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:	No.3 Stonecrop
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Cork
Type of inspection:	Announced
Date of inspection:	09 November 2023
Centre ID:	OSV-0005146
Fieldwork ID:	MON-0032783

About the designated centre

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

No.3 Stonecrop is a semi-detached, two-storey house in a residential area on the outskirts of Cork city. A full-time residential service is provided to a maximum of five female adults. Residents have an intellectual disability diagnosis and may also be autistic. The focus in the centre is meeting the individual needs of each person within a homely environment. Each resident has their own bedroom. There is a communal kitchen, a living room and an upstairs sitting room in the centre. There are also small garden areas to the front and rear of the property. The model of support is social care with staff supporting residents in the morning and evenings. Residents are supported at night by one staff sleeping in the centre.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

How we inspect

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

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 9 November 2023	09:20hrs to 18:00hrs	Caitriona Twomey	Lead

What residents told us and what inspectors observed

This designated centre was last inspected on behalf of the Chief Inspector of Social Services (the Chief Inspector) in March 2022. This announced inspection was completed to monitor the provider's implementation of the compliance plan submitted following that inspection, and also to assess other areas of regulatory compliance. The findings of this inspection, and others completed since April 2021, will inform the Chief Inspector's response to the provider's application to renew the registration of the centre for another three-year period.

No.3 Stonecrop is a semi-detached, two-storey house in a residential area on the outskirts of Cork city. A full-time residential service is provided to four adults in the centre. Residents have an intellectual disability diagnosis and may also be autistic. Previously five residents lived in the centre, however one moved out in early 2022. In their application to renew the registration the provider was seeking to reduce the number of residents who lived in the centre to four, reflecting the current situation. Another proposed change was to use the former resident's bedroom as a staff bedroom and office. This would create another communal space downstairs for all residents to use. Each resident living in the centre had their own bedroom, one was downstairs and three upstairs. There was one communal bathroom upstairs, and another downstairs. At the time of this inspection, there was a kitchen and living room downstairs and another smaller sitting room upstairs.

This was an announced inspection. On arrival the inspector was greeted by the team leader. They were the only staff on duty in the centre at the time. As had been arranged prior to the inspection, the person in charge arrived in the centre shortly afterwards. These members of the management team facilitated this inspection. Residents had been prepared for the inspection by members of the staff team, and there were two accessible documents with a photograph of the inspector on display in communal areas.

When the inspector arrived there were two residents in the house, both were getting ready for the day ahead and were due to leave the centre to attend their day service. One resident had stayed with a relative the previous night and was due to return to the centre that afternoon, following their day service. The fourth resident had gone to their family home for a few days in preparation for their university graduation the following day. This inspector did not have an opportunity to meet with this resident but did spend some time with the other three.

On the morning of the inspection, the inspector greeted both residents who were in the centre. One resident was being supported to have their breakfast in the kitchen and greeted the inspector warmly. Staff supported the resident to choose what they would like to eat. The resident was seen using Lámh (a sign system used by children and adults with intellectual disability and communication needs in Ireland), gesture, and other non-speaking communication methods when interacting with staff. The inspector left the kitchen while this resident was eating, in keeping with their

assessed needs and personal plan. They later briefly met with this resident again before staff supported them to go out for a walk.

The other resident was eating their breakfast in the living room and did not wish to engage with the inspector at this time. This was respected. They said goodbye before leaving for their day service, using the inspector's name. This resident met with the inspector later in the day and showed them a medal they had received for taking part in a run while at day service. Staff supported the resident to have their photo taken with their medal so they could share it with their family members.They appeared proud of this achievement and showed their medal to the inspector again before they left the centre that evening. At this time the resident was in their bedroom listening to music using their headphones and appeared to be at ease and enjoying themselves.

