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:	Newmarket Residential
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Announced
Date of inspection:	12 August 2024 and 13 August 2024
Centre ID:	OSV-0005528
Fieldwork ID:	MON-0035152

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.

Number of residents on the date of inspection:	4

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
Monday 12 August 2024	09:45hrs to 18:00hrs	Mary Moore	Lead
Tuesday 13 August 2024	09:30hrs to 16:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken by the Health Information and Quality Authority (HIQA) to monitor the quality and safety of the service and the provider's level of compliance with the regulations and standards. The provider had applied to the Chief Inspector of Social Services to renew the registration of this centre. While the residents reported that they were generally happy, the inspection findings were not satisfactory. The provider had not sustained the improvement found at the time of last HIQA inspection completed in May 2023. A full review by the provider was needed of this service in relation to the occupancy, residents' needs and compatibility of those needs, staffing arrangements, risk management and, the effectiveness of the governance and management arrangements in place.

This centre is comprised of two adjacent ground floor apartments in a larger apartment complex. Two residents live in each apartment. The location of the apartments is very important to three of the residents as they are from and have strong links with the local community. On arrival at the first apartment where the main administration office was based the inspector was greeted by one of the residents. The resident welcomed the inspector to their home and asked the inspector to sign the visitor's book. When the inspector visited the second apartment the apartment door was opened by one of the residents living in that apartment. The resident gave a great welcome back to the inspector.

The inspector was generally based in the first apartment. The residents living in this apartment pointed out to the inspector the new fitted storage unit in their living room. Each resident had their own side of storage space. New photographs had been hung representing a variety of events and activities enjoyed by both residents.

Residents came and went over the course of this two day inspection to attend to a range of tasks and activities but the inspector had the opportunity to meet with all four residents and to speak with three of them. Residents were out and about largely on a one-to-one basis with a supporting staff member. For example, residents went with staff to complete the weekly grocery shopping and other personal shopping. Residents went for drives and a coffee to nearby scenic amenities, were supported to meet up with friends that were important to them, to attend the barber, clinical appointments and, the local men's' shed.

However, while these observations were very positive there were evident ongoing issues with staffing levels and staffing arrangements. For example, while the provider had recruited staff and increased the amount of one-to-one staff support for residents there was only one staff member on duty in one apartment to support both residents (who had the highest needs and risks) five days a week after 16:00hrs. The majority of the staff worked on a less that full-time basis. The impact of these arrangements was evident on inspection but was poorly captured in the centre. For example, two residents evidently had an understanding of the inspector's role and specifically asked to speak with the inspector on a one-to-one basis. It was

a resident who raised the challenges that arose at times due to the staffing levels and arrangements.

Residents said that they loved living in the centre and were extremely grateful and appreciative of the service they were provided with. Residents knew who the designated safeguarding officer was and, had access as needed to the community manager. Residents spoke of the regular contact they had with family, home and friends and how important this was to them. Families had been invited to provide feedback on their views of the service so as to inform the annual service review. Three families had provided feedback. The inspector saw that very positive feedback was provided by two families while the feedback provided by the third family was not positive. The community manager acknowledged this and had put a process of communication and engagement in place in response. However, there were matters raised during this engagement that should have been formalised into the provider's complaint management procedures.

One resident discussed the recent holiday they had enjoyed with family abroad and their involvement in the planning of the holiday. The resident discussed their love of music and concerts they had attended and was looking forward to returning to their paid part-time employment. The resident had recently commenced a vocational training programme and reported that they were enjoying the programme very much. The resident sang a song in honour of the inspector's home county. The resident had a great sense of fun as they inserted their own words into the song in celebration of the recent county sporting win.

However, residents also raised matters with the inspector that they were not so happy with. What was evident from these discussions was how residents were somewhat challenged expressing dissatisfaction with their service as they did not wish to appear ungrateful or unkind. One resident reiterated their wish (as expressed at the time of the last HIQA inspection) for different living arrangements that would provide them with more space and the opportunity to live on their own but with the support of staff. The resident knew that the provider had plans to develop a new service in the village. The resident said that while his wishes and preferences had not changed he didn't like talking too-much about what he wanted as he knew it would take time to develop the new service.

