and responsibilities should there be an allegation or suspicion of abuse. They were aware of the control measures in safeguarding plans and discussed these in detail. Some of these controls included staggered mealtimes, one-to-one staffing supports for one resident, and additional 15 hours staffing supports for another resident. However, they discussed some of the difficulties implementing some control measures, including one to one support for one resident who values their privacy and independence and at times when there was one staff on duty.

On the second day of the inspection one resident described the impact of their difficulties sharing their home with their peer. They told the inspector 'its hard to live here'' and ''I get frustrated when …. shouts at me''. They spoke about the actions of their peer and how this impacted them. For example, they spoke of their peer's wishes and preferences around their environment and how this was not their preference. They said this was hard for them to handle. They also spoke about how

this made them avoid spending time in communal areas of their home. In addition, a preliminary screening report reviewed, notes that this person stated "I'm done living with ....". This alleged interaction was heard by staff and not witnessed as they were supporting another resident at the time. This demonstrates that the control measures in safeguarding plans could not be implemented, at times. The inspector reviewed another example of this when documentation relating to a reported safeguarding concerns where it was alleged a peer shouted at the person and called them names. Staff were not present as they were supporting another resident with personal care. In all three residents' safeguarding support plans, a control measure in listed as "staff can offer me 1:1 support if the person causing concern is showing signs of agitation". In addition, in one resident's risk assessment under what resources are required it stated "1:1 support for ... 24 hours a day", and "staff to supervise when with peers and when in communal areas". Due to current staffing levels these examples demonstrated that control measures relating to safeguarding could not be implemented, at times. A number of preliminary screenings and safeguarding plans reviewed referred to the provider reviewing the staffing arrangements to allow for supervision of all residents. This is discussed further under Regulation 15: Staffing.

Residents had money management assessments and plans in place and these detailed their wishes and preferences in relation to the levels of support they required, if any, to manage their finances. The inspector reviewed the arrangements in place for oversight and safeguarding of two residents' finances. These included a log of their income and expenditure, a review of their statements from financial institutions and a log of receipts for their spending. They also had property lists which included their large and valuable items. One resident had decided that they did not wish to log their smaller items such as CD/DVD's and computer games and this was clearly documented in their plan.

Overall, the inspector found that strategies in place to support residents were not effective, and there remained an ongoing risk to residents of further safeguarding incidents occurring, and negatively impacting on their lived experience.

Judgment: Not compliant

Regulation 9: Residents' rights

The inspector found that every effort was being made by the staff team to promote and uphold residents' rights.

Staff were observed to ensure residents' privacy by knocking on their bedroom doors and waiting for a response prior to entering. They were also heard asking for their permission before reviewing their plans or financial records. While speaking with the inspector, staff took every opportunity to speak about residents' interests,

preferences and talents. They spoke about how important it was to them to ensure that each resident was living their best life.

Staff were also observed to encourage residents' independence and ensure they were making choices and decisions over the course of their day. These mostly related to where they wanted to spend their time and what meals or snacks they would like. As previously mentioned, staff were heard reminding residents about their right to access communal areas of their home. They also spoke about their availability to support them, if needed. Residents' access to communal areas was discussed further under Regulation 17: Premises.

A sample of minutes from four residents' meetings held in 2025 and 2026 were reviewed. There was information on display in poster format on rights, safeguarding and complaints. These included pictures of designated officers for safeguarding.

There was an easy-read folder available for residents in the sitting room which included information on areas such as rights, inclusive communication, infection prevention and control (IPC), safeguarding and keeping me safe, complaints, matters relating to sexuality, restrictive practices, positive behaviour support and medicines. At each resident meeting reviewed a reference was made to the availability of easy-read documentation. It was highlighted that staff were available to review them with them, when they wished to.

Residents' likes, dislikes, preferences and support needs were clearly recorded in their assessments and plans. They were supported to develop goals and to plan and take part in meaningful activities daily. Some residents' goals were focused on developing their life and independence skills, taking positive risks and building their experiences in order to identify new hobbies. How residents make choices and decisions in their daily lives was also recorded in their assessments and plans.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 17: Premises	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Kare DC13 OSV-0005750

