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:	Garvagh House
Name of provider:	St Michael's House
Address of centre:	Dublin 13
Type of inspection:	Short Notice Announced
Date of inspection:	14 April 2021
Centre ID:	OSV-0002348
Fieldwork ID:	MON-0030362

About the designated centre

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

Garvagh House is a residential service for five adults with intellectual disabilities. The centre is operated by St Michael's House. The centre comprises of a six bedroom, detached house which is located in North County Dublin. There are five resident bedrooms, one staff sleepover room, a sensory room, quiet room, sitting room and kitchen/dining room. It is within walking distance of public transport and a range of local amenities which residents frequently use. There is a well proportioned garden to the rear of the centre for residents to enjoy. The centre is managed by a person in charge and is supported in their role by a deputy manager. A person participating in management forms part of the overall provider's governance arrangements for the centre. The staff team consists of a team of social care workers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	5

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 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 14 April 2021	10:00hrs to 16:30hrs	Ann-Marie O'Neill	Lead

What residents told us and what inspectors observed

This inspection found residents received a reasonable standard of care and support. However, the daily routines and safeguarding measures implemented in the centre, had resulted in a restrictive environment which did not promote residents' independence in accessing all areas of their home as they wished.

The inspector met with all residents present for the duration of the inspection and communicated with them on their terms and respected their choice to engage or not with the inspector. Interactions between the inspector, residents and staff took place from a two-metre distance, wearing the appropriate personal protective equipment (PPE) for short periods of time.

Due to a presenting risk in the centre, the inspector was unable to engage in observation periods with some residents.

Residents did not engage in feedback conversations with the inspector. The inspector therefore, greeted residents and observed them going about their daily routines and their interactions with staff and their peers. Residents were observed going on shopping errands with staff, spending time in the garden area to the rear of the centre and using hand held electronic devices.

Staff were observed interacting with residents in a kind and pleasant manner, they afforded residents the opportunity to spend time alone in their bedrooms or prepare for leaving the centre. Residents were supported in a discreet and dignified manner. Staff were observed speaking to residents, explaining what was happening next and seeking their understanding or acknowledgement before helping them with the next task.

The centre comprises of one detached building, located in North Dublin close to local amenities and public transport routes. Residents were afforded a large garden area to the rear of the centre which was well maintained and could provide residents with options to engage in activities if they wished. While a good standard of cleanliness was upheld throughout the centre a suite of refurbishment works were required.

The inspector noted considerable wear and tear of the skirting boards and door frames within many parts of the centre. A number of walls in the centre required repainting and there were some areas where plaster on the walls was cracked or missing and required repair. The flooring in the communal bath/shower area also required replacing and was observed to be lifting from the floor. While a sensory room had been made available for residents it was observed this space was also being used to store the centre's PPE which impacted on residents being able to use the space for it's intended purpose.

The upstairs part of the centre was used mostly by one resident and contained their bedroom and an additional sensory space room for them to use. The inspector

observed some risk reduction measures had been installed upstairs on the landing area in the form of Perspex fitted above the banisters of the stairs.

The person in charge informed the inspector that these measures had been put in place to mitigate the risk of the resident climbing onto the banisters. A wooden stair gate was also fitted to the top and bottom of the stairs, this practice was also identified as a risk measure to support the resident to remain upstairs at night time. It was however, unclear if this was the least restrictive measure and how it had been determined that the location of the resident's bedroom upstairs, was the most suitable arrangement given the potential risk posed for climbing and the restrictive measures required thereafter to mitigate this risk.

The inspector also noted other restrictive arrangements in place within the environment which were in place in order to mitigate and manage a safeguarding risk.

There were ongoing incompatibility issues in the centre which required close supervision and monitoring in order to mitigate the potential of safeguarding incidents from occurring. Some residents did not spend time in the company of their peers or enter the same room as their peers, in order to manage potential safeguarding risks. This required the person in charge and staff to orchestrate activities for residents which ensured they did not use the same areas in the centre at the same time.

