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:	Unannounced
Date of inspection:	19 October 2021
Centre ID:	OSV-0002348
Fieldwork ID:	MON-0033556

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
Tuesday 19 October 2021	10:00hrs to 16:20hrs	Ann-Marie O'Neill	Lead
Tuesday 19 October 2021	10:00hrs to 16:20hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

Inspectors greeted all five residents present on the day of inspection. Most residents living in the centre were unable to provide verbal feedback to inspectors about the service they received. Other residents did not wish to spend time in the company of inspectors and this choice was respected.

Inspectors met with staff working in the centre on the day of inspection. At the commencement of the inspection the person in charge was not present, a staff member, performing a social care leader role facilitated the inspection. The person in charge was on planned leave, the day of the inspection, but arrived to the centre to facilitate the inspection a short time later.

Physical distancing measures were adhered to, as much as possible, during interactions with residents and staff. Inspectors wore face coverings at all times throughout the inspection.

A not compliant finding for Regulation 17: Premises, was found on the previous April 2021 inspection. This had related to poor upkeep and maintenance of the internal premises and inadequate storage arrangements for personal protective equipment (PPE).

Inspectors observed the provider had carried out some required redecoration of the centre since the last inspection. The centre had been repainted outside and also throughout inside. Residents' bedrooms had been painted to reflect residents' individual personalities. New curtain poles and curtains had also been provided in residents' bedrooms as well as some additional furniture in the dining room area. These were pleasant and tasteful improvements in the centre and overall provided a more homely aesthetic.

Inspectors also observed skirting boards and door frames had been repainted which also contributed to the improved overall appearance of the centre throughout. A electric bath chair had also been installed to support residents' mobility and manual handling needs. This was also a positive improvement where previously some residents had been unable to use the bath in the centre without this aid.

However, despite these improvements, other areas of the house were not maintained to an acceptable standard and actions, from the previous inspection, in relation to storage arrangements and bathroom flooring and facilities, had not been suitably addressed.

On the previous inspection it had been identified that improvement works were required to downstairs bathrooms as they were not maintained to a good standard. On this inspection, inspectors found the improvements implemented were substandard and not suitable to promote good infection control standards. Flooring that was ripped and lifting, in the larger bathroom, had been stuck down with a

number of strips of masking tape.

The flooring in the second smaller toilet/shower space was also ripped and marked and could not be effectively cleaned to maintain good infection control standards. Inspectors also observed a metal toilet brush holder and the radiator in the toilet/shower facility was rusted. A rusted screw was sticking out from the wall where a towel holder had been removed. The grout behind the toilet and shower area was heavily stained and did not appear clean. Screw fixtures on the bottom of the toilet appeared heavily rusted also.

Inspectors also observed there were no toilet paper receptacles in either resident toilet facility in the centre. Staff told inspectors there had been previous incidents were the toilets were blocked from toilet rolls being discarded into them and therefore toilet rolls were not kept in those facilities. While inspectors were discussing this matter with the staff member a resident walked to the toilet facility in order to use it, the staff member retrieved a toilet roll and handed it to the resident as they entered.

This demonstrated a poor standard, of not only infection control management, but also in the upholding of residents' privacy and dignity.

Notwithstanding these matters, this inspection found additional infection control risks presenting in the centre which were not being effectively managed to promote good infection control standards in the context of incontinence management and associated infection control risks. These findings are further discussed in the quality and safety section of the report.

The previous inspection had highlighted an issue of incompatibility of residents which resulted in high levels of restrictive practices utilised in the centre and aspects of residents' civil liberties being impacted upon. On this inspection, it was observed these restrictions were still ongoing, despite some efforts by the provider to alleviate the issue through enhanced behaviour support planning arrangements.

As found on the last inspection, inspectors observed, stair gates located at the top and bottom of the stairs, a wooden gate between the kitchen and dining area which could be locked to prevent residents accessing the area at specific times, locked presses to manage personal risks related to ingesting inedible substances, wide sheets of perspex fixed to the top of the stairs to prevent a resident climbing over the banisters, time codes on some residents' electronic devices to limit their time watching specific video content, knives locked away, opaque contact on the windows of doors between the dining room and kitchen to prevent some residents seeing their peers and scheduling of residents' daily activities to prevent them from spending time with each other in order to manage a residual safeguarding risk relating to residents being in the same space as their peers.

