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

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| Name of designated centre: | Newmarket Residential |
| Name of provider: | Brothers of Charity Services Ireland CLG |
| Address of centre: | Clare |
| Type of inspection: | Unannounced |
| Date of inspection: | 10 July 2025 |
| Centre ID: | OSV-0005528 |
| Fieldwork ID: | MON-0045605 |

## About the designated centre

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

In this centre the provider aims to provide, in consultation with residents and their families, a safe and welcoming home environment for residents in their own community. The support provided is tailored to specifically meet each person's needs, to provide opportunities to enjoy independence while still connected to family and home and, to participate in social activities, hobbies and community engagement that is suitable, meaningful and age appropriate. Residents receive an integrated type service where both residential and day services are provided from their home. Support is provided by a team of social care staff with management and oversight provided for by the person in charge supported by a social care worker. Each apartment is staffed by day and at night one staff on sleepover duty provides support as needed for both apartments. The premises consists of two separate adjacent, ground floor apartments with accommodation provided in each apartment for two residents.

**The following information outlines some additional data on this centre.**

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| 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 10 July 2025 | 09:30hrs to 17:30hrs | Mary Moore | Lead |

## What residents told us and what inspectors observed

This inspection was completed by the Health Information and Quality Authority (HIQA) to follow-up on the findings of the previous inspection undertaken in August 2024. Those inspection findings were not satisfactory and in response the Chief Inspector of Social Services attached a condition to the registration of this designated centre. That condition required the provider to address the non-compliance found within a specified timescale.

The inspector found much improved systems of local management and oversight. However, while there was evidence that the provider continued to try to resolve matters in relation to the unsuitability of the premises, the absence of compatibility between residents and the expressed will and preference of two residents, these matters were not resolved. The provider did try to manage the impact of these matters and changes the provider had made such as increasing the evening staffing levels did help. However, these matters continued to impact on the quality and safety of the service experienced by residents and the level of compliance found.

The designated centre is comprised of two separate but adjoining ground floor apartments with two residents living in each apartment. The apartments are part of a larger complex of apartments on a main access route into a busy rural town. There is a wide pavement to the front of the properties and a car park that services the overall complex to the rear. Three of the residents are from the town or general area where they are well-known and have important personal and family connections. However, different factors such as the space available in one apartment and expressed preferences as to where residents would prefer to live and who they would like to live with if they did want to share, meant that the designated centre was no longer suited to the needs of all of the residents. This and how it impacted on resident safety and quality of life will be discussed in the main body of this report.

The inspector arrived unannounced. The inspector called to one apartment and was greeted by a regular member of the staff team. The staff member advised the inspector that one resident was having a lie-in and one resident was at home with family. The staff member discussed the circumstances of that home visit and confirmed that the resident was due to return to the centre at the weekend as the resident had a plan to attend a heavy vehicle show with staff. On previous inspections of this centre the resident had discussed this interest with the inspector and spoke of how much they enjoyed attending this annual show. The resident who was having a lie-in had plans to visit a local hotel for afternoon tea.

The inspector went to the second apartment and was greeted by a staff member and a resident. The resident was in great form and was waiting for the postman as they were expecting a package from a friend. The resident said that they were enjoying the good weather and would go out later in the day with staff. The second resident was also up and was sitting in the kitchen; a second staff member was in

the kitchen. The resident told the inspector about their trip to a religious shrine the previous day where they had met with a friend and their friends family. The resident had enjoyed their day, said that they were not tired and they would go out again later in the day with their supporting staff member. The resident and the staff member discussed the plan they had to travel to a traditional music festival that was ongoing elsewhere in the county. The resident said that they would take their mobility aid with them and dress appropriately for the weather. The resident discussed with the staff member arrangements such as their preference to take a packed lunch with them. The resident said that they wanted to get a photograph printed onto a card while they were out. The inspector noted that prior to departing the designated centre the staff member came to the staff office to collect the card.

Both residents chatted easily with the inspector about a range of topics including how they liked to spend their time and how they were supported to maintain contact with family, friends and personal relationships that were important to them. One resident even brought up in a very practical way discussions they had had about their end-of-life wishes and plans.