Inspection ID: MON-0048503

Date of inspection: 10/04/2026

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 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: All residents' assessments of need will be reviewed to clearly identify the required staffing supports before the 17th of July 2026. The staffing levels at night in this location have been increased to one sleepover staff and one waking night staff (8pm to 8am) to ensure that residents could safely evacuate in a timely manner ensuring correct support for all three residents. This commenced on the 4th of May 2026. One individual being supported with 1:1 staffing during the day (08:00 - 20:00) to respond to their changed needs remains in place. There are overall three staff on duty during the day time. Two staff work 8am to 8pm and one staff completes a sleepover from 10am to 10am the following day. This is in place since the 4th of May 2026.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A comprehensive review of the service provided in this location will be completed by the provider prior to the end of June 2026. The staffing levels at night in this location have been increased to one sleepover staff and one waking night staff (8pm to 8am) to ensure that residents could safely evacuate in a timely manner ensuring correct support for all three residents. This commenced on the 4th of May 2026. An additional resource of a computer which is portable will be sourced by the team through the IT team by the June 2026. A review of the transport available to be accessed by the team in this location in conjunction with the transport lead for Kare. If required, following this review a business case will be submitted to the HSE to access additional transport. This will be completed by the end of August 2026.	

A compatibility assessment will be completed for each of the three residents in this location by the 17th of July in 2026 by an independent person in conjunction with staff team. The outcome of the compatibility assessment will be discussed at the risk escalation forum on the 28th of July 2026.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
A smaller table that has a drop leaf section will be sourced for the dining room to enhance the physical space in the kitchen. This will be in place by the end of June 2026.
The OT team are conducting a review of the physical space in the first week of June 2026 and the learning from this review will be action accordingly. A review of the counter tops and under counter partitions will be conducted to create more space for wheelchair to go under the sink and associated action completed by the end of June 2026.
All residents' assessments of need will be reviewed to clearly identify the required staffing supports before the 17th of July 2026. A review of the assessment of need and consultation with the three residents as part of the compatibility assessment will be conducted. The resident will be supported by staff to create an environment that meets his needs and provide space to allow quiet time.

A feasibility study will be conducted on site to review any opportunities to develop further physical space for residents to have additional space for recreation purposes. The study will be completed by the end of September 2026. If opportunities are identified the necessary plan, including funding, as well as local planning application will be completed.

There are regular service user meetings in this location where the discussions occur about providing space needed. The next meeting for the group is scheduled for the start of June 2026.

Regulation 5: Individual assessment and personal plan	Not Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
An application for Independent advocacy will be made for each resident, dependent on their consent, in order to support them to make an informed decision regarding their future living arrangements. This application will be completed by the 19th of June 2026.

The provider will conduct a full review of all risk assessments developed in this location relating to safeguarding and protection by the end of June 2026.

The staffing levels at night in this location have been increased to one sleepover staff and one waking night staff (8pm to 8am) to ensure that residents could safely evacuate in a timely manner ensuring correct support for all three residents. This commenced on the 4th of May 2026.

A compatibility assessment will be completed for each of the three residents in this location by the 17th of July in 2026 by an independent person in conjunction with staff

team. The outcome of the compatibility assessment will be discussed at the risk escalation forum on the 28th of July 2026.
All residents' assessments of need will be reviewed to clearly identify the required staffing supports before the 17th of July 2026. A review of the assessment of need and consultation with the three residents as part of the compatibility assessment will be conducted. The resident will be supported by staff to create an environment that meets his needs and provide space to allow quiet time.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
An additional safeguarding report was completed on the 21st of May 2026 where one individual indicated a request to move to alternative accommodation which they named. This was the first time this resident expressed this wish. They will be supported to review the option to move to alternative accommodation by the staff member who will be conducting the review of the assessment of need. This will be completed prior to the end of June 2026. Any planned move will be completed following a comprehensive compatibility assessment for all individuals involved.

A review of restrictive practices in place will be completed in conjunction with the restrictive practice oversight group in this location on the 8th of June 2026.

Risk assessments for all three residents will be reviewed and updated by the end of June 2026 to ensure all current risks are accessed effectively.

The location risk register will be updated to ensure all current risks are recorded, rated and controlled where possible. This will be completed by the end of June 2026.

A compatibility assessment will be completed for each of the three residents in this location by the 17th of July in 2026 by an independent person in conjunction with staff team. The outcome of the compatibility assessment will be discussed at the risk escalation forum on the 28th of July 2026.
The staffing levels at night in this location have been increased to one sleepover staff and one waking night staff (8pm to 8am) to ensure that residents could safely evacuate in a timely manner ensuring correct support for all three residents. This commenced on the 4th of May 2026.

All residents' assessments of need will be reviewed to clearly identify the required staffing supports before the 17th of July 2026. A review of the assessment of need and consultation with the three residents as part of the compatibility assessment will be conducted. The resident will be supported by staff to create an environment that meets their needs and provide space to allow quiet time.

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.	Not Compliant	Orange	17/07/2026
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	17/07/2026
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	30/09/2026

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	30/09/2026
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	31/08/2026
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	31/08/2026
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried	Not Compliant	Orange	28/07/2026

	out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.			
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	28/07/2026
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	28/07/2026