Of additional concern however, was the impact, the incompatibility issue, was having on residents' lived experience. Some residents found vocalisations, made by their peers distressing, and therefore choose to spend periods of time outside in the garden area to the rear of the centre. Staff told inspectors the resident spent time in

the garden area in all types of weather.

During the course of the inspection, inspectors heard residents vocalise loudly and observed there were limited shelter options in the garden area, apart from the shed where incontinence incidents had occurred. Inspectors also observed the resident spending time in the garden and coming into the kitchen/dining area for short periods before going outside again to use their hand held electronic device.

In summary, residents were not in receipt of a good standard of care and support in this centre with a number of issues impacting on their lived experience.

Overall, the resident group were not compatible with each other resulting in the requirement for high levels of environmental restrictions and coordination of daily activities and location of residents in order to manage each resident's personal risk and mitigate potential safeguarding risks. These restrictions, in turn, resulted in residents' civil liberties, dignity and privacy being impacted upon. Personal risks for some residents and the systems to manage those risks, impacted on other residents that did not require such restrictions. These findings were also found on the previous April 2021 inspection.

The next two sections of this report presents 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

An inspection carried out in this centre in April 2021 found high levels of non compliance across a number of regulations. In response to the poor inspection findings, the provider was invited to attend a cautionary meeting with HIQA. In response, the provider submitted a compliance plan to the inspection report, setting out the actions they would implement to address the not compliant findings.

The purpose of this follow-up inspection was to assess the provider's and the person in charge's progress in implementing compliance plan actions and to assess the progress being made to reduce the high levels of environmental restrictions and incompatibility of residents.

Inspectors found that improvements and progress had been made in some areas. However, a number of key areas had not been actioned or addressed suitably. In addition, further areas of risk were found on this inspection. As a result it was not demonstrated residents were experiencing a good quality of service provision and they still experienced a highly restrictive environment with additional infection control and fire safety risks presenting.

Since the previous inspection, the provider had filled a 0.5 whole-time-equivalent (WTE) vacancy in the centre which addressed a finding from the previous

inspection.

Inspectors spoke to some members of the staff on duty during the course of the inspection. Staff were knowledgeable of the residents' needs and preferences and were observed to engage with residents in a warm and professional manner. A staff member who recently commenced working in the centre was complimentary toward the local management and the level of induction they received.

Some staff discussed ongoing issues with regards to the care and support of a resident in the centre who found it difficult to be in the same vicinity as their peers. Staff were transparent and forthright in describing areas where the service was not meeting residents' needs and raised some concerns with regards to proposals to reconfigure areas of the centre which had not considered the garden area to the rear of the property, for example.

Inspectors discussed these reconfiguration proposals with the person in charge. They provided inspectors with a copy of floor plan drawings which had been drawn up by an architect. These floor plan drawings laid out a proposed reconfiguration which would provide one resident with a single occupancy living arrangement within the centre but separate from their peers.

It was not demonstrated however, when these plans were due to commence. Equally, it was not demonstrated that consideration had been given to the garden area to the rear of the centre which would still be a shared space. Staff spoken with raised concerns that they would still need to coordinate times for when residents used the space and residents that found vocalisations distressing would still be able to hear their peers when they were inside or outside and residents' daily lives and activities would still be restricted.

Therefore, while reconfiguration floor plans had been drawn up and were available on the day of inspection, it was not demonstrated they had been informed by a compatibility assessment that gave due consideration of all areas of the centre and the collective needs of residents that lived in the centre. In addition, the provider and person in charge were unable to provide inspectors with a proposed time-line for their commencement and completion.

It was identified on the previous inspection there was an urgent requirement for all staff to be trained in breakaway techniques due to a presenting behavioural risk in the centre. This had been suitably actioned since the previous inspection and all staff had received this training. Inspectors noted some newly appointed staff required training in breakaway techniques however, one of those staff were due to complete this training the day after the inspection.