The inspector met the third resident that afternoon after they returned from day service. They appeared happy to speak with the inspector and discussed a range of topics. They were very positive when speaking about living in the centre and told the inspector that they felt happy and safe. They were clear on who they would speak to if there was something bothering or upsetting them, referencing their keyworker. This resident was very close to members of their family and spoke with the inspector about recent and planned visits. They told the inspector about their role in decorating the upstairs sitting room. Later, the inspector met briefly with the resident in this room. They had chosen to go there to listen to music and do some art activities. They appeared to enjoy being in this area and seemed happy with the input they had in its decoration.

The inspector walked around the premises with the team leader while the residents were attending their day services. There was a range of accessible information on display and available in the centre. Topics covered included residents' rights, the meal plan for the week, information about safeguarding, and photographs of people who had key roles relating to this centre. The centre was noted to be decorated to a very high standard. It was clean, well-maintained, and homely. There had been recent works to upgrade the kitchen and the inspector was informed that renovations works were planned for a bathroom. As well as new kitchen units, new dining room furniture had also been bought. There was comfortable furniture available throughout the centre. Both the living and sitting rooms had televisions and residents who wanted one also had a television in their bedroom. Management advised that some residents had their own mobile phones and other electronic devices. Wireless Internet was available in the centre for residents' use. Each bedroom was reflective of the interests and personal taste of those who stayed in them. Personal items including photographs, cosmetics, CDs, and DVDs were readily accessible. Residents had been involved in the decoration of their bedrooms and as referenced previously, one resident had taken a very active role in furnishing the upstairs sitting room.

When walking around the centre it was identified that one fire door did not close fully. This meant, that if required in the event of a fire, it may not serve as an effective containment measure. This and other findings regarding the fire safety arrangements in the centre are outlined in more detail in the 'Quality and safety'

section of this report.

As this inspection was announced, feedback questionnaires for residents and their representatives were sent in advance of the inspection. Two completed questionnaires were returned to the inspector. One was completed by a resident with support from staff, and the other questionnaire was completed by a resident with support from both staff and a family member. Topics referenced in the questionnaires included the premises, daily activities, opportunities for privacy, feeling safe in the centre, and the support provided by staff. Where questions were answered, all responses were positive. Compliments received regarding the service provided in the centre had been documented. These included comments of appreciation for the staff support provided to residents, with the staff team described as 'always going above and beyond'. Another referenced a relative's 'total peace of mind' regarding the service provided to a resident. The inspector also reviewed the feedback received from some residents and their representatives as part of the annual review process. This majority of this feedback was positive with respondents reporting that they were satisfied with the service provided, referring to the centre as a nice place to live, and saying they liked living there. Again, staff were praised, with references made to their hard work and availability. There was also reference to improvements made to the premises and other planned works. As part of the annual review consultation, one resident had expressed a wish to live closer to family members, and another had expressed that they wanted everyone to get along.

There were references to the incompatibility of this group of residents to live together in reports written following inspections completed on behalf of the Chief Inspector in 2017 and again in 2019. Following a series of notifications regarding adverse events that had occurred in the centre, management had advised the inspector in April 2023 that a compatibility assessment had been completed to review the living arrangements and look at the suitability of the residents to live together. Although efforts had been made by management staff, this group of residents continued to live together and there was no plan in place to address this ongoing issue at the time of this inspection. The impact of this ongoing situation on residents will be outlined further later in this report.

As well as spending time with the residents in the centre and speaking with staff, the inspector also reviewed some documentation. When the provider applied to renew the registration of the centre they were required to submit some supporting documentation. This included the centre's statement of purpose and a guide about the centre prepared for residents. Both of these met the requirements of the regulations, with one requiring a minor revision to ensure all of the information included was up-to-date. Other documents read by the inspector included the most recent annual review, and the reports written following the two most recent unannounced visits to monitor the safety and quality of care and support provided in the centre. These reports will be discussed further in the 'Capacity and capability' section of this report. Staffing arrangements and staff training were reviewed. The inspector also read the centre's complaints log. The inspector also looked at a sample of residents' individual files. These included assessments and personal development plans, healthcare and other support plans. Safeguarding, risk

management, and fire safety arrangements in the centre were also reviewed. The inspector's findings will be outlined in more detail in the remainder of this report.