Some of these measures included bringing residents out of the centre for an activity to allow the other residents, that remained at home, to use specific areas in the centre. When those residents returned to the centre, the other residents were brought on an activity away from the centre. In addition, staff had placed opaque contact coverings on the windows of the doors between the kitchen and dining area to prevent residents from seeing their peers when they were in either room.

In summary, residents were in receipt of a reasonable standard of care and support in this designated centre. However, there were a number of areas that required improvement to ensure their environment supported their assessed needs, personal risks and promoted their civil liberties and choice in how they wished to spend their day. Residents experienced a high level of restrictions in their daily lives which were further compounded by the National restrictions required to manage the ongoing COVID-19 pandemic.

The next two sections of this report present the inspection findings in relation to governance and management in the centre, and how governance and management affected the quality and safety of the service being delivered.

Capacity and capability

Overall, the management systems in place ensured the service was monitored in line

with the requirements of Regulation 23, however, these oversight arrangements were not effective in capturing the more serious risks in the centre and making arrangements to improve the quality of care to residents.

The provider had appointed a full-time person in charge for the centre who had the required management experience and qualifications to meet the regulatory requirements of the role.

There were clear lines of responsibility and reporting in the centre. The person in charge reported to a services manager who in turn reported to a director of services. At centre level, the operational management of the centre fell under the remit of the person in charge and a team leader.

There was evidence of the provider meeting their regulatory obligations for Regulation 23, whereby they had completed an annual report for 2020 and had carried out six-monthly quality audits of the centre to monitor it's compliance with the regulations. These audits were comprehensive in scope and provided an action plan for areas that required addressing. However, they had not captured the ongoing risks presenting in the centre in relation to the level of restrictive practices and restrictive routines in operation in the centre.

Additional centre based quality audits were completed by the person in charge, and additional health and safety audits had been carried out by a representative of the provider. One such health and safety audit, carried out in October 2020, was detailed and informative and identified a specific urgent risk in the centre that required addressing in relation to training and skills for staff for the management of incidents of aggression.

While the audit had identified this serious risk and made recommendations to address it, some seven months later, at the time of inspection, this action had not been addressed and no such training had been provided. Further reference to this is made in the quality and safety section of this report which outlines the impact of this poor governance arrangement on the risk measures in the centre.

Arrangements were in place for staff to receive training and refresher training in the areas of safeguarding vulnerable adults, fire safety and manual handling. However, it was noted there were gaps in refresher training in other key areas, for example, medication management. This required review.

The person in charge had appropriate measures in place to supervise staff working in the centre with a scheduled time-table for staff supervision meetings for the remainder of the year. Staff spoken with were complimentary of the person in charge and told the inspector that they were approachable and responsive to them.

Overall, the provider had ensured the staffing resources for the centre met the whole-time-equivalent as set out in the statement of purpose for the centre. There was a small shortfall of staffing resources at the time of inspection however this was managed by the person in charge within the staffing compliment and also with the use of regular relief or agency workers. While the staffing numbers were maintained to an appropriate level there were improvements required by the provider in this

regard.

Given the complex support needs for some residents, staff working in the centre required specific training and skills to support their needs. As relief or agency workers were utilised from time-to-time, the provider was required to review the staffing arrangements to ensure appropriately skilled staff worked in the centre with due regard to the needs of residents and personal risks they may present with.

Regulation 14: Persons in charge

The person in charge worked in a full-time capacity and had the required management experience and qualifications to meet Regulation 14.

The person in charge was knowledgeable of the care and support needs of residents. Staff spoken with were complementary of the person in charge and told the inspector they were approachable and they could raise concerns to them if and when they arose.

Judgment: Compliant

Regulation 15: Staffing

Overall, the provider had ensured there were adequate staffing numbers to support residents living in this centre.

Where some staffing resources gaps occurred these were managed within the staffing resources available in the centre. Regular relief staff worked in the centre also as part of this arrangement.