The inspector saw that each resident had individualised support from staff this enabled them to make these different choices and to do different things. The inspector found much improvement in how the provider managed staffing resources so as to improve continuity and the consistency of the support provided. However, the provider confirmed that additional staffing put in place was limited to three evenings a week and was not funded by the providers funding body.

The person in charge who facilitated this inspection could clearly describe and demonstrate to the inspector how they managed and maintained oversight of the designated centre. This was also evident in records seen such as the improved frequency of staff meetings and the good staff attendance at these meetings. While there were residual gaps, overall the inspector found improved standards of record keeping and meaningful review of these records by the person in charge.

The provider had, since the last HIQA inspection, completed the annual review and two reviews, at six-monthly intervals, of the quality and safety of the service. These internal reviews were generally positive including the positive feedback received from residents and their representatives. Three representatives had completed and returned questionnaires. The respondents had rated the service from good to excellent and reported their experience of the service as positive and improved with everything reported to be going well. There was no evidence on ongoing complainant dissatisfaction as found at the time of the last HIQA inspection.

The feedback provided by residents was also positive but the inspector saw that one resident had in their feedback again stated that their personal accommodation was too small and their peer relationship was not always a good one. The residents the inspector met with did not raise any specific concerns on this occasion with the inspector (having done so previously). However, the person in charge and the community manager confirmed that how residents felt about their living arrangements and what residents wanted had not changed. For example, one resident was reported to have clearly expressed through their independent advocate

where they wanted to live and that they wanted to live on their own in any future living arrangement.

Actions taken by the provider since the last HIQA inspection included meetings with their funding body, with housing associations, the commissioning of an external assessment, engagement with residents and their representatives. The provider was exploring different options and plans to provide residents with what they wanted and needed. However, there were obstacles such as planning challenges and the community manager reported that the provider had not received any additional resources for the service from its funding body despite having made reasonable efforts to secure the resources needed.

In summary, the inspector found improved systems of management and oversight in the designated centre and efforts made by the provider to manage the absence of compatibility between the residents. However, until the capacity of the designated centre was reduced and residents were provided with living arrangements suited to their needs and preferences there would be ongoing impacts on resident safety and quality of life.

The next two sections of this report will discuss the governance and management arrangements in place, the improvement that was found but also the areas where the governance and management arrangements in place did not ensure and assure the appropriateness, quality and safety of the service.

## Capacity and capability

The management structure was clear and there was clarity on individual roles and responsibilities. There was evidence of improved management and oversight. However, the provider had not succeeded in materialising the plans it had to reduce the occupancy of the service and to provide residents with services better suited to their needs and wishes. The provider reported that the centre was not adequately resourced in terms of how it currently operated but also in relation to progressing the plans to relocate residents.

The day-to-day management and oversight of the service was delegated to the person in charge. The person in charge had support from a social care worker. It was also evident that the community manager consistently supported and monitored the effectiveness of the local management systems and maintained oversight of the relocation plans. This was evident from records such as risk assessments, assessments of needs and updates in relation to meetings held with different stakeholders.

The person in charge had responsibility for a day service that was a distance from the designated centre. The community manager advised the inspector that this was not a long-term arrangement and was to cease in the coming weeks.

The person in charge endeavoured to be present in the designated centre at least three days each week and was clearly well-known to the residents and their representatives. The inspector noted during the inspection how residents sought out the person in charge by name and received the attention and reassurance that they needed. The inspector saw how the staff members on duty approached the person in charge, reported and updated the person in charge on matters arising such as a residents request to change their weekend plans.

The person in charge described how they supported, supervised and mentored staff. For example, the person in charge delegated tasks to the social care worker such as the preparation and maintenance of the staff duty rota but maintained oversight of the rota as the social care worker was new to this role.

The inspector reviewed the current and past staff duty rotas and saw the improvements that had been made such as the reduced crossover of staff between different services and the allocation of additional hours to staff. These measures improved continuity of staffing and the consistency of the support provided. Additional evening staff support had also been put in place. However, this support was limited to three evenings each week in one of the apartments and did not fully resolve the absence of compatibility between residents including the risks that could present if one staff member was on duty.