The majority of staff were trained in mandatory areas such as manual handling, safeguarding vulnerable adults and fire safety, inspectors noted there were some refresher training gaps but these had been scheduled and were recorded by the person in charge in the training schedule for the centre. Risk assessments related to management of behaviours that challenge, had identified training in positive behaviour support as a control measure. It was not demonstrated that all staff had

received this additional specific behaviour management training.

The provider had undertaken an annual review and six-monthly unannounced audits in the centre. In addition, the senior service manager held governance meetings with the person in charge which reviewed areas of compliance and other key quality indicator areas. However, improvements were still required.

Areas of non compliance found in the previous inspection report had not been addressed fully and in other instances did not have a measurable and clearly set out plan for when they would be completed. For example, the compliance plan response from the last inspection set out door closers would be fitted to doors by 30 September 2021, this had not been addressed and the person in charge was unable to provide a time-line for when it would be actioned.

While there had been actions undertaken to complete a comprehensive record of all restrictive practices in the centre, the development of an up-to-date behaviour support plan and a desensitisation programme for one resident, environmental restrictions, for the most part, remained unchanged from the previous inspection.

Aspects of the premises which required improvement to promote good infection control practices had not been suitably addressed. A formal compatibility assessment for residents, which would inform the provider on the type of environment and living arrangements suited to each individual resident, had not been completed.

Whilst the provider was exploring options in relation to the environment to address the incompatibility issue, there was no agreed plan or time frame for when the reconfiguration of the premises would take place.

Incidents of incontinence and soiling were occurring. It was unclear if these issues were behavioural in cause and/or as a result of the incompatible resident group as they were not recorded or monitored to inform support planning. For example, there were no associated documented risk assessments, incident recordings or written staff procedures to manage these incidents from an infection control perspective and it was unclear if these issues were being escalated, by the local management team, to the provider, as a result.

The local management team were not recording incidents, monitoring, tracking or escalating infection control and dignity risks. Therefore, it was unclear if the provider was fully informed of all risks presenting in the designated centre and their potential negative impact on residents.

Regulation 15: Staffing

The provider had addressed an action from the previous inspection by filling a 0.5 WTE post in the centre.

The person in charge maintained a planned and actual roster which set out the roles and skill-mix of staff on duty each day and night in the centre.

Newly appointed staff were complementary of the induction and orientation they had received from local management.

Staff spoken with during the course of the inspection were forthright and transparent in their communications with inspectors and raised concerns, on behalf of residents, that could not provide feedback to inspectors themselves.

Judgment: Compliant

Regulation 16: Training and staff development

The majority of staff were trained in mandatory areas such as manual handling, safeguarding vulnerable adults and fire safety.

There were some refresher training gaps but these had been scheduled and were recorded by the person in charge in the training schedule for the centre.

- Two recently appointed staff required training in breakaway techniques. One had been scheduled to attend this training the day after the inspection.
- Two staff required refresher manual handling training.
- Two staff required refresher training in COVID-19 infection control management.

Judgment: Substantially compliant

Regulation 23: Governance and management

The provider had undertaken an annual review and six-monthly unannounced audits in the centre.

The senior service manager held governance meetings with the person in charge which reviewed areas of compliance and other key quality indicator areas.

Areas of non compliance found in the previous inspection report had not been addressed fully and in other instances did not have a measurable and clearly set out plan for when they would be completed.

For example, the compliance plan response from the last inspection set out door closers would be fitted to doors by 30 September 2021, this had not been addressed and the person in charge was unable to provide a time-line for when it would be

addressed.

Aspects of the premises which required improvement to promote good infection control practices had not been suitably addressed.

A formal compatibility assessment for residents, which would inform the provider on the type of environment and living arrangements suited to each individual resident, had not been completed.

Whilst the provider was exploring options in relation to the environment to address the incompatibility issue, there was no agreed plan or time frame for when the reconfiguration of the premises would take place.

The local management team were not incident recording, monitoring, tracking or escalating infection control and dignity risks. Therefore, it was unclear if the provider was fully informed of all risks presenting in the designated centre and their potential negative impact on residents.

Judgment: Not compliant

Quality and safety

There were considerable improvements required across all regulations reviewed on this inspection.