However, while it was demonstrated there were adequate staffing resources each day to meet the needs of the residents there continued to be a short-fall in the overall whole-time-equivalent staffing numbers for the centre.

In addition, given the support needs of residents, the provider was required to ensure the centre was resourced with a consistent staff team that were appropriately trained staff given the specific risks presenting in the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The person in charge had made arrangements to provide supervision to the staff team at appropriate intervals with supervision dates scheduled in advance for the remainder of the year.

Overall, staff had received training in mandatory areas as required, for example, fire safety, manual handling and safeguarding vulnerable adults.

Some further improvements were required to ensure staff received refresher training in other areas, for example medication management.

Judgment: Substantially compliant

Regulation 23: Governance and management

While it was demonstrated the provider had appropriate systems in place to meet the specific requirements of Regulation 23, in terms of caring out an annual report, six-monthly provider led audits, it was not demonstrated that these oversight arrangements were effectively informing the provider of the risks presenting in the centre.

In addition, where audits did identify serious risks, it was not demonstrated the provider had effective systems in place to address those risks when they were identified.

There was an ongoing incompatibility issue occurring in the centre which posed a safeguarding risk to residents.

While it was demonstrated localised safeguarding planning arrangements were effective, it was not demonstrated that the provider was undertaking effective action to address these issues with a focus on a longer term solution to bring about a positive living environment for all residents.

Judgment: Not compliant

Quality and safety

Residents living in this centre were in receipt of a reasonable standard of care and support. However, there were considerable improvements required to ensure residents' quality of life was improved, their right to choice in their daily lives was promoted and their civil liberties upheld while balancing safeguarding and behavioural risks in the centre.

The inspector reviewed a sample of residents' personal plans. They were found to

be comprehensive, detailed and up-to-date. Residents' assessments of need had been reviewed and where needs arose or were identified support planning was in place. While ongoing incompatibility issues presented in the centre, it was not demonstrated the provider had appropriately assessed the compatibility of residents and identified the type of environment and peers they would be most suited with, which in turn would lessen the requirements for restrictive practice measures to manage safeguarding risks. This required improvement.

As referred to, there was a high level of restrictive practices implemented in this centre for the purpose of managing risks of a safeguarding nature whereby residents were restricted from being in the same room and area as their peers. Daily routines for residents were focused on keeping some residents separate and further environmental adjustments had been made to prevent residents from seeing their peers while in another room. For example, staff had placed opaque contact on the windows of doors leading from the dining room to the living room to block some residents' view of their peers.

Other restrictions observed were the use of gloves as a means of mitigating the risk of scratches to staff while implementing intimate care supports for some residents. The inspector observed stair gates and sheets of Perspex installed on the stair case to prevent the risk of residents climbing or falling when using the upstairs part of the centre.

While it was demonstrated these measures had been put in place to manage specific risks, they also demonstrated the environment and peer group were incompatible, given such level of restrictions were required. While a number of these restrictions had been referred to and reviewed by the provider's positive approaches group, not all restrictive practices in the centre had been identified as such and therefore had not been reviewed, for example, the restrictive daily routines operating in the centre.

Where required residents had positive behaviour supports in place created and regularly reviewed by appropriately qualified allied professionals. The inspector reviewed a sample of behaviour support plans which promoted proactive management of behaviours that challenge and took into consideration the emotional well-being of residents with detailed support guidelines for staff to implement in this regard.

However, further improvements were required to ensure staff had the appropriate skills to manage ongoing behaviour risks and associated incidents of aggression that could present. No staff working in the centre had received training in the management of behaviours that challenge. Therefore, while behaviour support planning was detailed and informative, staff had not been provided with the necessary skills training in this regard. This required improvement.

There were further considerable improvements required in relation to the management of the risk of aggression in the centre. In September 2020 staff working in the centre had experienced serious incidents of aggression. On foot of these incidents, a health and safety audit had been carried out in the centre in

October 2020, which identified a number of staff had not been trained in breakaway techniques or skills to respond to these risks. The audit had identified there was an urgent requirement for staff to receive training in these skills. However, at the time of the inspection staff had not yet received this training.