The inspector reviewed the staff training matrix and saw that good progress had been made in ensuring staff attendance at training. Centre and resident specific training had also been provided to the staff team.

The inspector reviewed the minutes of three staff team meetings held since February 2025. The person in charge facilitated each of these meetings and there was much improved and good staff attendance at the meetings. Staff engaged well with the meetings and did voice any concerns they had about the quality and safety of the service such as the adequacy of the evening staffing levels.

As discussed in the opening section of this report the provider had completed the provider-led quality and safety reviews as specified by the regulations. The reviews provided for consultation with staff, residents and their representatives. Where suggestions for improvement were made in the feedback received, the inspector saw the actions taken by the person in charge in response such as the introduction of an additional support and care checklist.

The provider-led reviews acknowledged the ongoing efforts to address each residents living arrangements and the fact that this was not yet addressed. Different factors impacted on the progression of the provider's plans but one resident's relocation plan could not progress without additional resources and the inspector was advised that these resources were not available. The impact on residents of their current living arrangements will be discussed in the next section of this report.

## Regulation 14: Persons in charge

The person in charge worked fulltime and had the experience, skills and qualifications needed for the role. The person in charge described and demonstrated to the inspector how they planned, managed and maintained oversight of the designated centre. The person in charge was accessible to residents, staff and residents representatives. This was evident from what the inspector observed and read.

Judgment: Compliant

## Regulation 15: Staffing

The provider had improved the arrangements for the management of staff resources and had also put some additional evening staffing in place. However, there were ongoing concerns for the adequacy of the existing staffing resources and active business cases seeking additional one-to-one support for residents.

The inspector saw that planned and actual staff duty rotas were in place. The rota was well maintained with minimal staff changes noted. There was evidence of improved continuity and consistency of staffing with staff members working more hours in the designated centre. There was good continuity of staffing evident in the duty rotas from April 2025 to July 2025 when these were compared by the inspector.

The provider sought to manage the limitations of the premises and the different needs of the residents by providing additional evening time one-to-one staff support up to 20:00hrs or 21:00hrs. The person in charge reported that this had had a positive impact. However, this additional support was only available three evenings each week in the apartment where residents had the highest needs and associated risks in relation to their physical and emotional being. This meant that there were ongoing constraints and concerns as to how one staff member could adequately and safely support both residents if they were out together in the community. For example, in relation to the risk for seizure activity and the risk for behaviour of concern. These residents could and did make different choices and this had to be negotiated when there was only one staff member on duty as it was not safe for either resident to stay in the apartment without staff support. This was evident from discussion and from records seen such as the providers own risk assessments and the staff meeting minutes. Staff spoken with described how this negotiation could be challenging as a resident might struggle to understand why their peer did not want to do the same thing as them and might want to stay in the apartment rather than going out.

Judgment: Not compliant

## Regulation 16: Training and staff development

The inspector reviewed the staff training matrix and was assured there was good oversight of staff training needs and staff attendance at training. Training specific to the needs of residents and the centre was provided.

The inspector saw that there was a training record in place for each staff member listed on the staff duty rota. Training was completed and was in date for safeguarding adults from abuse, responding to behaviour that challenged including de-escalation and intervention techniques, fire safety and the administration of medicines including rescue medicines that were prescribed.

Site specific training had been provided for staff in supporting residents to eat and drink safely and in first aid. The person in charge was re-scheduling a third session of this training for staff who were not employed when the previous training sessions had been facilitated. The training record however indicated that the majority of staff currently working in the centre had completed this training.

The inspector also saw from records seen that the positive behaviour support team liaised directly with staff and supported staff on the strategies for the prevention and response to behaviour of concern.

Centre specific fire safety training was completed on the day of this inspection by an external trainer with five staff and two residents participating in the training. The trainer modified the training to the sensory needs of the residents and reassured a resident that the alarm did not need to be sounded.