The next two sections of the report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre.

Capacity and capability

Although there was evidence of strong leadership in the centre, improvements were required to ensure that the centre was adequately resourced and an effective resolution was put in place to address the incompatibility of these residents to live together in this centre. As was identified previously, the management of notifications to the Chief Inspector and complaints required improvement.

There was a clearly-defined management structure in place that identified lines of accountability and responsibility. This meant that all staff were aware of their responsibilities and who they were accountable to. Support staff reported to the team leader, who reported to the person in charge. The team leader worked full-time in this centre only. They advised that they worked across the week and typically had eight supernumerary hours a week for administrative and other management tasks. The person in charge fulfilled this role for two other designated centres and also had other management responsibilities. They dedicated 20% of their working week to this centre. Staff meetings were held at least once a month. These were facilitated by the team leader. The person in charge advised that they aimed to attend these meetings once every three months. Meeting records indicated that relevant updates were routinely shared among the staff team. There was an evident focus on supporting residents to achieve their goals. Any recent audits and incidents, and possible learning from them, were also discussed. Management presence in the centre across the seven day week and regular staff meetings provided staff with opportunities to raise any concerns they may have about the quality and safety of the care and support provided to residents. Staff spoken with were positive about the support they received from their line manager.

There was a consistent and committed staff team working in the centre. All interactions between staff and residents observed and overheard by the inspector throughout this inspection were warm, respectful, and unhurried. It was clear that positive relationships had been developed and residents appeared comfortable with the supports provided to them. All residents who lived in the centre either attended a day service or went to work from Monday to Friday. As a result, typically the centre was not staffed from the morning to early afternoon during the week. However, it was explained to the inspector that if residents wished or were required to stay in the centre, for example if unwell, staffing would be arranged to facilitate this. Typically two staff were present when residents were in the centre during the

day. There was then one staff in the centre from 9pm who completed a sleepover shift. They then supported the residents the following morning to get up and start their day.

Due to the assessed needs of one resident they had previously received one-to-one support from a second staff member in the morning before leaving to attend their day service. At the time of this inspection, a second staff member was no longer rostered to work in the centre in the mornings and these staffing hours were not referenced in the statement of purpose. The person in charge told the inspector that this had not been in place for approximately one year. They advised that if a relief staff member had worked in the centre overnight, a member of the core team would provide support in the morning. When reviewing the record of incidents in the centre, it was noted that in the six months prior to this inspection there had there had been a number of incidents involving this resident in the morning when there was only one staff on duty. Documents indicated that one resident required one-to-one support for personal care, at mealtimes, and when showing signs of distress. One-to-one staffing support for this resident from a core staff member was also included as a control measure in the risk assessment completed regarding this resident's behaviour and its potential impact on them and others. It was therefore determined by the inspector that the number of staff working in the centre was not always appropriate to the assessed needs of the residents.

The provider had completed an annual review and twice per year unannounced visits to review the quality and safety of care provided in the centre, as required by the regulations. The annual review was completed in December 2022 and involved consultation with residents and their representatives, as is required by the regulations. This feedback was referenced in the opening section of this report. No actions had been developed in response to the feedback from residents. An unannounced visit had taken place in October 2022, and again in April 2023.There was evidence that the majority, but not all, actions to address areas requiring improvement were being progressed or had been completed. Some actions were repeated in consecutive visit reports indicating that they were not addressed when first identified, for example to recruit staff to work in the centre from 8am to 10am, and the need to document any actions taken on foot of a complaint, as is required by the regulations.

The inspector reviewed the centre's complaints log. One complaint had been made since the centre was last inspected on behalf of the Chief Inspector. According to the log, the complaint related to the staffing arrangements in the centre overnight and the availability of two named personnel. At the time of this inspection, the actions taken in response to this complaint were documented. As no dates were included it was not possible to assess if this complaint had been investigated promptly. Although the outcome of the complaint was not noted, it was recorded that the complainant was satisfied with the actions taken. It is a requirement of the regulations that a person who is not involved in the matters is nominated to deal with complaints made. This requirement was not met in this instance.