In consideration of the serious incidents that had occurred and the ineffective response by the provider to manage this risk, the inspector issued an urgent compliance plan to the provider, requiring them to address this risk within a specific time-frame. The provider responded with a plan for addressing this urgent risk which would see all staff receive training in breakaway techniques with further training in positive behaviour support also forming part of their response.

The provider was required to further review all other presenting risks in the centre and to ensure robust and considered control measures were in place while also balancing the rights of residents.

There were systems in place to safeguard residents. At the time of inspection there were a number of safeguarding plans in place which set out the measures required to mitigate and manage peer-to-peer safeguarding concerns. Staff had received mandatory training in safeguarding vulnerable adults with refresher training also provided. Staff spoken with were knowledgeable of safeguarding procedures also.

Intimate care planning was of a comprehensive standard and detailed supports required by residents to ensure their independence as much as possible while maintaining their privacy, dignity.

However, despite these safeguarding measures in place, there continued to be a residual safeguarding concern in the centre that required ongoing monitoring and supervision in order to prevent peer-to-peer safeguarding incidents from occurring. While the safeguarding plans were effective in preventing incidents, they encompassed keeping some residents away from the vicinity of their peers at all times which demonstrated the incompatibility of the resident group and the restrictive measures required to keep residents safe.

There were systems in place for fire safety management. The centre had suitable fire safety equipment in place, including emergency lighting, a fire alarm and fire extinguishers which were serviced as required. Residents had a personal emergency evacuation plans (PEEP) in place which guided the staff team in supporting them to safely evacuate the centre. There was evidence of regular fire evacuation drills. Actions from the previous inspection in relation to fire safety precautions had been addressed and overall it was demonstrated there were good fire and smoke containment measures in the centre.

However, some improvement was required to ensure door closing devices were fitted to fire doors in the centre to ensure the most optimum containment measures were in place. In addition, while residents had up-to-date, detailed personal evacuation plans in place, not all staff had been trained in the use of a fire evacuation aid which formed part of a resident's evacuation plan. This required improvement.

Observations of the premises noted a suite of refurbishment works were required to ensure the premises was maintained in it's most optimum condition and a pleasant environment for residents to live and enjoy. In addition, it was not demonstrated there were appropriate storage options in the centre for PPE.

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19. There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required. There was infection control guidance and protocols for staff to implement while working in the centre. Personal protective equipment (PPE), including hand sanitisers and masks, were available and were observed in use in the centre on the day of the inspection. The centre was supported by the provider's internal COVID19 management team and had access to support from Public Health.

Regulation 17: Premises

A considerable suite of refurbishment works were required to bring the premises of the centre into it's most optimum condition.

The inspector observed the following:

- Skirting boards in some areas of the property were damaged and required replacing, for example it was observed the paint on the skirting had come away exposing the bare damaged wood underneath.
- Some door frames were damaged.
- There were areas of the premises where paint had come away from the walls but had not been touched up leaving noticeable marks.
- There were visible cracks on some walls and areas where plaster had broken away in some areas.
- The floor covering in the bathroom/shower area required repair/replacing as it was observed to be lifting from the floor in places.

Improvements were also required in relation to the storage of Personal Protective Equipment. The inspector observed a number of boxes and bags of PPE stored in the sensory room of the centre. This arrangement impacted on residents' enjoyment of the space.

Judgment: Not compliant

Regulation 26: Risk management procedures

While the provider had created policies, procedures and risk management oversight systems in their centre, it was not demonstrated they had the capability to address

serious risks if and when they occurred or were identified.

A health and safety audit carried in October 2020, by a representative of the provider, had identified the urgent requirement for staff training in techniques to manage incidents of aggression and violence. However, at the time of inspection in April 2021 no such training had taken place.

The inspector issued an urgent action to the provider instructing them to address this serious risk within a specific time-frame.

