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:	23 May 2024
Centre ID:	OSV-0002348
Fieldwork ID:	MON-0043550

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 and physical disabilities. The centre is operated by St Michael's House. The centre comprises a large detached house located in North County Dublin. There are four resident bedrooms, one staff sleepover room, a sensory room, quiet room, sitting room and kitchen/dining room, as well as a self-contained apartment attached to the main building. The centre 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 with support from a social care leader, and they report to a service manager. The staff team consists of social care and direct support 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 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

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

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

1. Capacity and capability of the service:

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

2. Quality and safety of the service:

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

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

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Thursday 23 May 2024	10:00hrs to 16:00hrs	Michael Muldowney	Lead

What residents told us and what inspectors observed

This unannounced inspection was carried out in response to solicited information received by the Chief Inspector of Social Services. The solicited information, submitted by the provider, related to allegations of abuse and serious injuries sustained by residents in the centre, and raised concerns about the provider's management of these matters.

The inspector used observations, conversations with staff, interactions with residents, and a review of documentation to form judgments on the governance and management of the centre, and on the quality and safety of the care and support provided to residents. Overall, the arrangements and measures in place to ensure that residents' assessed needs were met in a safe manner were found to require improvement.

The centre comprised a large two-storey detached house in a busy Dublin suburb. The house was close to many amenities and services, including shops, bars, parks, and the beach. There was also a vehicle available for residents to access their wider community. The house comprised individual bedrooms, shared communal spaces including an open-plan kitchen and dining room, sitting rooms, a utility room, bathrooms, and a staff office. One resident lived in a self-contained apartment connected to the house. The apartment contained a bedroom with an en-suite bathroom, and an open-plan kitchen and living area.

The inspector had the opportunity to meet four residents living in the centre (one resident was staying with family on the day of the inspection). Three residents were in their day services when the inspector arrived at the centre, but returned in the afternoon. They did not verbally communicate with the inspector. However, two of the residents briefly engaged with the inspector through eye contact and gestures. One resident pointed to their ears and the fire alarm in the kitchen. Staff told the inspector that the resident does not like loud noises, and they assured the resident that the alarm would not be activated.

One resident's healthcare and mobility support needs had significantly increased in recent times. On the day of the inspection, they were observed to be resting in bed. They were being supported by a day services staff, and were happy to meet the inspector. They showed the inspector some of their prized possessions and spoke about their favourite television programmes. They were watching videos on their smart device tablet and on the television. Their bedroom window looked onto the front of the house. The window blind was down, and they indicated to the inspector that this was because they did not want to see or hear other residents coming and going from the house. Staff told the inspector that the resident could become upset if they saw or heard certain residents.

The 2023 annual review had consulted with residents and their representatives. The annual review noted that while residents appeared to like living in the centre, they

had concerns regarding the staffing arrangements and the behaviours of others. Three residents' representatives provided feedback, which was generally positive and included comments such as "staff are all very nice and take great care of my relative".

During the inspection, staff were observed engaging with residents and responding to their needs in a kind and familiar manner. For example, staff were observed joking with residents, and talking to them about their interests. The residents appeared comfortable with the staff supporting them. Aspects of the environment were homely. For example, there was a pleasant aroma as staff cooked dinner, and the residents' bedrooms were personalised to their tastes. However, the inspector also heard sporadic loud vocalisations in the afternoon, which were known to upset other residents.

The inspection was primarily facilitated by the social care leader with support from the person in charge and service manager. The inspector also spoke with them and other staff working during the inspection.

The management team demonstrated a good understanding of the service to be provided in the centre. They knew the residents' individual personalities well, and spoke about them with affection. They shared concerns regarding the incompatibility of residents, the suitability of the centre to meet all residents' needs, and the staffing arrangements. They told the inspector that these concerns were being managed by the permanent staff and management team to the best of their ability, and had being escalated to senior management. They told the inspector that while some of the safeguarding concerns had lessened and the centre was 'calmer' than before, there remained an ongoing risk to residents' wellbeing. They were very satisfied with the management arrangements, and support from the provider's multidisciplinary team, and described the permanent staff team as being 'fantastic'.

The service manager also spoke about the provider's recruitment campaign which they hoped would resolve the staffing issues in the centre. The service manager was satisfied with the local management structure, and described the person in charge and social care leader as being 'strong advocates' for residents.