In advance of this inspection, the inspector reviewed notifications that had been submitted regarding this designated centre to the Chief Inspector. When in the

centre, the inspector reviewed the records maintained locally regarding adverse incidents and events that had occurred. A number of these records included statements from residents expressing their dissatisfaction with the behaviour of a peer and its impact on them. The inspector asked if these had been subject to the provider's complaints policy and procedures. Management advised that these were addressed with reference to the provider's safeguarding and protection policies. Safeguarding and protection is discussed in the next section of this report.

Following the inspector's review of adverse incidents, they queried with management why some incidents had not been notified to the Chief Inspector, in keeping with the requirements of the regulations. One example was an incident where it was recorded that a staff member had apologised to, and reassured, residents affected by the behaviour of a peer. Management advised that these events were not incidents that required notification. It was suggested that these records had not been worded accurately or clearly. When discussing another documented incident, it was identified that staff had responded to this in line the provider's safeguarding policy and it was intended for it to be notified to Chief Inspector. Management apologised for this error.

Registration Regulation 5: Application for registration or renewal of registration

The provider had submitted an application to register this centre in line with the requirements outlined in this regulation.

Judgment: Compliant

Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities

The registered provider had paid the annual fee outlined in this regulation.

Judgment: Compliant

Regulation 15: Staffing

The number of staff working in the centre was not always appropriate to the number and assessed needs of the residents. Staff personnel files were not reviewed as part of this inspection.

Judgment: Not compliant

Regulation 16: Training and staff development

A review of training records indicated that all five permanent members of the staff team had recently completed training in the areas identified as mandatory in the regulations. However, due to the assessed needs of the residents living in the centre, the provider had determined that staff also required training in the safe administration of medication, and epilepsy awareness. There was one staff member required to attend each of these trainings and both were scheduled to complete them in the month following this inspection.

The inspector also reviewed the training records of three staff who worked in the centre on a relief basis. It was identified that some of these staff required training in fire safety, the management of the behaviour that is challenging including de-escalation and intervention techniques, and safeguarding residents and the prevention, detection and response to abuse. Staff training in these areas is a requirement of the regulations.

Judgment: Substantially compliant

Regulation 22: Insurance

The registered provider ensured that insurance against injury to residents was in place.

Judgment: Compliant

Regulation 23: Governance and management

The centre was not sufficiently resourced to ensure the effective delivery of the care and support in accordance with the statement of purpose. All audits and reviews as required by the regulations were being conducted, however repeated findings in consecutive reports indicated that not all areas requiring improvement were effectively addressed when first identified. There were also repeated findings from previous inspections completed in behalf of the Chief Inspector regarding the notification of incidents and management of complaints. Despite the acknowledged incompatibility of the residents to live together in this centre and the impact this was having on their lived experience, there was no plan in place to address this matter. Therefore, management systems in place did not ensure that the service provided was safe and appropriate to each resident's needs.

Judgment: Not compliant

Regulation 3: Statement of purpose

The inspector reviewed the centre's statement of purpose. This is an important document that sets out information about the centre including the types of service and facilities provided, the resident profile, and the governance and staffing arrangements in place. This document met the requirements of this regulation. However some minor revisions were required to ensure that all information was up-to-date and accurate. This was completed during the inspection.

Judgment: Compliant

Regulation 31: Notification of incidents

As was found in the last two inspections of this centre, not all adverse incidents had been notified to the Chief Inspector, as is required by this regulation. Improvement was required in how incidents were documented in the centre.

Judgment: Not compliant

Regulation 34: Complaints procedure

The maintenance of the record of complaints required improvement to ensure that it included all details as specified in this regulation and was completed in a timely manner. The provider had not ensured that someone not involved in the subject of a complaint had been nominated to deal with it.

Judgment: Not compliant

Regulation 4: Written policies and procedures

The registered provider had prepared in writing, adopted and implemented policies and procedures on the matters set out in Schedule 5 of the regulations. However, not all of these had been reviewed in the previous three years, as is required.