While it was noted a number of risks presenting in the centre were managed through the presence of restrictive practices, for example, the use of Perspex and stair gates, it was not demonstrated that a proactive risk management approach was taken at all times to mitigate risks for residents to ensure the least restrictive option was utilised to manage risks presenting.

It was not demonstrated if the risk posed by storage of PPE in the sensory room had been assessed in relation to potential trips/slips and falls for example.

Judgment: Not compliant

Regulation 27: Protection against infection

The provider had ensured that systems were in place for the prevention and management of risks associated with COVID-19.

There was evidence of ongoing reviews of the risks associated with COVID-19, with contingency plans in place for staffing and isolation of residents, if required.

There were good supplies of PPE in the centre, alcohol hand gel was also available for staff and residents to use.

Appropriate arrangements were in place for testing residents and staff as required. Residents and staff also had their temperature checked daily.

Judgment: Compliant

Regulation 28: Fire precautions

Fire safety servicing records were up-to-date for the fire alarm, emergency lighting and extinguishers.

Staff had received up-to-date fire safety training with refresher training also

provided.

Personal evacuation plans had been created for each resident and were evaluated for their effectiveness through regular fire safety drills both during the day and night time. However, it was noted not all staff had been trained in the use of some evacuation aids which formed part of the evacuation planning for some residents.

Good fire containment measures were in place however, while it was noted there some fire doors throughout the property they had not all been fitted with hold open/closing devices to ensure the most optimum containment measures in the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan in place which was comprehensive, up-to-date and reviewed regularly.

Residents support needs were regularly reviewed through a multi-disciplinary allied professional framework with associated support planning arrangements in place for each identified need for residents.

While comprehensive assessment and planning arrangements were in place, it was not demonstrated that a known incompatibility issue had been assessed. Therefore, it was not clear what arrangements were required to support residents to live in the most appropriate environment and peer group in order to meet their needs and mitigate and manage safeguarding concerns.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Overall, there were a high level of restrictive practices implemented in the centre which included not only environmental restrictions but also restrictions in the daily routines of residents. These restrictions had been implemented as part of overall safeguarding measures required to keep residents safe from their peers.

While these restrictions were effective in mitigating the safeguarding risk, it was not demonstrated that they had been appropriately reviewed in relation to their impact on residents' civil liberties and their right to enjoy freedom and choice within their day and in their home.

Not all staff had received training in breakaway techniques or managing incidents of

aggression and behaviours that challenge, despite a number of incidents that had occurred in the previous year where staff had experienced assaults from residents.

No staff working in the centre had received training in positive behaviour supports despite a number of residents living in this centre requiring positive behaviour support planning arrangements.

Judgment: Not compliant

Regulation 8: Protection

All staff had received training in safeguarding vulnerable adults. There was evidence to demonstrate the implementation of safeguarding policies and procedures in the centre which were in line with National safeguarding policy.

Staff spoken with demonstrated an understanding of safeguarding reporting systems and were knowledgeable of the designated officer for the centre and their contact details.

Safeguarding plans were in place and were up-to-date and it was noted there had been a reduction in the frequency of peer-to-peer safeguarding incidents occurring in the centre over the previous year.

However, despite these safeguarding measures being effective in mitigating and managing safeguarding risks, there remained an ongoing potential safeguarding risk for residents living in the centre which required considerable restrictive measures and separation of the resident group on a consistent basis in order to maintain residents' safety.

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 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Garvagh House OSV-0002348