Judgment: Compliant

## Regulation 21: Records

Much improvement was found in the creation, maintenance and availability of records. The inspector was provided with any of the records requested to inform and validate these inspection findings. For example, the assessment of the resident's needs and the plans put in place based on the findings of the assessment. Records of the ongoing assessment, treatment and medical care provided to residents were in place. The staff duty rota and staff training records were properly maintained. There were some gaps in the recording of incidents. This is addressed in Regulation 26: Risk management procedures.

Judgment: Compliant

## Regulation 23: Governance and management

There was evidence of improved systems of governance and oversight. It was also evident from discussions and documents seen by the inspector that the provider had plans and was trying to progress those plans so as to address the issues in the designated centre that impacted on the appropriateness, safety and quality of the service residents were provided with. These plans included the provision of alternative living accommodation for two residents, a reduction in the overall capacity of the designated centre and changes as to who residents lived with where there was a shared living arrangement.

However, these issues were not addressed and there was no definitive time-frame by which the different plans could be delivered by. For example, the inspector saw from records seen that planning challenges had arisen that had delayed the plan for a local housing development.

One resident wanted to move back to a different town where they had spent much of their life. The inspector was advised that suitable housing had to be sourced and a full funding package was needed to establish the service for the resident. The provider had submitted business cases for this new service but also in relation to the resident's current service. The inspector was advised that no additional resources had been received in relation to residents' current needs, changing and future needs.

The expressed preferences of the residents were not based simply on resident wishes. Their current living arrangements were impacting on the safety and quality of their service.

Judgment: Not compliant

## Regulation 34: Complaints procedure

The person in charge confirmed that there were no new or active complaints and all previous complaints were satisfactorily resolved. The inspector saw that this concurred with the findings of the most recent provider-led review.

The inspector also noted that a previous complainant had provided feedback as part of the provider-led annual review. Their feedback was positive with no residual or new dissatisfaction with the service noted.

The inspector saw and noted that residents were spoken with, had access to and readily approached the person in charge and the community manager. Residents were supported to access and utilise the services of an independent advocate.

Judgment: Compliant

## Quality and safety

There were positive outcomes for the residents living in this designated centre. For example, the designated centre was close to home for three residents in a town where they were well known and where they had ready access to home and family. Residents were supported to maintain these and other relationships that were important to residents. Residents had the opportunity to be visible and meaningfully engaged in activities and events that they enjoyed. Since the last inspection there was noted improvement in systems such as in personal planning and the oversight of incidents. However, fundamental matters in relation to the limited space in one apartment and the shared living arrangements in both apartments that were not working well, impacted on resident safety and quality of life. These matters were not, as discussed in the previous section of this report addressed.

In response to the findings of the last HIQA inspection (completed in August 2024) the provider had arranged for an assessment, by an external appropriate person, of the living arrangements in each apartment and of each residents lived experience. That assessment validated how those living arrangements were impacting negatively on the lived experience of each resident. While there were nuanced differences between each apartment the assessor reported on matters such as the evident lack of space and privacy in one apartment, the inequitable sense of ownership over the available communal space and how one resident's bedroom had become as a consequence their primary living space. While there were more positive aspects to the relationship between residents in the other apartment, changes in relation to what residents wanted were acknowledged and that living arrangement was described as no longer tenable.

The lack of space and privacy was first voiced to HIQA by a resident in May 2023 and reiterated in August 2024. The person in charge and the community manager confirmed that how residents felt about their living arrangements and what residents wanted had not changed. For example, one resident had clearly expressed through their independent advocate in January 2025 where they wanted to live and that they wanted to live on their own in any future living arrangement. This was based on the residents own experience and learning as the resident has been through two successive unsuccessful shared living arrangements due to compatibility issues.

There were serious consequences to the current unsuitable living arrangements. The provider had in late 2024 notified the Chief Inspector of a safeguarding incident. It was accepted that the lack of space and privacy in which to receive visitors and the facilitation of a visit in a bedroom was a significant contributing factor to this incident.