A second resident also raised in conversation with the inspector their wish to live elsewhere and to live on their own but with staff support. The resident knew that they needed staff support and assistance. The resident was happy and satisfied that they were making a good recovery from a recent period of illness and hospitalisation. The resident spoke of the challenges they faced at times in their current living arrangements and the impact that this had on them. The resident spoke of feeling uncomfortable and anxious when incidents occurred though they knew and understood that the incidents were not directed at them.

The residents had also been supported to complete a HIQA questionnaire. Residents reported that they had good choice and control and liked the staff team. However, two residents used the questionnaire to again convey their wish for alternative living arrangements. The community manager confirmed to the inspector that the wishes

of one resident had recently been brought to their attention and the resident's wishes would be explored. A referral for the support of an independent advocate for the resident had been sent. The community manger also discussed with the inspector the status of the providers plan to develop a new purpose built centre in the village.

However, the inspector found that the systems in place for recording, reporting and monitoring matters of importance to residents such as these were poor. For example, when the staffing levels did not support residents to make different choices, how this might upset one resident and how this might then unintentionally impact on their peer. This absence of monitoring did not provide assurance as to how the provider had the information that it needed to effectively monitor and improve the service and resident quality of life as needed.

In general, the standard of record keeping and documentation in the centre was poor and there was inconsistency at times between what was discussed with the inspector, what residents told the inspector and, what was recorded. For example, in relation to staffing levels, the monitoring of incidents including incidents of behaviour that challenged, the management of complaints and, the general maintenance of residents' personal plans and healthcare records. This level and standard of record keeping was of concern not only in terms of how it did not support effective monitoring and oversight but also in terms of not ensuring continuity and consistency of care and support where staff worked on a less than full-time basis.

For example, based on these inspection findings the inspector was not assured that staff were fully informed of controls put in place to manage a specific and serious risk to resident health and well-being. The provider was requested by the inspector to immediately address two risks that arose on the first day of inspection one in relation to a resident's safe eating and drinking plan and, one in relation to the excessively hot temperature of the water at the wash-hand sinks. The inspector required assurance that all staff members were aware of the risk, of the safe eating and drinking controls and, that efforts were made by the provider to prioritise the speech and language assessment that was in process since a previous incident in May 2024. These risks and the request for immediate actions were appropriately responded to by the community manager.

In summary, as reported by residents themselves, residents liked their service and were supported to be closely connected to family, friends and the local community. However, there were also matters that were impacting on the appropriateness, safety and quality of service that residents received. Systems were not in place to consistently monitor, capture and appropriately respond to these matters such as the absence of compatibility between residents.

The next two sections of this report will discuss the governance and management arrangements in place and how these failed to ensure and assure the quality and safety of the service.

Capacity and capability

There was a clear management structure in place. The person in charge was on-site at least three days each week and was supported in the management and oversight of the service by a social care worker who had allocated administration time. The social care worker also worked alternate weekends. The person in charge confirmed that they had excellent access to and support from their line manager the community manager. Based on records seen the community manager was directly inputting into the service such as in the management of complaints, the review of risks and matters that were escalated to them.

The provider has quality assurance systems that it used on a regular and consistent basis to collect information and data about the quality and safety of the service. However, there were gaps and deficits in the local systems of monitoring and oversight and in the associated records. This did not provide assurance as to how the broader management and governance structure maintained effective oversight of the service such as through these formal quality assurance systems. Based on these HIQA inspection findings internal quality improvement plans were not satisfactorily progressed in a timely manner.

For example, the inspector noted the maintenance and updating of residents' personal plans and healthcare plans was a repeat action from these internal reviews as far back as 2023. An action had also issued at the time of the last HIQA inspection. This was not, based on these inspection findings, satisfactorily addressed or progressed. Additional deficits included gaps in the recording of incidents including incidents that impacted on peers. The inspector was told that incidents were under reported and records requested by the inspector such as compatibility assessments and records of meetings between staff and residents following incidents were not available for inspection. If records were not created or not retained it was difficult to see how the provider was accurately informed so that trends and impacts such as those reported by a resident were effectively tracked and responded to.