Judgment: Substantially compliant

Quality and safety

Residents living in this centre were supported to participate in activities of their choosing, be active members of their community, and to enjoy and further develop their independence. While residents often got on well living together, due to the size of the designated centre and residents' assessed needs, when an incident did occur it often had a negative impact on residents. It had been assessed that the arrangements in the centre were not sufficient to meet each resident's needs. Although the provider had assessed and acknowledged the incompatibility of these residents to live together in this centre, there was no plan in place to address this ongoing situation at the time of this inspection.

Residents who lived in this centre had busy, active lives. All four residents attended either day service or work from Monday to Friday. They also enjoyed going out. In recent months different residents had gone to the cinema, to musicals in both Cork and Dublin, out for dinner, for a spa day, and for afternoon tea. One resident had recently bought tickets to see one of their favourite groups in concert next year. Contact with friends and family was important to the residents in the centre and this was supported by the staff team. Residents regularly spent time with their family members, at times staying overnight with them. Although all four residents could stay in the centre seven days a week, the inspector was informed that some chose to stay with relatives at the weekends. Residents were also supported to enjoy and maintain these important relationships between visits.

Residents were involved in the day to day running of the centre, each participating in everyday household tasks. Residents were involved in developing a weekly household menu but in instances where one resident wanted to eat something else, as was the case on the day of the inspection, this was facilitated. Rather than group meetings, for the last number of years each resident had a regular one-to-one meeting with their keyworker. The inspector was informed that this arrangement was found to work better than a group meeting due to the varied communication profiles of the residents. A review of records of these meetings demonstrated that residents were involved in planning what they did with their time, were consulted about the annual review of their personal plans, were reassured following incidents in the centre, and were provided with information in a way that was accessible and meaningful to them. One resident had been provided with an opportunity to take up a paid role as a member of a staff interview panel.

It was referenced in the previous inspection report that one resident had expressed a wish to live in a more independent setting. This resident was independent in many areas of their life. They had two jobs, their own key to the centre, and had recently completed a course in a local university. The inspector queried what progress had been made to support the resident with this goal. Management advised that this was still something that the resident would like but at the time of this inspection the resident was happy living in this centre. The inspector reviewed this resident's personal development goals for the year. These included goals to further develop

their independence in areas such as money management, cooking, and laundry skills. No goal referenced moving out of the centre.

The inspector reviewed a sample of the residents' assessments and personal plans. These provided guidance on the support to be provided to residents. Information was available regarding residents' interests, likes and dislikes, the important people in their lives, and daily support needs including communication abilities and preferences, personal care, healthcare and other person-specific needs such as mealtime support plans. These plans were detailed and personalised to each resident in the centre. A multidisciplinary review of each plan had been completed.

Residents' healthcare needs were well met in the centre. Residents had an annual healthcare assessment. Where a healthcare need had been identified a corresponding healthcare plan was in place. There was evidence of input from, and regular appointments with, medical practitioners including specialist consultants as required. There was also evidence of input from other health and social care professionals such as occupational therapists, psychologists, and speech and language therapists. One resident had a recent assessment and documented recommendations regarding feeding, eating, drinking and swallowing. A summary document had been developed for each resident to be brought with them should they require a hospital admission.

Residents' personal plans also included plans to maximise their personal development in accordance with their wishes, as is required by the regulations. Personal development goals outlined what each resident wanted to achieve in the year. It was documented that residents had been involved in the development of these goals and an accessible summary document was available. Goals were personal to the residents and reflected their interests and what was important to them. There was evidence that goals were regularly reviewed, and adapted if required due to changes in personal circumstances.

As referenced previously in this report it was acknowledged by the provider that the residents were not compatible to live together in this centre. The compatibility assessment completed by the provider referenced that incidents could be heard throughout the centre and other residents were often distressed. It also stated that routines in the centre were focused on the needs of one resident, reducing the opportunities for other residents to participate in activities of their choosing. It was also documented that incidents may restrict where residents could spend time in the centre.