It was clear from the above that the arrangements in the designated centre were

not suited to the needs of the residents. In terms of the day-to-day assessment of and planning for meeting residents needs improvement was found. The person in charge had sound knowledge of each resident's needs, preferences and changing personal circumstances and how these changes had the potential to impact on resident well-being. For example, residents had experienced recent personal losses and bereavements. The person in charge ensured that residents had access to the healthcare services that they needed such as speech and language therapy, neurology and psychiatry. Assessments were underway in relation to how appropriate supports such as bereavement counselling would be.

The personal plan reviewed by the inspector contained details of these reviews and plans of support and care. The improved continuity of staffing meant that it had been possible to introduce the role of personal planning key-workers. The resident had signed their name to confirm their input into their plan while staff had recorded that the resident had said that they wanted a personal plan as the plan supported them to do things that they liked.

Overall, the inspector found that the standard of assessment and planning was much improved and there was good continuity between different plans of support and different systems such as between the personal plan, the risk register and the minutes of the staff team meetings. However, based on observations of this inspection there was clearly a need to review the effectiveness and implementation of a safe eating and drinking plan.

The person in charge described and records seen confirmed good and consistent input from the positive behaviour support team who met directly with residents and with the staff team. The inspector saw a positive behaviour support plan that was most recently reviewed in May 2025 following engagement with the staff team. The inspector tracked four behaviour of concern records and saw that on each occasion staff had provided good detail that would be sufficient to review why the behaviour may have occurred and how effective staff responses were.

Improved systems were in place for the identification, management and ongoing review of risks and incidents. For example, the inspector saw from the risk register that the person in charge and the community manager maintained and updated centre and resident specific risk assessments such as the risk posed by the limited space in one apartment and the absence of compatibility in both apartments. The person in charge reviewed incidents that had occurred, corrective actions were taken and learning from incidents was discussed with staff. However, there was evidence that there was still some under reporting of incidents. This would impact on how the provider monitored for example, the effect of behaviours of concern on peers.

## Regulation 17: Premises

HIQA inspections completed in May 2023 and August 2024 have found that the design, size and space available in one apartment are not suited to the number of or

the needs of the residents living in that apartment. Given the available facilities such as the open plan communal-dining-kitchen space that was shared by both residents and the staff member on duty, residents were required to live in close proximity to each other. This arrangement exacerbated their differences and limited the opportunities that they had for privacy and for time alone. One resident's bedroom was compact and was used as a sleeping and recreational space by the resident. Their peers bedroom was of a suitable size and it was three square metres larger than the other residents bedroom.

An independent assessment commissioned by the provider since the last HIQA inspection confirmed the limitations of the apartment and the impacts such as the anxiety experienced by one resident. That assessor reported on matters such as the evident lack of space and privacy in one apartment, the inequitable sense of ownership over the available communal space and how one resident's bedroom had become as a consequence of such factors their primary living space. The inspector saw from documentation such as the updating of the relevant risk assessments that residents had not changed their views in relation to how they felt about their current living arrangements and the living arrangements that they wanted so as to have a better quality of life.

The limited space and inequitable sense of ownership created anxiety for a resident, impacted their quality of life but also compromised their safety. The provider had notified the Chief Inspector of Social Services of a safeguarding incident that had occurred in one apartment triggered by the absence of a suitable space for receiving visitors. The most recent provider-led review cited the importance of the different premises plans in relation to ensuring residents were safeguarded.

Their living arrangements and their experiences impacted and informed what residents wanted. For example, one resident wanted to move back to a town where they had spent much of their life and they did not want to share with a peer again due to two successive unsuccessful shared living arrangements.

Judgment: Not compliant

## Regulation 26: Risk management procedures

Improvement was found in the arrangements for identifying, assessing, managing and reviewing risk. However, based on the oversight maintained by the person in charge and the findings of this inspection there was still some under-reporting of incidents. This under-reporting had the potential to impact on how the provider monitored and measured the effectiveness of the controls in place and the impact on resident safety and quality of life. For example, the possible triggers for behaviour and the impact of that behaviour in the context of the shared living arrangements.

