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 DC6
Name of provider:	KARE, Promoting Inclusion for People with Intellectual Disabilities
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	04 June 2025
Centre ID:	OSV-0001983
Fieldwork ID:	MON-0046836

About the designated centre

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

Kare DC6 is registered to provide support for up to two adults over the age of eighteen years with an intellectual disability. The centre is located in Co. Kildare and is a dormer bungalow located in a rural setting. There are single bedrooms, sitting rooms and a kitchen dining area, suitable bathroom facilities and homely external rear gardens accessible to residents. Residents are supported by social care staff during the day and night. Residents staying in Kare DC6 may have a broad spectrum of support needs which range from requiring minimum support with daily activities and personal care to those requiring a high level of support with daily activities and personal care. The centre has exclusive use of two vehicles to provide community access.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

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
Wednesday 4 June 2025	10:45hrs to 18:00hrs	Gearoid Harrahill	Lead

What residents told us and what inspectors observed

The inspector had the opportunity to meet two service users and spoke with their support staff, as well as review living spaces, care and support plans and resident consultation notes, to use as evidence to indicate the lived experience of people living in this designated centre.

One service user had just finished their respite break as the inspector arrived, however their direct support staff member was available to describe what they had been doing in the centre and community, before they too left the centre. At the end of the inspection, the inspector met a service user who had arrived for their first night of respite, who gave a smile and a thumbs-up before returning to watching a movie on the couch. The inspector also met another service user who was on their way out to run errands with staff and spend time in the community. The resident indicated they were in a good mood by giving staff a hug, and smiling and laughing as staff supported them to describe their plans and choices for what to do when out for the day. The inspector observed staff demonstrating good knowledge of the resident's needs and interests and speaking with them in a casual, friendly and respectful manner.

Previously registered to accommodate four service users for short respite breaks, this designated centre had been reconfigured in 2025 to split the house in two halves divided by a coded door. On one side, regular respite service operated for one person at a time. In the other side, one service user was accommodated full-time as an interim measure following an emergency discharge from another designated centre due to incompatibility with a shared accommodation. The remaining bedrooms had been refurbished to service as a temporary living room and a dining area with a kitchenette.

The inspector observed that the reorganised space was suitable as a short-term measure to provide living space to this resident. The resident had access to a stocked fridge and cabinets, a toaster, microwave and kettle. They also had a sitting area with their TV, music and DVDs set up, and a space to draw. The resident was also supported to furnish the space with photos, choice boards and information on social and community events and calendars.

The inspector was provided evidence to indicate that the resident had overall been doing well in their single living space since they were admitted in March 2025. The resident was supported to continue to attend discos and social clubs they enjoyed in their previous setting. They were supported to meet up with family at least weekly, and enjoyed using the activity shed in the centre and accessing the community. This resident had exclusive use of a vehicle and support staff who could drive, to ensure that they had optimised flexibility to get out of the centre as and when they wished.

Residents' bedrooms and communal spaces had quick response (QR) codes posted which led service users to online surveys, through which they could comment on

what they liked or did not like about the service. The inspector was provided a spreadsheet which was populated by these responses, and reviewed 19 responses from February to June 2025, which included positive commentary on staff, activities and meals. Some residents commented that they wanted to stay on weekends more often. As the capacity for respite stays had decreased, the inspector observed evidence that residents and their representatives were advised of alternative options, and those with priority arrangements were supported to continue with same.

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

The purpose of this unannounced inspection was to monitor and review the arrangements the provider had in place to ensure compliance with the Care and Support regulations (2013), follow up on solicited and unsolicited information received by the Chief Inspector of Social Services, and to verify assurances received from the provider related to an emergency admission and associated change in the centre's service and layout. The inspector found that the provider had amended the resources appropriately to meet the revised needs of the centre, and had maintained oversight following the new admission to ensure the centre was adequately meeting all residents' support needs.