High levels of non compliance was found on this inspection. Inspectors were not assured that sufficient progress had been made to address the not compliant findings from the last inspection and residents continued to experience a poor quality of service and live in a highly restrictive environment which continued to impact on their civil liberties and dignity in some cases.

The previous inspection had identified a not compliant finding in relation to storage facilities in the centre. While the centre was a large two storey premises, it was not demonstrated that there were suitable arrangements for the storage of personal protective equipment and resident incontinence wear, for example.

Previously, PPE was being stored in the residents' sensory room, having been moved from an outdoor shed, due to incidents of incontinence and quantities of PPE needing to be discarded as a result. On this inspection, inspectors observed no PPE or other items were being stored in the sensory room.

Inspectors carried out an observation of the shed in the garden area of the centre. Inspectors saw quantities of residents' incontinence wear and aprons stored in the shed. Staff told the inspector that there had been incidents of incontinence again in the shed and packs of resident incontinence wear had been thrown out as a result.

Inspectors brought this to the attention of the person in charge who informed inspectors that they were unaware those items were being stored in the shed and would put them under the storage space in the stairs. However, inspectors looked at the storage space under the stairs and noted it was very full and there was no extra space to put the items from the shed into it.

It was not demonstrated therefore that there were suitable storage arrangements in the centre for PPE and residents' personal effects resulting in damage to their property and the resources put in place for the centre to manage infection control.

Inspectors found additional infection control risks, outside of the context of COVID-19, which required considerable improvement. Notwithstanding the premises issues presenting in the bathroom areas of the centre, incidents of soiling and incontinence were not managed in a manner that promoted good infection control standards.

Staff told inspectors residents had incidents of soiling or incontinence while using the garden area to the rear of the property. In addition, there had been incidents where residents had urinated in the kitchen sink and incidents where faeces had been smeared in the centre or placed in the kitchen sink. While these incidents were not recorded on the centre's incident recording system, various records mentioned these incidents could occur and staff also confirmed this.

It was not demonstrated there were any infection control risk management procedures in place for the management of this dignity and infection control risk. Inspectors further discussed these infection control risks with staff to ascertain how they were managed.

The access route from the rear garden to the centre was through the kitchen. This meant, when residents experienced incontinence of urine or faeces while spending time in the garden, they moved through the kitchen in order to receive personal care in the bathroom of the centre. In some instances, those residents chose to enter the bathroom through another resident's bedroom in order to avoid walking near a peer's bedroom, where the toilet was located.

While staff informed inspectors that they used PPE equipment and specific laundry bags as part of the laundry management of incontinence incidents. There were no associated documented laundry management guidelines in place. This infection control risk had not been added to the centre's risk register which would in turn inform the provider of the presenting risk in the centre.

Overall, inspectors were not assured this serious infection control risk was being identified as such resulting in an absence of comprehensive risk management to guide and inform staff.

These matters also further demonstrated the poor compatibility of the resident group and the negative impact this had on all residents living in the centre

While there had been considerable involvement from the provider's psychology department in the development and review of residents' behaviour support plans and the implementation of a desensitisation plan to ease one resident's behaviours

of concern. It was not demonstrated that they had yet to have a positive impact on reducing the level of environmental restrictions in the centre. Residents' routines and daily lives were still restricted and coordinated in such a manner so as to reduce and limit the time some residents spent in their peers' company.

The provider had systems in place for the reporting and management of allegations of abuse. There was an identified designated person in place with responsibility for investigating allegations. All staff working the centre were trained in the safeguarding and protection of residents. The person in charge recorded and reporting safeguarding incidents occurring in the centre. Safeguarding plans were developed and implemented where required.

In the past residents had experienced peer-to-peer safeguarding incidents. Safeguarding planning heavily relied on the separation of residents in the centre and while this effectively mitigated the safeguarding risk, there remained a residual risk to residents due to the ongoing incompatibility of residents.

The provider had a risk management policy and procedures in place however the practice of identifying and assessing risks, by the local management team, required improvement. Specific risks in relation to infection prevention and control and slips, trips, and falls were not assessed to identify measures and actions to control the risks, as discussed not all infection control risks were recorded or identified on the centre's risk register and not all behaviours of concern related to incontinence and soiling were being monitored or reviewed. This resulted in a lack of overall risk management procedures for those risks.