The impact of this ongoing situation on residents was also documented in the records of incidents that had occurred in the centre. Several incidents were noted where residents' sleep was disrupted by a peer. As well as being woken up, residents were noted to appear distressed and anxious at times during incidents. It was documented that in response to their peer's behaviour some residents had shouted, sworn, threatened, or directed them to leave the centre. It was documented in one report that a resident had said that this peer was not allowed in their house. On other occasions, due to staff efforts to keep residents apart, residents weren't able to access some communal areas in the centre, such as the

kitchen. It was written in a psychology report dated May 2023 that one resident did not feel safe in a peer's company and that this peer's presentation impacted significantly on the opportunities available to them. It also referenced that the configuration of the centre and the staffing levels available were not conducive to meeting this resident's needs.

Staff spoken with were also conscious of the incompatibility of the residents in the centre. One staff member told the inspector that when incidents occurred it impacted on other residents' moods and also restricted their opportunities to engage in activities of their choosing. In keeping with the support plan in place, if one resident began to show indicators of distress they received one-to-one staff support and were often supported to leave the centre, either going for a walk or a drive. As a result there was only one staff remaining in the centre, and at times no car, which meant other residents may not be able to go out as they wished. Staff advised that recently a resident who may become distressed had not been in the centre for a week. They told the inspector that this had highlighted the impact of the current situation on residents, as during that week they had gone out more than usual in the evenings and had more opportunities for one-to-one time with staff.

Incidents had been subject to the provider's safeguarding policy and there was evidence of correspondence with the local safeguarding and protection team. The inspector read the safeguarding plans developed in response to these incidents. These plans made reference to separating residents from each other at times of anxiety. While the inspector observed this in action on the day of inspection, as has been highlighted previously, staffing arrangements were not always in place to facilitate this.

Regulation 11: Visits

Residents were supported to receive visitors in line with their wishes. Staff also supported residents to visit their family homes. There were suitable communal facilities and private areas for residents to receive visitors in the centre.

Judgment: Compliant

Regulation 13: General welfare and development

Residents had access and opportunities to engage in activities in line with their preferences and interests. Opportunities were provided to participate in a wide range of activities in the centre and the local community. One resident had recently completed a university course and worked a few days a week. The ongoing incompatibility of residents to live together did at times impact on some opportunities to be involved in everyday experiences. This finding is reflected in the

judgment for Regulation 5: Individual assessment and personal plan.

Judgment: Compliant

Regulation 17: Premises

The premises were clean, well-maintained, and decorated in homely manner. Residents had been involved in the decoration of their own bedrooms and some communal spaces.

Judgment: Compliant

Regulation 18: Food and nutrition

There was evidence that choices were offered at mealtimes and that staff had a good knowledge of residents' assessed needs and individual dietary needs and preferences. The support observed during a meal time was consistent with the recommendations and plan in place. There was a supply of fresh and frozen nutritious food in the centre. Residents were supported to be involved in grocery shopping, meal preparation, and baking in line with their wishes.

Judgment: Compliant

Regulation 20: Information for residents

The inspector reviewed the guide prepared by the provider regarding the centre. A copy of this had been provided to each resident. This guide met the requirements of this regulation.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a system in place for the assessment, management and ongoing review of risk. The centre's risk register was recently reviewed. Some risk assessments required further review to ensure that the risk ratings were reflective of the current risk posed by the hazards identified, for example the impact rating in a risk assessment regarding poor road safety awareness was not accurate. The

staffing levels outlined as control measures in two risk assessments were not consistently in place in the centre. No risk assessment was available regarding one resident spending time in the centre without staff presence or support.

Judgment: Substantially compliant

Regulation 28: Fire precautions

Fire detection and alarm systems, emergency lighting, and fire fighting equipment were available in the centre. These were regularly serviced by external contractors. It was noted that one door in the centre was not closing fully. As a result it may not serve as an effective containment measure if required in the event of a fire.