It was possible that the standard of documentation was linked to the staffing levels and arrangements of the service. For example, there was only one staff member on sleepover duty to support all four residents and only one staff member was on duty most evenings in the apartment where residents needs and risks were highest. These staffing levels were compounded by the fact that half of the staff team worked on a less than full-time basis and at times only worked one shift each week.

While regular staff meetings were to be convened they had not been held as scheduled and, the inspector saw that there was a consistent pattern of poor staff attendance at the three meetings that had been held to date in 2024. In the absence of up-to-date personal and healthcare plans and poor attendance at staff meetings it was not evidenced how these arrangements ensured continuity and consistency of care and support for residents.

In response to the findings of internal audits additional training for staff had been provided such as in the promotion of residents human rights and, human rights based report writing. There was good staff attendance at this training with over 70% of staff having attended the report writing training. However, the record of staff training was not up-to-date and given these inspection findings, the inspector had to make further enquires as to the status of training in supporting residents to eat and drink safely and, first-aid training. The latter was identified as urgent for two staff members on the matrix. The community manager confirmed and provided documentary evidence that one staff member had recently completed the training and the other was scheduled to attend in the coming weeks. However, further training was needed preferably on-site and in person to ensure staff had the skills and knowledge needed to respond to the needs of the residents including emergency situations.

The inspector requested and was provided with a sample of three staff files to review. The files contained all of the required information such as employment history, previous employer references and vetting disclosures.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted, within the specified timescale, an application seeking the renewal of the registration of this centre.

Judgment: Compliant

Regulation 15: Staffing

The person in charge described to the inspector how staffing levels. arrangements and skill-mix were altered in response to specific circumstances such as during times of resident ill-health and recovery from illness. The provider had also increased the amount of one-to-one staff support available to residents. However, based on these inspection findings staffing levels, staffing arrangements and staff-skill mix were not consistently suited to residents needs, choices and risks. For example, there was evidence that in the evenings when only staff member was on duty residents might make choices that were different and residents had to agree whether to stay in or go out as neither resident could safely stay alone in the centre. These compromises and other changes made such as in response to an unexpected staff absence were not always received well by a resident and could be a trigger for behaviour that challenged. This was reported by a resident and the inspector saw that it was clearly documented in the positive behaviour support plan. The suitability and impact of staffing levels and staffing changes on residents was however poorly monitored in the centre. Regular changes were evident in the staff rotas seen. What was not evident from the rota was that there were times when the staffing levels were not

as planned. This was reported by a resident and the inspector saw that it had been recorded by a staff member on one recent daily narrative note. The staff member had reported that due to staffing levels personal care and community access plans for a resident were changed. The staffing deficit was not however evident from the staff rota.

The inspector was not assured that all risks to resident safety could be safely responded to and safely managed if there was only one staff member on duty. For example, a recent significant choking incident had required the intervention of a second staff. Both residents in one apartment had different and competing risks. In addition, though the inspector was advised that staff had access to on-call, there was a protocol in the staff office advising staff that in the event that it was necessary to admit a resident to hospital when there was only one staff member on duty, family were to be contacted and they (family) had to accompany the resident to hospital.

The inspector was not assured how the staffing arrangements ensured and assured continuity of care and support for residents as almost 50% of the staff team worked on a less than full-time basis and there was consistent poor attendance at the staff team meetings. For example. the inspector noted that only two staff members had signed as having read the revised positive behaviour support plan issued in July 2024. The inspector saw that the controls outlined in a safe eating and drinking plan were not implemented on the first day of this inspection. The provider itself had a open high red rated risk for its staffing levels and arrangements. The provider was challenged by these staffing arrangements (as identified during internal reviews) to implement systems such as key-working so as to improve continuity and consistency.

Judgment: Not compliant

Regulation 16: Training and staff development

The staff training matrix was not up to date. Further enquiry and additional records provided to the inspector confirmed that training highlighted as urgent on the matrix was recently completed by one staff member and was due to be shortly completed by a second staff member: this was the next available training date. Other training requirements such as in safeguarding, fire safety and responding to behaviour that challenged were complete. Staff had also attended and completed additional training they were requested to complete such as on-line human rights training and in-person report-writing training. However, it was evident from these inspection findings and records seen that additional training specific to the needs of the centre and the residents was needed. For example, in supporting residents to eat and drink safely, first-aid-basic-life support and, implementing and monitoring evidenced based elimination plans.