The person in charge described how the daily narrative notes completed by staff

were reviewed as part of the enhanced systems of quality assurance in the centre. The most recent review of these notes by the person in charge had identified three behaviour incidents for which there was no corresponding incident record. The inspectors review of a small sample of narrative notes from the 1st July identified another possible incident where one resident was stated to be upset by an action of their peer but no further detail was provided and there was no corresponding incident report. Only one resident's narrative notes made reference to the incident.

Oversight and review of the accident and incident reports was a core part of the providers monitoring of the quality and safety of the service particularly in the context of needs that were not compatible. The inspector found that the quality of completed incident records was good with staff providing detail as to what happened, why it might have happened and how they responded. However, in addition to the confirmed gaps in reporting little detail was provided in the completed incident records as to whether the incidents had impacted on peers or not. This information was a cited control in the associated risk assessment.

Judgment: Substantially compliant

## Regulation 5: Individual assessment and personal plan

Overall the inspector found much improvement in the systems for assessing resident needs and in the planning of how to support those needs. It was evident that residents were spoken with and listened to and they were supported to enjoy good health, be meaningfully engaged, visible in their community and to do things that they enjoyed.

However, based on observations of this inspection the effectiveness of a residents eating and drinking plan required review. A review was also needed as to how the plan including the recommendations of the speech and language therapist was implemented and supervised. The inspector saw that the staff sought to give the resident some independence and choice over the preparation of their meal. However, based on what the inspector observed this did not assure the safe implementation of the safe eating and drinking plan.

The personal plan included a suite of personal objectives and goals to be achieved with and for the resident such as enjoying a holiday with a peer and engaging with community based activities. However, a better system was needed for evidencing how these goals were to be progressed, by whom and when they would be achieved by.

Ultimately the designated centre and the shared living arrangements were not suited to the needs of the residents. This is addressed in Regulation 17: Premises.

Judgment: Substantially compliant

## Regulation 6: Health care

The person in charge ensured that residents had access to the clinicians and allied healthcare services that they needed. This included referral to and review by the relevant general practitioner (GP), other members of the multi-disciplinary team (MDT) such as psychiatry, physiotherapy and the positive behaviour support team and, hospital based clinicians and services. Records of referrals and reviews were in place.

Staff monitored resident health and well-being, sought advice and care for residents and implemented any recommendations made. For example, the inspector saw records of the monitoring of a residents blood pressure as requested by the GP and the feedback provided to the treating GP.

Judgment: Compliant

## Regulation 7: Positive behavioural support

The personal plan reviewed by the inspector included a detailed positive behaviour support plan advised by the positive behaviour support specialist. The plan was clear and up-to-date. The plan set out the behaviours that could be exhibited, possible triggers for the behaviour, therapeutic supports, reactive planning and crisis intervention.

Staff were trained in positive behaviour support and in the use of de-escalation and intervention techniques. Since the last HIQA inspection the positive behaviour support team had met with the residents and with the staff team. The positive behaviour support plan was reviewed and updated following consideration of any feedback provided by staff.

The inspector reviewed incident reports and saw that were completed by staff in way that conveyed what behaviour was exhibited, why it was exhibited and how it was responded to. However, there was also evidence that all recent incidents had not been reported on the providers incident reporting system. This had implications for oversight and risk management and is addressed in Regulation 26.

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 | Not compliant |
| Regulation 16: Training and staff development | Compliant |
| Regulation 21: Records | Compliant |
| Regulation 23: Governance and management | Not compliant |
| Regulation 34: Complaints procedure | Compliant |
| **Quality and safety** | |
| Regulation 17: Premises | Not compliant |
| Regulation 26: Risk management procedures | Substantially compliant |
| Regulation 5: Individual assessment and personal plan | Substantially compliant |
| Regulation 6: Health care | Compliant |
| Regulation 7: Positive behavioural support | Compliant |