Fire safety precautions in the centre had not been suitably addressed to meet the non-compliances found on the previous inspection. A further fire safety risk was identified during the course of the inspection and resulted in inspectors issuing an instruction to the person in charge and provider to take urgent action on the day of inspection to address the risk.

The provider had not installed door closing devices to all fire doors in the centre, despite giving an undertaking to have these fitted by 30 September 2021 in their compliance plan response and additional updated compliance plan response submitted to the Chief Inspector.

Inspectors were concerned in relation to the systems in place for opening of exit doors from the premises for the purpose of evacuation. All exit doors, apart from the front exit door, required keys for locking and opening them. Many exit doors in the centre did not have a key available either in the door lock or in a key holding container beside the door.

While some staff held bunches of keys, for the purposes of opening and locking doors, not all staff had a set of keys on the day of inspection. In addition, the keys were not labelled to identify which door they opened.

Spare keys were contained in a box in the staff room which meant they were not accessible at any of the exit doors and required staff to travel from an exit location to retrieve keys and come back to the exit door location, therefore potentially

impacting on the timeliness of evacuation from the centre.

The provider submitted a written response to the urgent action a short time after the inspection informing HIQA they had mitigated some of the presenting risks by ensuring all staff held a set of keys, keys had been colour coded to ensure staff knew what door they opened. Further review of the doors would take place following a review by an engineer and alternative open and close devices would be fitted if deemed suitable.

Regulation 12: Personal possessions

Due to the poor storage arrangements in the centre, some residents' personal property had been damaged as a result of incidents of incontinence occurring in the shed they were stored.

The person in charge and provider were required to review systems in place for the storage of all residents' personal property and make arrangements to replace the damaged items.

Judgment: Not compliant

Regulation 17: Premises

The provider had repainted and refurbished the house in a number of areas externally and internally.

The designated centre had been repainted internally and externally. Residents bedrooms had also been redecorated with new curtains and furniture.

Considerable improvements were required in relation to the bathing and toilet facilities in the centre. Improvements implemented to address issues with bathrooms were substandard and not suitable to promote good infection control standards.

- Flooring that was ripped and lifting, in the larger bathroom, had been stuck down with a number of strips of masking tape.
- The flooring in the second smaller toilet/shower space was also ripped and marked and could not be effectively cleaned to maintain good infection control standards.
- A metal toilet brush holder in the toilet/shower facility was rusted.
- The radiator in the toilet/shower facility was heavily rusted.
- A rusted screw was sticking out from the wall where a towel holder had been removed.
- The grout behind the toilet and shower area was heavily stained and did not

appear clean.
- Screw fixtures on the bottom of the toilet appeared heavily rusted also.
- There were no facilities put in place to ensure toilet paper was made available to residents in any of the resident toilet facilities in the centre.

Judgment: Not compliant

Regulation 26: Risk management procedures

The provider had a risk management policy and procedures in place however the practice of identifying and assessing risks, by the local management team, required improvement.

- Not all slip, trip and fall risks for a resident accessing an outdoor shed had been identified, assessed or reviewed.
- Not all infection control risks presenting in the centre were recorded or identified on the centre's risk register.
- Not all behaviours of concern, related to incontinence and soiling, were being monitored or reviewed within that context.
- Risk assessments related to management of behaviours that challenge, had identified training in positive behaviour support as a control measure. It was not demonstrated that all staff had received this additional specific behaviour management training and there were no specific plans in place to ensure this occurred.

Judgment: Not compliant

Regulation 27: Protection against infection

Infection control management in the context of COVID-19 was found to be suitable and in line with public health guidelines as was found on the previous inspection.

Inspectors found additional infection control risks, outside of the context of COVID-19, which required considerable improvement.

Notwithstanding the premises issues presenting in the bathroom areas of the centre, incidents of soiling and incontinence were not managed in a manner that promoted good infection control standards.