Judgment: Substantially compliant

Regulation 21: Records

In general, the inspector found that records in relation to residents such as the assessment of needs, personal plans, medical care provided, and, incidents that impacted on resident well-being such as behaviour related incidents were not well-maintained and available for inspection by the Chief Inspector of Social Services. For example, records to be maintained on a server were not maintained there and some of these records were reported to be shredded.

Judgment: Not compliant

Regulation 22: Insurance

The provider submitted, with it's application seeking renewal of the registration of this centre, evidence that it had insurance in place such as insurance against injury to a resident.

Judgment: Compliant

Regulation 23: Governance and management

There was a clear management structure in place and systems to support governance and management such as formal systems of quality assurance. However, based on these inspection findings this did not ensure and assure the appropriateness, quality and safety of the service. Matters that impacted on residents and the quality and safety of their service such as staffing arrangements and deficits, absence of compatibility and behavioural incidents were not adequately recorded and monitored. This did not provide assurance as to how the provider was consistently and accurately informed as to the quality and safety of the service or, how it could complete effective formal quality assurance reviews. These reviews were completed on schedule and they were detailed and comprehensive but if, for example, accurate and complete records were not available of matters arising between residents, it was challenging to see how the provider could respond appropriately to this matter. For example, the community manager advised the inspector they were not aware until July 2024 that a second resident had a preference to live elsewhere. Quality improvement plans did issue from these reviews but they were not, based on these HIQA inspection findings satisfactorily addressed. For example, there were ongoing deficits in residents healthcare and

personal plans and no evident improvement in staff attendance at team meetings.

Judgment: Not compliant

Regulation 3: Statement of purpose

The inspector read the statement of purpose and function and saw that it contained all of the required information such as the number of residents who could be accommodated, the governance and management arrangements, how to male a complaint and, the arrangements for receiving visitors.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had complaint management policy and procedures. The inspector discussed and reviewed records of the management of a complaint that had been received. The inspector was satisfied that the complaint was managed in line with the providers policy and procedures. The complaints officer who was not involved in the matter complained of investigated the complaint. The complaints officer recorded the actions that they had taken to investigate the complaint and to substantiate the conclusion reached. These actions included speaking with the complainant, the resident and other relevant parties. The complaints officer accepted that while the complaint was closed to the provider, potentially, it was not fully resolved for the complainant. There was an ongoing process of communication and engagement with the complainant. There were other matters arising from this engagement. What these were and how the provider was and intended to respond to them was not formally set out within the complaints process.

Judgment: Substantially compliant

Quality and safety

There were positive outcomes for residents. For example, residents were supported to be positively and meaningfully connected to home, family, peers, friends and the wider community. Where appropriate, residents were supported to have some independence. However, while there was respect and friendship between residents there was also an absence of compatibility between residents in both apartments and two residents had expressed preferences for alternative living arrangements.

Much improvement was needed in capturing the impact of this absence of compatibility, in the process of personal planning, in the maintenance of healthcare records and plans and, in systems for monitoring and managing risks.

The inspector reviewed records as they pertained in the main to two residents. These two residents had the highest needs and requirement for support such as in relation to their physical and healthcare needs. From the daily narrative notes the inspector saw that staff monitored and were attentive to the needs of the residents by day and by night. This attention and support included seeking medical advice and review and providing practical support and askance as needed. However, there were gaps in records and out of date healthcare plans.

For example, one personal plan was overdue an annual review and had not been reviewed on a six-monthly basis as required by the provider.

The personal plan included a positive behaviour plan that had been reviewed in July 2024. However, this was signed as read by two staff members only. Behavioural incidents did occur and there was a reported increase in these incidents. However, it was acknowledged on inspection that all incidents were not recorded and not reported. The inspector could not access complete or meaningfully completed records to ascertain the frequency of incidents between residents, establish how these incidents had impacted on residents, how they were responded to by staff and monitored by management.