Each resident had a personal emergency evacuation plan (PEEP). These did not include residents' support needs at the assembly point. There were documented evacuation procedures in place. Staff advised that if working alone in the centre they would contact a nearby designated centre and some neighbours for support. However, calling for additional help was not included in the evacuation procedure. Regular evacuation drills had taken place in the centre and were completed in a time assessed as safe by the provider. A drill with night-time staffing levels had been completed, however residents were not in bed at the time. Management committed to completing a drill when all four residents were in bed to assure themselves that the centre could be safely evacuated in this scenario.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident's health, personal, and social care needs had been assessed and these assessments were used to inform the development of their personal plans. There was evidence of regular review and updating of personal plans. Each plan had been subject to a multidisciplinary review, as is required by the regulations. Residents had been supported to develop and achieve personal development goals that were meaningful to them.

However, it had been assessed that this group of residents were not compatible to live together. At the time of this inspection there was no plan in place to address this longstanding, ongoing situation. From the inspector's observations, speaking with staff, and reviewing a number of documents, including incident reports, multidisciplinary reports, and a compatibility assessment, it was determined that the designated centre was not suitable for the purposes of meeting the needs of each resident.

Judgment: Not compliant

Regulation 6: Health care

Residents' healthcare needs were well met in the centre. Residents had access to medical practitioners, dentists, and other health and social care professionals, as required. There was evidence of regular review and updating of residents

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents who required one had a recently reviewed behaviour support plan in place. One plan had been developed by staff and a referral had been made for multidisciplinary support to further enhance it. A consultation had been provided in October 2023. Staff spoken with were very knowledgeable about situations that residents found difficult or distressing, and were familiar with the interventions outlined in their plans. Preventative approaches to implement to reduce the likelihood of an incident occurring and guidance to follow if needed in the event of an incident were outlined. From speaking with staff and reading the incident records in the centre, it appeared that the effectiveness of one resident's response plan was inconsistent.

There were no restrictive practices used in the centre.

Judgment: Compliant

Regulation 8: Protection

All safeguarding concerns had been addressed in line with the provider's and national safeguarding policies. There was evidence of liaison with the local safeguarding and protection team, as appropriate, and regular review of safeguarding plans. Due to the staffing levels and the size of the centre, it was not possible to consistently implement the safeguarding plans, as outlined. As a result, despite the best efforts of staff, the provider was not consistently protecting residents from all forms of abuse.

The finding that one relief staff member required training in relation to safeguarding residents and the prevention, detection and response to abuse is reflected in the findings for Regulation 16.

Judgment: Not 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
Registration Regulation 9: Annual fee to be paid by the registered provider of a designated centre for persons with disabilities	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Not compliant
Regulation 34: Complaints procedure	Not compliant
Regulation 4: Written policies and procedures	Substantially compliant
Quality and safety	
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially 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	Compliant
Regulation 8: Protection	Not compliant

Compliance Plan for No.3 Stonecrop OSV-0005146

Inspection ID: MON-0032783

Date of inspection: 09/11/2023

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: The Provider will work with the Person in Charge to support the outcome of the review the risk assessment in relation to the staffing levels within the centre which is due to be completed on 01/03/2024. This will be kept under ongoing review.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • The Person in Charge will ensure staff, scheduled for medication and epilepsy training are identified on the training matrix, complete trainings as scheduled [20/02/24]. • The Person in Charge will ensure that all staff working in the centre have updated mandatory trainings as required [01/03/2024].	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: Regulation 23: Governance and management Not Compliant Outline how you are going to come into compliance with Regulation 23: Governance and management: The Provider will ensure • that the resident who previously wished to move from the Centre but who did not pursue the option is again supported to consider this n with her natural support network. The PIC will ensure that this goal is reinstated into the person's Person Centred Plan • All issues arising on the Annual Review of the Centre have associated time-framed	