- There had been incidents where residents had urinated in the kitchen sink and incidents where faeces had been smeared in the centre or placed in the kitchen sink.
- When residents experienced incontinence of urine or faeces, while spending

time in the garden, they moved through the kitchen in order to receive personal care in the bathroom of the centre.
- In some instances, those residents chose to enter the bathroom through another resident's bedroom in order to avoid walking near a peer's bedroom. This posed an infection control risk.

There were no associated documented infection control procedures, staff guidelines or documented laundry management guidelines in place.

These infection control risks had not been risk assessed or added to the centre's risk register which would in turn inform the provider of the presenting risk in the centre.

Overall, inspectors were not assured this serious infection control risk was being identified as such resulting in an absence of comprehensive risk management to guide and inform staff.

Judgment: Not compliant

Regulation 28: Fire precautions

While an action from the previous inspection in relation to training all staff in the use of an evacuation aid had been addressed. Two recently appointed staff to the centre had not received training in how to use this aid.

The provider had not installed door closing devices to all fire doors in the centre, despite giving an undertaking to have these fitted by 30 September 2021 in their compliance plan response and additional updated compliance plan response submitted to the Chief Inspector.

Inspectors were concerned in relation to the systems in place for opening of exit doors from the premises for the purpose of evacuation. All exit doors, apart from the front exit door, required keys for locking and opening them. Many exit doors in the centre did not have a key available either in the door lock or in a key holding container beside the door.

While some staff held bunches of keys, for the purposes of opening and locking doors, not all staff had a set of keys on the day of inspection. In addition, the keys were not labelled to identify which door they opened.

Spare keys were contained in a box in the staff room which meant they were not accessible at any of the exit doors and required staff to travel from an exit location to retrieve keys and come back to the exit door location, therefore potentially impacting on the timeliness of evacuation from the centre.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

It was not demonstrated that there had been a formal compatibility assessment completed for each resident in the centre, that set out the most optimum living environment for them and reflected their assessed needs and personal risks and the impact the support requirements to manage those would have on any potential peers they lived with.

This required improvement.

Judgment: Not compliant

Regulation 7: Positive behavioural support

While there had been considerable involvement from the provider's psychology department in the development and review of residents behaviour support plans and the implementation of a desensitisation plan to ease one residents behaviours of concern. it was not demonstrated that they had yet to have a positive impact on reducing the level of environmental restrictions in the centre.

Residents' routines and daily lives were still restricted and coordinated in such a manner so as to reduce and limit the time some residents spent in their peers' company.

As found on the last inspection, inspectors observed the following restrictions had remained in place:

- Stair gates located at the top and bottom of the stairs
- A wooden gate between the kitchen and dining area which could be locked to prevent residents accessing the area at specific times.
- Locked presses to manage personal risks related to ingesting inedible substances.
- Wide sheets of perspex fixed to the top of the stairs to prevent a resident climbing over the banisters.
- Time codes on some residents' electronic devices to limit their time watching specific video content.
- Knives and cutlery knives locked away.
- Opaque contact on the windows of doors between the dining room and kitchen to prevent some residents seeing their peers.
- Continued scheduling of residents' daily activities to prevent them from spending time with each other in order to manage a residual safeguarding

risk relating to residents being in the same space as their peers.

Judgment: Not compliant

Regulation 8: Protection

The provider had systems in place for the reporting and management of allegations of abuse.

There was an identified designated person in place with responsibility for investigating allegations.

All staff working the centre were trained in the safeguarding and protection of residents.

The person in charge recorded and reporting safeguarding incidents occurring in the centre.

Safeguarding plans were developed and implemented where required.

In the past residents had experienced peer-to-peer safeguarding incidents.

Safeguarding planning heavily relied on the separation of residents in the centre and while this effectively mitigated the safeguarding risk, there remained a residual risk to residents due to the ongoing incompatibility of residents

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents regularly experienced situations where their privacy and dignity was not upheld.

Inspectors observed some practices in the centre were not promoting residents' privacy and dignity.

Residents continued to experience a highly restrictive environment which could not meet their collective needs.

Residents civil liberties continued to impacted upon, despite the provider's efforts to implement behaviour support planning and a desensitisation programme to support some residents to spend time in the centre in the company of their peers.