There were processes in place for reviewing incidents that were reported and for managing associated risks. The community manager had recently reviewed and updated the register of risks and had put in place a new risk management plan in response to a serious incident that had occurred in May 2024. However, on the first day of this inspection specified controls were not implemented and this resulted in another serious risk to resident safety and well-being.

Additionally there was a risk assessment in place for the risk of a resident making claims that were without foundation. It was very unclear from the risk assessment what process was in place to establish if claims made were without foundation and not an actual safeguarding concern.

The premises was fitted with the required fire safety precautions such as emergency lighting and a fire detection and alarm system. An unannounced fire drill that simulated night-time conditions (for example residents were in bed or in the process of getting up) had been completed in February 2024 and had established that one staff member could evacuate all four residents. However, better oversight was needed of the scheduling of drills and staff participation in these drills.

Regulation 11: Visits

Residents spoke of the importance of family, home, friends and peers and were supported to maintain these relationships. Staff maintained a record of the visits

residents received in the centre.

Judgment: Compliant

Regulation 13: General welfare and development

The inspector saw that as appropriate to their needs and wishes residents led busy and active lives and were out and about in the local community and further afield supported by staff. For example, over the course of this two day inspection residents went grocery shopping and shopping for other personal items, residents enjoyed trips to local scenic amenities and were supported by staff to meet with friends that were important to them. One resident enjoyed part-time paid employment and attended the local men's shed. Four different vehicles were available and staffing levels generally supported individualised choices and activities up to 16:00hrs each day. The challenge arising was different choices that residents might make after this time. This is addressed in Regulation 15: Staffing.

Judgment: Compliant

Regulation 17: Premises

As highlighted at the time of the last HIQA inspection the design, size and space available in one apartment was not suited to the number or the needs of the residents living in the 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 and 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 limited the personal possessions that they could keep in their bedroom. Their peers bedroom was of a suitable size as set down for example in other applicable standards and it was three square metres larger than the other bedroom. There was no space to accommodate staff on sleepover duty if needed. One resident repeated their preference for more space and again expressed their dislike of the fact that sleepover staff were based in the adjoining apartment. The resident said that they often felt lonely when everyone had left in the evenings. In addition, some dissatisfaction had recently arisen about the operation of a main staff office in the other apartment. The office was adjacent to one resident's bedroom.

Judgment: Not compliant

Regulation 20: Information for residents

The provider had produced a guide for residents. The inspector read the guide and saw that it included all of the required information such as the arrangements for consulting with residents, how to make a complaint and, how to access any inspection reports on the centre.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had systems in place for the identification and management of risks. The suite of risk assessments seen by the inspector reflected the risks arising in the centre such as the risk of behaviour that challenged, the risk from the absence of compatibility between residents and, the risk for choking. However, based on these inspection findings arrangements were not in place to effectively monitor the adequacy of the controls put in place and the status of the risk that presented. For example, the provider had a risk assessment for the poor staff attendance at staff meetings and the impact this could have due to poor communication. There was no evident improvement in attendance and there was, based on these inspection findings poor communication and record keeping that did impact on the quality and safety of the service. Based on what the inspector observed controls were not implemented. The inspector saw that food had not been prepared and provided to a resident in bite-sized pieces as stipulated in a risk assessment put in place by the community manager following a previous serious choking incident in May 2024. In general, the records of the food provided each day did not state how the food and meals were provided so as to promote their safety and suitability. The gravity of the risk arising to resident safety and staff well-being following a near-miss incident on the first day of inspection resulted in the issuing of an immediate action to the provider.