actions
• All actions that remain outstanding from previous provider visits are identified on the risk register and escalated for resolution as necessary
• The Person in Charge will arrange a formal review of the incompatibility issues in the Centre with MDT as necessary. Options to change the layout of the Centre if one resident progresses their goal to leave the Centre to live more independently will be considered in the short term. The longer-term plan will also be identified. The recommendations from the review will be escalated to the Sector Manager for Provider consideration [31/3/24].
• the recommendation on the compatibility review outlined in regulation 5 and 8 below are supported by means of a clear plan to implement the recommendations with a view to resolving the issues with short-term solution by 30/09/2024 and full resolution, which may involve securing an alternative placement for some resident by 30/04/2025.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
The Person in Charge will
• review procedure for return of notification when on leave to ensure all incidents are reported in line with regulations [01/03/2024].
• review wording of incident reports with staff to ensure there is no ambiguity that could be misinterpreted as physical intervention or notifiable incident. [01/03/23]

Regulation 34: Complaints procedure	Not Compliant

Outline how you are going to come into compliance with Regulation 34: Complaints procedure:
The Provider will ensure that the Person in Charge reviews the recording of complaints in the centre to ensure that the local complaint is completed in full and in line with the policy including the complaint identified by the inspector. [01/03/24].

Regulation 4: Written policies and procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 4: Written policies and procedures:
The Provider will ensure that all local Regional policies are updated by 31/03/2024 and that National Polices are updated by 30/04/2024.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The Provider will ensure that:
• the Person in Charge reviews the risk register to ensure the risk assessments and ratings are reflective for the current level of risk and support needs [01/03/2024].
• The Person in Charge will ensure that the risk assessment for one resident to be on own in house at times when staff are not present is up to date and added to the risk register [30/11/23].
The Person in Charge will review and update the risk rating identified by the inspector in relation to road safety. [30/11/23]

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: The Provider will ensure that • the fire door identified on the day by the inspector closes properly. [30/11/24] • the Person in Charge reviews all PEEPs and evacuation procedures to ensure they include what to do at assembly points and if assistance is required who will be called [01/03/2024]. • the Person in Charge will ensure that a simulated nighttime evacuation drill, when residents are in their bedrooms is completed and recorded and any risks identified for resolution [01/03/2024].

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: • The Person in Charge will ensure that the resident who previously prioritized their goal to move from the Designated Centre but did not wish to progress this, is supported to review and consider reinstating this in their personal plan • The Person in Charge will ensure all recommendations in relation to incompatibilities will be escalated to the Sector Manager for Provider consideration [01/03/2024]. • Following this, the Provider will ensure that a team review including the designated officer, staff team, management and MDT (if required) will be conducted on the current environment to assess and make recommendations to address the ongoing situation [01/05/24]. The Provider will work to implement the recommendations in the short term by 30/09/2024 and overall by 30/04/2025

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: The Provider will ensure that • an interim safeguarding management plan will remain in place and will be reviewed at staff team meetings. • As outlined in regulation 23, will ensure a team review, including the designated officer, staff team, management and MDT (if required), will be conducted on the current environment to assess and make recommendations to address the ongoing situation [1/5/24]. It is hoped to have plans to address the issues by some changes to the layout of the Centre in the short term (30/09/2024) and to have longer term solution in place by 30/04/2025

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 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	01/03/2024
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	01/03/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Not Compliant	Orange	01/03/2024

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	30/04/2025
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	01/03/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	01/03/2024
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	01/03/2024

Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any resident.	Not Compliant	Orange	01/03/2024
Regulation 34(2)(a)	The registered provider shall ensure that a person who is not involved in the matters the subject of complaint is nominated to deal with complaints by or on behalf of residents.	Not Compliant	Orange	01/03/2024
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, outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.	Substantially Compliant	Yellow	01/03/2024
Regulation 04(3)	The registered provider shall review the policies and procedures referred to in paragraph (1) as	Substantially Compliant	Yellow	30/04/2024

	often as the chief inspector may require but in any event at intervals not exceeding 3 years and, where necessary, review and update them in accordance with best practice.			
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	01/05/2024
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	30/04/2025
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/04/2025