# Compliance Plan for Newmarket Residential OSV-0005528

## Inspection ID: MON-0045605

## Date of inspection: 10/07/2025

**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 15: Staffing | Not Compliant |
| Outline how you are going to come into compliance with Regulation 15: Staffing:<br>1. Additional one to one support's will be increased from three days a week, to seven days a week, by September 2025. This will ensure the individuals can choose different activities, as per their will and preference, and mitigate any associated safety concerns.<br>2. The staff team, guided by the P.I.C. will continue to provide a flexible and responsive roster to ensure individuals can attend desired activities.<br>3. A business case, seeking additional one to one supports was sanctioned in July '25. Recruitment of additional staff is underway, and due for completion Nov. 2025. | |
| Regulation 23: Governance and management | Not Compliant |
| Outline how you are going to come into compliance with Regulation 23: Governance and management:<br>1. A full business case was sanctioned in July 2025, and alternative accommodation has been identified. Transition is scheduled for completion in Dec 2025.<br>2. The capacity of the centre will decrease, from four to three individuals, by December 2025. This reduction in capacity, will enable the P.P.I.M. and the P.I.C. to address any compatibility issues between remaining residents. The lack of adequate privacy in one living space will also be addressed.<br>3. The P.P.I.M. and the P.I.C, in conjunction with the multidisciplinary team, will assess the existing living arrangements with the persons supported.<br>4. A plan will be developed with each individual, to address concerns relating to private living space, and compatibility.<br>5. 5.The P.I.C. through the POMs process, will continue to advocate for the individuals' | |

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| preferred living arrangements. |

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| Regulation 17: Premises | Not Compliant |

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Alternative premises have been sourced for one individual.
2. The capacity of the centre will be reduced from four individuals, to three individuals, by December 2025.
3. The P.P.I.M. and the P.I.C, in conjunction with the MDT, will review the current living arrangements, for all individuals. Compatibility of residents, and available space within the centre, will be addressed as part of the assessment process.
4. The P.P.I.M. remains in weekly contact with the County council, to explore all options for alternative accommodation.
5. Consultation between the P.I.C. and all individuals, in relation to their preferred living arrangements, is ongoing.

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| Regulation 26: Risk management procedures | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. Site specific report writing training will be repeated for all staff team, by Dec 2025.
2. Weekly audits of support notes will be completed by the SCW and P.I.C.
3. All incidents of under reporting will be addressed with individual staff contemporaneously.
4. Under reported incidents identified in support note audits, will be logged, and reviewed quarterly by P.I.C. and P.P.I.M. The risk matrix will be updated in line with quarterly review of accidents/incidents.
5. Behaviour support will continue to provide ongoing advice/guidance to the staff team, with particular focus on how to identify, and report impact behaviours between peers.
6. The P.I.C. will continue to carry out unannounced site visits to ensure all staff are adhering to risk management protocols.
7. The capacity of the service will be reduced from four individuals to three individuals by Dec 2025.

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| Regulation 5: Individual assessment and personal plan | Substantially Compliant |

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:

1. The eating and drinking support plan for one individual was reviewed and updated on the day of the inspection. The additions to the plan address the risks associated with staff attempts to promote independence for the individual.
2. The education plan used to support the individual at mealtimes was updated in July 25. The individual has this document in easy read format for ongoing reference/guidance.
3. The P.I.C. will continue to make regular unannounced visits to the service at mealtimes, to observe and ensure adherence to SLT recommendations, associated risk mitigations and support plans.
4. A transition plan is being developed for one individual to support a move to alternative accommodation.
5. Psychiatry, and psychology input will be available to all residents, to support them through the upcoming changes to the living arrangements and the service.

## 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 |
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| 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 | 31/12/2025 |
| Regulation 17(7) | The registered provider shall make provision for the matters set out in Schedule 6. | Not Compliant | Orange | 31/12/2025 |
| 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. | Not Compliant | Orange | 31/12/2025 |

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| Regulation 23(2)(a) | The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support. | Not Compliant | Orange | 31/10/2025 |
| Regulation 26(2) | The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies. | Substantially Compliant | Yellow | 31/08/2025 |
| Regulation 05(7)(c) | The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for | Substantially Compliant | Yellow | 31/07/2025 |

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| | pursuing objectives in the plan within agreed timescales. | | | |
| Regulation 05(8) | The person in charge shall ensure that the personal plan is amended in accordance with any changes recommended following a review carried out pursuant to paragraph (6). | Substantially Compliant | Yellow | 31/07/2025 |