Judgment: Not compliant

Regulation 28: Fire precautions

There was documentary evidence on file that fire safety systems including the emergency lighting, the fire detection and alarm system and fire fighting equipment were inspected and tested at the appropriate intervals. Each resident had a personal emergency evacuation plan. There were alternative means of escape to the front and rear of each apartment. An external person had been requested to review and evaluate the centres evacuation procedures in April 2024. An unannounced evacuation drill had established that one staff member could effectively evacuate the two residents most dependent on staff support and assistance. However, the inspector again found that better oversight was needed of the scheduling of these

drills and staff participation in the drills. The providers fire safety policy stated that each staff member had to participate in a simulated drill at least once a year. However, while there was a planned drill schedule the records available to the inspector indicated that the majority of staff still had to participate in an evacuation drill this year.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The inspector reviewed two residents personal plans. It was evident that the residents and their representatives as appropriate were consulted with and had input into the plans. However, the plans were poorly maintained and were not kept up to date. For example, one residents personal outcomes (POM's) were based on information gathered between December 2022- April 2023. A review of the progress of these outcomes had been due in September 2023 but this date was manually crossed out and the first formal review date recorded was July 2024. The second resident's POM's while more up-to-date had not been reviewed as planned in April 2024 to assure its progress and effectiveness. While there were records of clinical reviews such as with the GP, a resident's overarching plans of care had not been updated since December 2022-January 2023 to reflect changes in needs and care requirements. For example, there was no record in place of a clinical review completed in July 2024 as had been discussed with the inspector. The residents "hospital passport" (a record to accompany the resident on hospital admission) had not been updated to include the risk for choking. This was of concern given the stated requirement for family to support hospital admissions. Two plans to manage seizure activity were stated to be in progress since November 2023 and had not been updated to reflect recent neurology reviews. While the daily narrative notes provided evidence that staff were attentive and supportive it was of concern, based on these inspection findings, as to what guided staff practice and knowledge and ensured continuity of care in the absence of up-to-date records and plans

Judgment: Not compliant

Regulation 6: Health care

There were gaps and out-of-date healthcare plans so the inspector was not assured how staff always had the evidence based guidance that they needed to provide and monitor the care needed. This is addressed in Regulation 5 and Regulation 15. There was sufficient evidence in other records seen such as the daily narrative notes and discussions with residents themselves for the inspector to be assured that staff monitored resident well-being and supported residents in times of illness and recovery from illness. Residents had good access to their general practitioner (GP).

Nursing care was accessed as needed for community and hospital based resources and the community manager who was a registered nurse was currently inputting into the review of some healthcare plans. Residents were provided with chiropody, dental care, physiotherapy and occupational therapy as needed and had access to psychiatry and psychology. The GP supported any request for blood sampling, for example for the purposes of health screening and to monitor the impact of prescribed medications.

Judgment: Compliant

Regulation 7: Positive behavioural support

There were times when a resident was challenged by certain events such as changes to staffing levels and arrangements or when they could not do what they wanted to do. For example, if both residents expressed different preferences but the evening staffing levels could not support their different choices. These possible triggers were clearly outlined in the recently reviewed (July 2024) positive behaviour support plan. A resident spoken with described such incidents and said that they happened "often enough". Records seen such as the quarterly analysis of incidents did state that there was a recent increase in behavioural incidents. There was a protocol in place for responding to incidents that caused unintentional anxiety in their peer. However, based on the inspectors enquiries there was scant recording of these incidents and what records were available (two) had little to offer by way of describing what had happened, why it had happened, what the impact was and how it had been resolved. Likewise, where more significant incidents had occurred there was little recorded as to the possible impact on the residents peer and how they were supported if for example, there was only staff member on duty. It was challenging to see how such incomplete record keeping would effectively inform the review of the positive behaviour plan and its effectiveness.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had safeguarding policy and procedures and implemented these when any concerns were raised. Staff had completed safeguarding training. Residents spoken with evidently knew who they could raise concerns with and were familiar with the designated safeguarding officer. The inspector saw records where staff recorded that they had discussed safeguarding and how to stay safe with residents at regular intervals. Residents had personal and intimate care plans.

The inspector reviewed a risk assessment for the risk of a resident making "unfounded claims" against staff and others. However, it was not clear from this risk

assessment how these statements were screened and managed so that the resident was safeguarded against the risk that claims or statements made by the resident had validity but were deemed or assessed to have no foundation.

The inspector saw that staff had since January 2024 completed a number of "body maps" for one resident to record injuries they had noted. However, there was no recorded evidence to demonstrate that these "body-maps" had been reviewed and followed-up on by management as a safeguarding assurance.