Staff demonstrated a good knowledge of their roles, and of the interests and activities of the service users. Local and provider-level audits indicated areas in which the service required action to improve adherence to regulation, standard of care, best practice and provider policy. The team was resourced by an experienced person in charge, and while some improvement was required in the structure of the supervision cycles per the provider's policy, staff including those on probation noted that they felt supported in their role by the management. The inspector observed good examples of the team ensuring that links between audits, team discussions, incidents and observations by the staff team were cohesive and reflected each other for consistent and up to date information to guide the centre operation. Records in general were complete and clear, however some improvement was required to ensure that the complaints log was up to date and the outcomes and actions from same clearly documented for use by the person in charge.

Regulation 15: Staffing

Staffing support needs for this designated centre had been revised to reflect the

change in the service offered. In order to mitigate the potential impact of a break in support continuity, some staff members had transitioned with the resident living in this centre full-time and were now part of this team and reported to this centre's management. Staff were encouraged to work with both the full-time resident and the residents attending for respite short breaks. The inspector observed that, where required, service users were supported by staff on a 1:1 or 2:1 basis. The inspector reviewed worked rosters for the previous six weeks and found these to be clear and complete on staff working in the centre and the shift patterns they worked.

Judgment: Compliant

Regulation 21: Records

In the main, documentary evidence required to determine regulatory compliance was readily available for inspection and could be retrieved by the person in charge as necessary. Information related to the support needs of the residents and the operation of the designated centre were kept up-to-date and have been revised to reflect changes in the circumstances of each. Some gaps observed in records are noted under their respective regulations.

Judgment: Compliant

Regulation 23: Governance and management

Prior to this inspection, at the time when the nature of the service was changed to provide full-time accommodation, the inspector sought written assurance from the provider on how they were assured that this centre would be safe and suitable to meet the needs of the full-time resident and those of the respite service users, including how they would be provided with a safe environment and staff who were supported to meet their assessed needs. In the main, the risk controls set out by the provider had been observed to be implemented in practice during this inspection.

The inspector reviewed the provider's policy on staff supervision and performance management, dated September 2023, and records of performance management and development for a sample of staff members. This policy directed staff members and their line manager to set out competency and career development goals which were specific and measurable, in a planning meeting, and to hold at least one interim meeting during the year to measure the progress of achieving these goals, closing the year with a reflection on what was successful and where challenges arose. The inspector reviewed supervision records for six staff members, one of whom was on their 12-month probation period. For the five staff who were fully contracted to the provider following completion of probation, only one of these had any record of

attendance at a supervision or performance management meeting, and that record had not been updated in a year following the last objectives set out.

However, staff who were on probation were supported to attend regular meetings, and records indicated where staff had either completed this process or not been passed following their final review. The inspector met one newly-recruited member of staff who felt well-supported in their role, and both they and their manager commented on where they were performing well in their role and what objectives they wished to work on. The inspector also reviewed the minutes of team meetings. These discussed matters related to adverse incidents or accidents, audit findings, medicine errors and updates on discussions in previous meetings.

The inspector reviewed the report from a provider inspection in April 2025. In the main, findings were centre-specific with timely and specific actions set out to bring the service into compliance with regulatory requirements and provider policy.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The provider had submitted a revised statement of purpose to the Chief Inspector of Social Services to reflect changes made to the service and layout of the designated centre.

Judgment: Compliant

Regulation 34: Complaints procedure

The inspector reviewed records available for complaints made by or about the designated centre by service users or their representatives. The inspector requested information on a sample of six complaints noted as received to date in 2025.

Some of these were being resolved locally with learning or action taken on foot of matters raised, in relation to quality of support, attention to residents' personal care and hygiene supports, consistent delivery of residents' health and social care needs and communication related to respite coordination. In some instances, the complaint had been escalated for review at provider-level management to ensure a timely response. In some of these entries, the inspector observed gaps in information related to the correspondence with the complainant, the outcome or actions being taken and the satisfaction status of the complainant. For some complaints, the complaints manager could not locate information related to the complaint. The inspector observed that improvement in record-keeping of complaints logs had been identified by the provider as an area in which they were required to improve.