Inspection ID: MON-0030362

Date of inspection: 14/04/2021

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	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • 10.5 Wholetime Equivalant, there is currently 10 WTE staff inplace. A 0.5 WTE Vacancy currently exists. HR are in the process of recruiting staff. • All staff, except 3 who are currently on leave, have now completed the online PBS Training. The 3 remaining staff will have this completed by 31/05/2021. • TIPS training complete by 8 members staff on the 20/04/2021 & 23/04/2021. There was 2 staff members on leave at this time and training will be scheduled for them by 31/05/2021	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • All staff, except 3 who are currently on leave, have now completed the online PBS Training. The 3 remaining staff will have this completed by 31/05/2021. • TIPS training complete by 8 members staff on the 20/04/2021 & 23/04/2021. There was 2 staff members on leave at this time and training will be scheduled for them by 31/05/2021 • Evacuation Aid training took place on the 11/05/2021, 5 staff were trained. Second session scheduled on 14/05/2021 for remaining staff. • SAM Training is now taking place again. 3 staff due for Initial training. 1 staff is scheduled for training on the 26/05/2021. A second staff is scheduled on 09/07/2021. And remaining staff will be scheduled for 15/07/2021. Staff members who have not yet received training will always be rostered on with a SAM trained member of staff	

Regulation 23: Governance and management	Not Compliant

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

• All identified risks from internal Audits including 6 monthly visits have now been reviewed and actions in place, including training plan outlined below.

• All staff, except 3 who are currently on leave, have now completed the online PBS Training. The 3 remaining staff will have this completed by 31/05/2021.

• TIPS training complete by 8 members staff on the 20/04/2021 & 23/04/2021. There was 2 staff members on leave at this time and training will be scheduled for them by 31/05/2021

• Evacuation Aid training took place on the 11/05/2021, 5 staff were trained. Second session scheduled on 14/05/2021 for remaining staff.

• SAM Training is now taking place again. 3 staff due for Initial training. 1 staff is scheduled for training on the 26/05/2021. A second staff is scheduled on 09/07/2021. And remaining staff will be scheduled for 15/07/2021. Staff members who have not yet received training will always be rostered on with a SAM trained member of staff

• A Restrictions Audit was carried out by Quality and Standards Manager on the 05/05/2021. All restricive practices reviewed. Where the inspector outlined that there is a restriction on civil liberties, this will be on the agenda of the next Positive Approaches Monitoring Group (PAMG) meeting on the 13/05/2021. All recomendations from the PAMG meeting will be implented by the PIC.

• All Sageguarding plans reviewed with Social Worker and all are necessary at present.

• Supports are in place for residents with guidance from Psychology department to address and minimise current compatability issues .

• Ongoing review of compatibility issues within the centre has begun with Individual Coordination Meeting (ICM) that was held on 05/05/2021 which involved a Multi Disciplinary team.

• Individual Coordination Meeting (ICM) took place on the 05/05/2021 to discuss Compatibility issue.

o Current plan is to review Assessment of Need of residents that were identified during inspection.

o PBS guidelines will also be reviewed.

o Psychiatric Review referral submitted .

o Risk Assessment for peers being put in place.

o

• This process has commenced. Based on these reviews further ICM will be scheduled to examine outcome of reviews and indentify possible actions needed to address the issue of compatibility for residents in Garvagh.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Painting of interior and exterior of house has been approved.
• PIC has liaised with painting contractor .Work will commence on 12/05/2021 Schedule will be planned that causes least disruption for residents whilst also following all IPC guidelines.
• Technical Service Department (TSD) have been made aware of all works needed . Plan in place to have works comleted by 10/08/2021. Work will be carried out following all IPC protocols whilst causing least amount of disruption to residents.
• The floor covering in the bathroom/shower area will be replaced by 10/08/2021. This has been priced and contractor identified.
• Alternate storage arrangements have been made within the unit as of 26/04/21

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Health & Safety audit October 2020 has been reviewed and all recommendations implemented
• All staff, except 3 who are currently on leave, have now completed the online PBS Training. The 3 remaining staff will have this completed by 31/05/2021.
• TIPS training complete by 8 members staff on the 20/04/2021 & 23/04/2021. There was 2 staff members on leave at this time and training will be scheduled for them by 31/05/2021
• PBS guidelines for all relevent residents are currently being reviewed and updated.This process should be complete by 31/05/2021.
• A Restrictions Audit was carried out by Quality and Standards Manager on the 05/05/2021. All restricive practices reviewed. Where the inspector outlined that there is a restriction on civil liberties,this be on the agenda of the next Positive Approaches Monitoring Group (PAMG) meeting on the 13/05/2021. All recomendations from the PAMG meeting will be implented by the PIC. Awaiting outcome of meeting to establish actions and time frame.
• Sensory room has been cleared of PPE as 26/04/2021