Judgment: Substantially 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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 21: Records	Not compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Newmarket Residential OSV-0005528

Inspection ID: MON-0035152

Date of inspection: 12/08/20224 and 13/08/2024

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:

1. A full review of the staff rota template, will be carried out, to ensure all rostered hours, annual leave, and unexpected absences, are clearly outlined on the roster. The PIC will ensure that the planned and actual roster remain as 2 separate documents, clearly identify any changes and the division of planned and actual rosters will be monitored by the PIC and the SCW to ensure version control.

2. The PIC and SCW will liaise with the team as to a responsive roster for desired activities and identify and implement flexible support shifts to avoid triggers for behavior that challenge.

3. Part time staff vacancies have been amalgamated to facilitate the recruitment of additional fulltime staff members. The PIC will liaise with HR to ensure these vacancies are prioritized.

4. An updated business case is been developed for submission to the HSE highlighting the need for additional supports and alternative accommodation for the residents.

5. Two additional agency staff familiar with needs of the residents are providing care and support alongside current experienced service support staff where there are gaps in the roster.

6. Hybrid staff team meetings will be conducted to enable staff to attend in person and/or Microsoft teams. Team meetings will be scheduled 6 months in advance.

7. PIC will ensure that new/updated protocols, behavior/MDT supports plans, and any other guidance will be discussed at team meetings and staff comprehension of same is recorded.

8. All staff will receive updates to risks, support plans, procedures etc.

contemporaneously to their work email address. Staff will be requested to confirm by return email that they have received and understood the information.

9. Issues relating to non-attendance at team meetings will be addressed at individual staff support and supervision meetings.

10. The PIC and PPIM will review the keyworker arrangements within the service to improve continuity and consistency.

Regulation 16: Training and staff development	Substantially Compliant

Outline how you are going to come into compliance with Regulation 16: Training and staff development:
1. A site-specific training on choking has been arranged for all staff.

2. A schedule has been put in place to ensure the training matrix is updated by the SCW on a weekly basis.

3. PIC and PPIM in conjunction with Training Department will undertake a training needs analysis to identify and organise any relevant site-specific training.

Regulation 21: Records	Not Compliant

Outline how you are going to come into compliance with Regulation 21: Records:
1. A full review of all documentation including assessment of need, personal plans, medical/MDT records and incidents, will be carried out by the SCW and the Community manager to clarify and agree document control and management, filing and storage process for the service location.

2. Records will be archived and stored appropriately in line with policy and procedures.

3. All staff scheduled to complete files and record keeping training.

Regulation 23: Governance and management	Not Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:

1. The Community Manager is undertaking the direct management of the DC as PIC, supported by SCW on the day to day operation of the service.

2. The Community Manager/PIC will also be supported by Quality & Compliance Officer in ensuring the provider is consistently and accurately informed as to the quality and safety of the service through effective, formal quality assurance reviews.

3. The P.I.C/PPIM will ensure that actions identified in annual reviews, and internal and external audits are completed within specified time lines.

4. All incidents will be recorded, reviewed, and shared with MDT as appropriate, to ensure the quality and safety of the service, and to highlight areas/opportunities for service enhancement.

5. Part time staff vacancies have been amalgamated to facilitate the recruitment of additional fulltime staff members. The PIC will liaise with HR to ensure these vacancies are prioritized.

6. An updated business case is been developed for submission to the HSE highlighting the need for additional supports and alternative accommodation for the residents.

7. Two additional agency staff familiar with needs of the residents are providing care and support alongside current experienced service support staff where there are gaps in the roster.

8. Hybrid staff team meetings will be conducted to enable staff to attend in person and/or Microsoft teams. Team meetings will be scheduled 6 months in advance.

9. PIC will ensure that new/updated protocols, behavior/MDT supports plans, and any other guidance will be discussed at team meetings and staff comprehension of same is recorded.

10. All staff will receive updates to risks, support plans, procedures etc. contemporaneously to their work email address. Staff will be requested to confirm by return email that they have received and understood the information.

11. Issues relating to non-attendance at team meetings will be addressed at individual staff support and supervision meetings.

Regulation 34: Complaints procedure	Substantially Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
1. Ongoing concerns from one family member have been formalized within the complaint's procedure, and engagement between the complaints officer and the family is continuing.