Judgment: Substantially compliant

Quality and safety

The inspector found evidence from speaking with the residents and their support staff, reading documents and observing routines that the residents were generally safe and happy in this house and supported in their choices and plans. The residents were observed to enjoy varied and meaningful recreation opportunities in the house and community. The provider had ensured that care and support plans for residents' assessed needs were subject to routine and as-required review by the multi-disciplinary team, and had been updated to reflect changes in needs and circumstances. Guidance to staff in supporting the residents in personal care, food and nutrition, exercises, pain management and support during times of upset or distress were person-centred, evidence-based and developed with input from relevant clinicians.

The change in the centre layout was suitable as a temporary arrangement and ensured that the resident admitted as an emergency did not lose access to their food and kitchen, garden and vehicle facilities. Some maintenance issues required attention in the house, as did a number of fire safety observations which will be described later in this report. Outside of these, risk management and assessments were detailed, kept current and were informed by adverse events, audits and concerns raised.

Regulation 17: Premises

The rearrangement of the premises was found to be suitable as a short-term arrangement only, for the resident being accommodated on a full-time basis. The resident was provided with a small living room and kitchenette which was equipped with small appliances. The resident had sufficient access to bathroom and garden space with limited restrictive practices applied. The person in charge advised the inspector that prior to the living room and kitchenette being returned to being active bedrooms, they would be redecorated to replace and refresh furniture and old wardrobes.

In the rest of the house, living rooms and garden spaces were clean, well-maintained and suitable for the number and mobility needs of service users. The respite bedroom was equipped with equipment that may be used to support activities of daily living and accessible bathroom facilities. The premises included an ancillary standalone room accessible from the back garden which could be used as an activity or hang-out spot with space to watch movies or play games. The inspector walked the premises and observed some areas requiring maintenance

work, including kitchen cabinet doors which were damaged, a bathroom sink which required resealing to the wall, and a ceiling which was flaking and requiring repainting.

Judgment: Substantially compliant

Regulation 18: Food and nutrition

The inspector observed that both the main kitchen and the smaller kitchenette for one resident were sufficiently stocked with healthy food, drinks and snacks. Residents could select their dinners on arrival and there were options if residents wanted different choices. A folder of menus was available in the hall for when residents were supported to have an occasional takeaway night.

The inspector reviewed examples of risk assessments and feeding, eating, drinking and swallowing (FEDS) assessments where choking or aspiration risk had been identified. Choking risk controls were resident-specific and provided sufficient guidance on food types which were safe to be available without restriction.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector reviewed a risk management policy date September 2023 which set out general risk control measures for risks identified under the regulations. The inspector also reviewed a sample of needs assessments and incident records, and the register of active risks in this designated centre. The inspector found that where an action following adverse incidents or resident assessments was to conduct a risk analysis on specific matters, these had been done in a timely fashion. Risk ratings had been revised or escalated to reflect changing circumstances, or amended where new or revised risk controls were required. In the main, incident logs were clear and tied into the risk register and relevant staff team discussion and resident care plans.

Judgment: Compliant

Regulation 28: Fire precautions

The inspector walked the premises and observed that the centre was equipped with suitable fire-fighting equipment and emergency lighting, which were subject to regular servicing and certification. Bedroom, kitchen and living room doors were fire

rated and fitted with self-closure mechanisms to slow spread of fire or smoke. However the provider had conducted an audit on fire safety in April 2025 in which it was identified that attic spaces were not adequately fire-proofed. The inspector observed that there had been no risk assessment conducted for a staff sleepover space which was located in an inner room.