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• Organization plan of completion of self closing fire doors in Garvagh is 31/09/2021

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• Individual Coordination Meeting (ICM) took place on the 05/05/2021 to discuss Compatibility issue. Current plan is to review Assessment of Need of residents that were identified during inspection. PBS guidelines will also be reviewed. This process has started. Based on these reviews further ICM will be scheduled to examine outcome of reviews and indentify possible actions needed to address the issue of compatibility for residents in Garvagh.

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
• A Restrictions Audit was carried out by Quality and Standards Manager on the 05/05/2021. All restricive practices reviewed. Where the inspector outlined that there is a restriction on civil liberties,this be on the agenda of the next Positive Approaches Monitoring Group (PAMG) meeting on the 13/05/2021. All recomendations from the PAMG meeting will be implented by the PIC. Awaiting outcome of meeting to establish actions and time frame.
• All Sageguarding plans reviewed with Social Worker and all are necessary at present.
• Supports are in place for residents with guidance from Psychology department to address and minimise current compatability issues .
• Ongoing review of compatibility issues within the centre has begun with Individual Coordination Meeting (ICM) that was held on 05/05/2021 which involved a Multi Disciplinary team.
• TIPS training complete by 8 members staff on the 20/04/2021 & 23/04/2021. There was 2 staff members on leave at this time and training will be scheduled for them by 31/05/2021

• All staff, except 3 who are currently on leave, have now completed the online PBS Training. The 3 remaining staff will have this completed on their return.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:

• A Restrictions Audit was carried out by Quality and Standards Manager on the 05/05/2021. All restricive practices reviewed. Where the inspector outlined that there is a restriction on civil liberties,this be on the agenda of the next Positive Approaches Monitoring Group (PAMG) meeting on the 13/05/2021. All recomendations from the PAMG meeting will be implented by the PIC. Awaiting outcome of meeting to establish actions and time frame.

• PBS plans are in place for residents that may pose a safegurding risk to others. Theses PBS guidelines are followed by all staff in order to minimise any safeguarding risks.

• All Sageguarding plans reviewed with Social Worker and all are necessary at present.

• Supports are in place for residents with guidance from Psychology department to address and minimise current compatability issues .

• Ongoing review of compatibility issues within the centre has begun with Individual Coordination Meeting (ICM) that was held on 05/05/2021 which involved a Multi Disciplinary team.

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.	Substantially Compliant	Yellow	31/05/2021
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	31/05/2021
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre	Not Compliant	Orange	10/08/2021

	are of sound construction and kept in a good state of repair externally and internally.			
Regulation 17(1)(c)	The registered provider shall ensure the premises of the designated centre are clean and suitably decorated.	Not Compliant	Orange	10/08/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	10/08/2021
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	30/09/2021
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	30/04/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the	Not Compliant	Red	30/04/2021

	designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Substantially Compliant	Yellow	30/09/2021
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	20/05/2021
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently	Substantially Compliant	Yellow	30/09/2021

	than on an annual basis.			
Regulation 07(1)	The person in charge shall ensure that staff 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.	Not Compliant	Orange	31/05/2021
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	31/05/2021
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Not Compliant	Orange	30/06/2021
Regulation 7(5)(a)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation	Not Compliant	Orange	30/06/2021

	every effort is made to identify and alleviate the cause of the resident's challenging behaviour.			
Regulation 07(5)(b)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation all alternative measures are considered before a restrictive procedure is used.	Not Compliant	Orange	30/06/2021
Regulation 07(5)(c)	The person in charge shall ensure that, where a resident's behaviour necessitates intervention under this Regulation the least restrictive procedure, for the shortest duration necessary, is used.	Not Compliant	Orange	30/06/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	30/04/2021