2. The person supported has been referred to an independent advocate to ensure the service is fully aware of the individuals will and preference with regards to a desire for alternative accommodation.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. Alternative premises have been sourced, and a planning application for renovation of the property is awaiting approval.

2. An updated business case is been developed for submission to the HSE highlighting the need for additional supports and alternative accommodation for the residents.

3. Community Manager remains in contact with the County council to explore options for alternative accommodation for the residents.

4. A protocol has been put in place to ensure the main staff office is occupied by one staff member only, before 10am and after 5pm daily, to limit the risk of individual being disturbed when resting.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. PIC will ensure that new/updated protocols, behavior/MDT supports plans, and any other guidance will be discussed at team meetings and staff comprehension of same is recorded.

2. All staff will receive updates to risks, support plans, procedures etc. contemporaneously to their work email address. Staff will be requested to confirm by

return email that they have received and understood the information.

3. All staff will attend a site-specific Choking workshop to enhance their understanding of the risk and their ability to manage emergency situations.

4. Three residents have been assessed by SLT and all recommendations shared and discussed with the individuals and the staff team.

5. All staff have read, understood, and signed the eating support plans and these have been discussed at team meeting.

6. The Community Manager will carry out unannounced spot checks at mealtimes to observe and ensure staff adherence to SLT recommendations, associated risk mitigations and support plans.

7. Community Manager and SCW have met with staff team to discuss the challenges associated with attending team meetings. A hybrid model will be trialed over the coming months and attendance will be reviewed by the Community Manager.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
1. A fire drill has been completed to ensure participation of additional members of the staff team.

2. A schedule of fire drills has been put in place to ensure all staff have the opportunity to participate in a fire drill. This schedule includes a night time drill.

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:
1. Through Personal Outcome Measures, the individual goals of the persons supported will be addressed, particularly in relation to building independence, and living arrangement preferences.

2. Hospital passports for all four individuals will be updated.

3. Community manager and SCW will review all plans to ensure they are accurate, and up to date, and to make certain plans adequately guide and enhance staff practices and knowledge.

4. A schedule for ongoing review of all documentation by the P.I.C. and SCW, has been put in place to ensure files remain up to date, and accurately reflect the changing needs of the persons supported.

5. Quality and compliance officer will review the working file as part of next 6 monthly review.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. All incidents will be recorded, reviewed, and shared with MDT as appropriate, to ensure the quality and safety of the service, and to highlight areas/opportunities for service enhancement.

2. A joint PBS review, for two residents, has been scheduled to further investigate the impact of behaviours of concern, and current living arrangements.

3. Following this review guidance will be issued to staff in relation to appropriate support provision for both individuals following peer to peer incidents and/or behaviours of concern.

4. Principal Psychologist will continue to meet with staff team and provide guidance on how best to support and respond to individuals during periods of anxiety.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The risk in relation to individual making unfounded claims has been reviewed and updated to ensure all disclosures are given credence and investigated thoroughly.

2. All body maps will be reviewed and signed off by the SCW contemporaneously, and these will also be reviewed quarterly by the Community manager to ensure any trends are identified and additional measures implemented.

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	30/11/2024
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.	Not Compliant	Orange	30/09/2024
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota,	Not Compliant	Orange	30/08/2024

	showing staff on duty during the day and night and that it is properly maintained.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Substantially Compliant	Yellow	31/10/2024
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	31/03/2025
Regulation 21(1)(b)	The registered provider shall ensure that records in relation to each resident as specified in Schedule 3 are maintained and are available for inspection by the chief inspector.	Not Compliant	Orange	31/10/2024
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	30/11/2024
Regulation 23(1)(c)	The registered provider shall ensure that management	Not Compliant	Orange	30/11/2024

	systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.			
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.	Not Compliant	Orange	30/09/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	31/08/2024
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,	Substantially Compliant	Yellow	31/08/2024

	outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.			
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/09/2024
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Not Compliant	Orange	31/12/2024
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).	Not Compliant	Orange	30/09/2024
Regulation 07(1)	The person in charge shall ensure that staff	Substantially Compliant	Yellow	31/10/2024

	have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/09/2024