The inspector observed a laundry room with a washing machine and tumble dryer. This room's door was observed to be open all day with no mechanism for it to close automatically and provide containment if fire or smoke originate in this room. This was important as this door was on an identified evacuation route on the emergency plan, which was also the route for staff to get to one resident's bedroom from the back door or from inside the house. While this bedroom also had an external door to evacuate a wheelchair or bed, it required a key for staff to enter from outside and there was no emergency key available when inspected. The inspector brought this to the attention of the person in charge, who reported this to the facilities team to be rectified so that an emergency key would be in place before this exit door would be locked shut again.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed the assessment of social, personal and health care supports for residents, in full for a resident living in the centre full-time, and in part of regular respite users based on information observed from identified needs and risks. The inspector found that care plans had been created based on identified needs and person-specific risks, and had been kept up to date to reflect changes in needs and circumstances, barring some minor text changes to reflect the most recent recommendations. Care plans were informed by identified risks and the residents' histories, as well as complaints, adverse events, audits and recommendations from the multidisciplinary team. For information which was referred to more frequently, such as daily exercises and activities, this information was readily available to staff and residents as necessary.

Judgment: Compliant

Regulation 6: Health care

In reviewing risk analyses, assessments of support needs, and resident personal plans, the inspector observed evidence that residents were in receipt of timely review and recommendations from relevant healthcare professionals, and that said assessments and guidance documents were informed by clinical input. The inspector observed review of guidance provided to the centre team from the speech and

language therapist, physiotherapist, psychiatrist, mental health nurse, and behavioural specialist as required. The inspector observed examples of residents being supported to attend doctor or dentist appointed as required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The inspector reviewed a sample of positive behaviour support planning and staff guidance on how to identify and respond to actual or potential events in which a resident may respond to anxiety or distress in a manner which poses a risk to themselves or others. The inspector observed that this guidance was detailed and person-centred on the proactive and reactive strategies to be followed by staff, and was kept up to date with input from the relevant clinicians and based on trends in adverse incidents.

The inspector observed examples of the provider working to retain a restraint-free environment in this designated centre. For example the driveway gate being latched closed instead of being locked had been identified as sufficient to mitigate the risk related to road safety. There was no identified need to separate the garden when separating the house as this was not linked to the associated risk. Where food was restricted due to identified choking risk, this was limited only to specific food types.

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	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant

Compliance Plan for Kare DC6 OSV-0001983

Inspection ID: MON-0046836

Date of inspection: 04/06/2025

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Leader has scheduled performance management with the required staff in Kare DC6, during their performance management, leader and staff are agreeing on their interm and end of year meeting date and marking it on a calender to ensure good one on one supervision. These initial meetings will have taken place by the end of July 2025.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: Leader will ensure that the communication that has occurred following complaints with each person has the necessary documentation and follow up records done as per complaints policy on the CID internal database. This will be completed by the end of July with support from the Complaints Officer in Kare.	
Regulation 17: Premises	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Premises: A number of doors have been water damaged due to SU water play. In the short term we looked at replacing the doors but were unable due to age of existing kitchen. The kitchen is programmed to be fully replaced as part of sinking fund cluster works for completion Q1 2026. Bathroom sink which required resealing to the wall - Leader submitted on track plan on 02.07.25 to be completed by Facilities by the end of September 2025.	

Ceiling wall which was flaking and requiring repainting - Leader submitted on track plan on 02.07.25 to be completed by Facilities by the end of September 2025.	
Regulation 28: Fire precautions	Not Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: A risk assessmsent for sleep over staff space was conducted on the 3rd of July 2025. Fire rated attic hatches completed June 2025. The hatch in the kitchen has been upgraded and is now fire proof. This was completed in June 2025. Laundry room door will be fitted with a mechanism to close auto. Leader submitted on trackplan 02.07.25 to be completed by Facilities by the end of July 2025. The external door to evacuate which required a key has been addressed by an Emergency key box is in place. Emergency procedure training undertaken with all staff. This was complete prior to the 7th of July 2025.	

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 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.	Substantially Compliant	Yellow	30/09/2025
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Substantially Compliant	Yellow	31/07/2025
Regulation 28(3)(a)	The registered provider shall	Not Compliant	Orange	31/07/2025

	make adequate arrangements for detecting, containing and extinguishing fires.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	31/07/2025
Regulation 34(2)(f)	The registered provider shall ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	31/07/2025