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

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 12: Personal possessions	Not compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 27: Protection against infection	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 7: Positive behavioural support	Not compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Not compliant

Compliance Plan for Garvagh House OSV-0002348

Inspection ID: MON-0033556

Date of inspection: 19/10/2021

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 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: • 2 staff completed TIPS training training on 10/11/21. • All staff have completed Manual Handling refresher training as of 05/11/21. • All staff have completed covid training as of 12/11/21.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Door self closer installation work completed . • Bathroom floors replaced • Director of Adult services , Administration Manager, Service manager , PIC and Psychologist met on 05/11/2021 to discuss process of assessing compatibilty of residents in Garvagh. It was decided that a MDT will be established to assess comatibilty of all residents in Garvagh and make recommendations after aseesment is complete. Initial meeting of MDT was held on 11/11/21 and action plan was drawn up . Compatibility assesment is scheduled to be completed by 31/01/2022 • SMH have engaged an architect to draw up further plans for reconfiguration of house, which will also include the possibility soundproofing . Behaviour tracker is in in place for all incidents of incontinence as of 22/10/21. This will be used to as part of review of PBS plan. Psychologist is linking in regularly with team to develop strategies to reduce behaviour.All relevant Risk assessements and guidelines	

are in place .

Regulation 12: Personal possessions	Not Compliant

Outline how you are going to come into compliance with Regulation 12: Personal possessions:
• New shed was ordered in August of this year and we are awaiting delivery.
• Alternative storage arrangements are in place in the centre as of 10/11/2021 .

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
• Bathroom flooring replaced with new flooring
• New toilet brushes are in place
• Radiator has been replaced
• Rusted screw removed
• Whiterock wall covering fitted in smaller Shower Room
• Rusted screws to toilet were changed once new flooring in place, and toilet refitted. Toilet roll dispensers fitted in toilets

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
• Risk assessment in place for residents using shed ,this will include slips , trips and falls as of 04/11/21
• Infection control risks associated with residents incontinence have been drawn up and are included on risk register as of 21/10/21.
• Behaviour tracker is in in place for all incidents of incontinence as of 22/10/21. This will be used to as part of review of PBS plan.
• All relevant staff have completed online PBS training module by 05/11/21. PIC has updated training plan to reflect all current training needs of staff team. PIC has reviewed and updated all associated Risk Assessment to reflect current training needs as of

05/11/21

Regulation 27: Protection against infection	Not Compliant

Outline how you are going to come into compliance with Regulation 27: Protection against infection:
PBS plan is under regular review by centre Psychologist to explore strategies to reduce or prevent all infection control risk.
Risk assessment now in place and cleaning guidelines in line with SMH environmental hygiene and cleaning policy as of 21/10/21
Plan in place as of 05/11/2021 to direct resident to access toilet from garden using alternative entrance
Identified Resdient no longer has access to other residents room
Laundry guidelines are in place and are in line with SMH Infection control Policy as of 05/11/21.
All Infection control risks have been identified and relevant Risk assessments and guidelines have been put in place and added to register as of 21/10/21
SMH Infection Control Policy is in place.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
• 2 new staff recieved Evac aid training on 27/10/21
• Installation of selfing closing doors completed
• All exit doors now have thumb turn locks that do not require a key
All staff now have sets of colour coded keys and there are additional sets available to agency or relief staff

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:

• Director of Adult services , Administration Manager, Service manager , PIC and Psychologist met on 05/11/2021 to discuss process of assessing compatibilty of residents in Garvagh. It was decided that a MDT will be established to assess compatibilty of all residents in Garvagh and make recommendations after aseesment is complete. Initial meeting of MDT was held on 11/11/21 and action plan was drawn up . Compatibility assesment is scheduled to be completed by 31/01/2022

Regulation 7: Positive behavioural support	Not Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:

• All environmental restrictions have been reviewed and have been referred to SMH Positive Approaches Monitoring Group (PAMG)
• Gate at bottom of stairs has been removed as of 15/11/2021.
• Kitchen access is restricted when 1 resdient is present and is used for the shortest time possible. This restriction has beeen reviewed by SMH PAMG and is deemed necessary and is used in line with SMH restrictive practice policy.
• Locked press in hallway is stationary press for office use only .
• Wide sheets of perspex are in place to prevent falls risks.
• Time codes on residents devices In place to encourage enagemant in other activities and recieving anti epileptic medication.A record of when this is implemented will be kept for review. This restriction has beeen reviewed by SMH PAMG and is deemed necessary and is used in line with SMH restrictive practice policy.
• Only sharp knives have restricted access, all other cutlery is accessible.This restriction has beeen reviewed by SMH PAMG and is deemed necessary and is used in line with SMH restrictive practice policy.
• Opaque contact on windows in doors is in place as part of densensitisation plan.This can be removed when resident has progessed sufficiently through plan.
• Director of Adult services , Administration Manager, Service manager , PIC and Psychologist met on 05/11/2021 to discuss process of assessing compatibilty of residents in Garvagh. It was decided that a MDT will be established to assess compatibilty of all residents in Garvagh and make recommendations after aseesment is complete. Initial meeting of MDT was held on 11/11/21 and action plan was drawn up . Compatibility assesment is scheduled to be completed by 31/01/2022
• SMH have engaged an architect to draw up further plans for reconfiguration of house, which will also include the possibilty of soundproofing .

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection: • All safeguarding incidents are reported as per national & SMH safeguarding policies and procedures • Director of Adult services , Administration Manager, Service manager , PIC and Psychologist met on 05/11/2021 to discuss process of assessing compatibilty of residents in Garvagh. It was decided that a MDT will be established to assess compatibilty of all residents in Garvagh and make recommendations after aseesment is complete. Initial meeting of MDT was held on 11/11/21 and action plan was drawn up . Compatibility assesment is scheduled to be completed by 31/01/2022 • SMH have engaged an architect to draw up further plans for reconfiguration of house, which will also include the possibilty of soundproofing .	
Regulation 9: Residents' rights	Not Compliant
Outline how you are going to come into compliance with Regulation 9: Residents' rights: • Behaviour Tracker in place for 1 resident and their PBS guidelines are under regular review . • All staff will work to promote , respect and maintian the dignity and privacy of all residents in Garvagh. • Director of Adult services , Administration Manager, Service manager , PIC and Psychologist met on 05/11/2021 to discuss process of assessing compatibilty of residents in Garvagh. It was decided that a MDT will be established to assess compatibilty of all residents in Garvagh and make recommendations after aseesment is complete. Initial meeting of MDT was held on 11/11/21 and action plan was drawn up . Compatibility assesment is scheduled to be completed by 31/01/2022 • SMH have engaged an architect to draw up further plans for reconfiguration of house, which will also include the possibilty of soundproofing .	

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 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.	Not Compliant	Orange	10/11/2021
Regulation 12(3)(d)	The person in charge shall ensure that each resident has adequate space to store and maintain his or her clothes and personal property and possessions.	Not Compliant	Orange	10/11/2021
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	12/11/2021

	as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	07/11/2021
Regulation 17(7)	The registered provider shall make provision for the matters set out in Schedule 6.	Not Compliant	Orange	17/11/2021
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	31/05/2022
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	31/05/2022
Regulation 23(3)(b)	The registered provider shall	Substantially Compliant	Yellow	17/11/2021

	ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Orange	05/11/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.	Not Compliant	Orange	05/11/2021
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for	Not Compliant	Orange	27/10/2021

	maintaining of all fire equipment, means of escape, building fabric and building services.			
Regulation 28(3)(a)	The registered provider shall make adequate arrangements for detecting, containing and extinguishing fires.	Not Compliant	Orange	01/11/2021
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 than on an annual basis.	Not Compliant	Orange	31/01/2022
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	31/01/2022
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or	Not Compliant	Orange	31/05/2022

	environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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	31/05/2022
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	31/05/2022
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	17/11/2021
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice	Not Compliant	Orange	31/05/2022

	and control in his or her daily life.			
Regulation 09(2)(c)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability can exercise his or her civil, political and legal rights.	Not Compliant	Orange	31/05/2022
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.	Not Compliant	Orange	31/05/2022