A social care worker and direct support worker spoke to the inspector together. They told the inspector about the strategies to reduce the impact of the incompatibility issues. For example, they were vigilant in recognising triggers that could upset residents, and followed the interventions outlined in residents' behaviour support plans. However, they told the inspector that the interventions were not always successful. They were also concerned about the suitability of the centre to cater to each residents' needs, particularly for one resident whose needs had recently significantly increased. For example, the environment was too small to accommodate their mobility aids and equipment. They also told the inspector how staffing deficits were compounding other issues in the centre. For example, some residents did not like unfamiliar staff and could become nervous or display an increase in behaviours when they worked in the centre. The staffing deficits had also impacted on residents being able to access their community at times, and put

additional pressures on the permanent staff team.

They also spoke about some of the positive developments in the centre, which were contributing towards a better service for residents. For example, one resident had started a new day service which they appeared to enjoy. They also praised the new social care leader for the support they provided to staff, and their initiatives, such as implementing better communication systems for staff, increased management presence in the centre, and promoting ongoing advocacy of residents' needs and wishes.

The inspector found that the registered provider, the management team and staff working in the centre were endeavouring to provide a quality and safe service for residents. There were some good arrangements and systems, such as an effective management team structure, and support from the provider's multidisciplinary team. However, the incompatibility of residents and staffing deficits in the centre had not been resolved by the provider, and were adversely impacting on the service provided to residents, with an ongoing risk to their safety and wellbeing.

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

Capacity and capability

This section of the report sets out the findings of the inspection in relation to the leadership and management of the service, and how effective it was in ensuring that a good quality and safe service was being provided in the centre.

This inspection primarily focused on concerns raised from solicited information received by the Chief Inspector from the provider. The information pertained to safeguarding allegations, and notifications of unrelated injuries. Overall, the inspector found while efforts were being made to ensure that the centre was well-resourced and effectively operated, these efforts were limited in effectiveness, which was impinging on the quality and safety of the service provided to residents.

There was a clearly defined management structure with lines of authority and responsibility. The inspector met with the social care leader, person in charge, and service manager during the inspection. They demonstrated a good understanding of the service to provided in the centre, and the inspector found that they were advocating for the residents' needs. For example, they had escalated concerns to the provider regarding the quality and safety of the service. However, the response had not been successful in mitigating the concerns.

There were good oversight and monitoring systems in place. Annual reviews (which consulted with residents and their representatives) and six-monthly unannounced visit reports, and a suite of audits on areas such as infection prevention and control.

safeguarding, medication, and health and safety had been carried out. Actions from these audits were monitored by the management team, and escalated as necessary.

The staff skill-mix consisted of a social care leader, social care workers and direct support workers, totalling a permanent staffing whole-time equivalent of 10.5 (an additional two whole-time equivalent staff were also working in the centre at the time of the inspection due to the increased needs of some residents), which the provider had determined was appropriate to the number and needs of the residents. However, there were four permanent whole-equivalent vacancies, which were adversely impacting on the quality and continuity of care provided to residents. For example, residents' activities could not be facilitated at times, and the high-use of relief and agency staff was not in line with their assessed needs.

Staff also told the inspector about how the vacancies added increased burdens on them. For example, not all agency and relief staff could drive the centre's vehicle or administer medication, which meant that permanent staff had to do all of these tasks while on duty. The inspector also read that some staff had raised concerns during their supervision meetings about the impact of the staffing deficits on residents and permanent staff.

The inspector reviewed the files of three permanent staff working in the centre during the inspection. The inspector found that the files contained the required information, such as vetting disclosures in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012, written references, and copies of qualifications. The inspector also reviewed the staff training log, and found that permanent staff working in the centre were up to date with their required training.

There were effective arrangements for staff to raise concerns. In addition to the support and supervision arrangements, staff also attended team meetings. The inspector reviewed a sample of the recent team meeting minutes, including the April 2024 minutes, which reflected discussions on residents' needs and updates (and noted that the environment was no longer appropriate for one resident), safeguarding, health and safety matters, staff training and supervision. Members of the provider's multidisciplinary team also attended staff meetings as appropriate. For example, the psychologist attended the April 2024 meeting to give staff guidance on managing challenging situations.

Regulation 14: Persons in charge

The registered provider had appointed a full-time person in charge. The person in charge had commenced in their role in January 2024, and was found to be suitably skilled and experienced, and possessed relevant qualifications in social care and management.

The person in charge also had responsibility for managing a nearby day service operated by the provider. However, there were good arrangements to ensure that this not impact on their effective governance and management of the centre. For

example, the person in charge was supported in managing the centre by a full-time social care leader who was based in the centre. The person in charge also worked in the centre one day per week and had a formal weekly management meeting with the social care leader.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had not ensured that the staffing arrangements were appropriate to the needs of the residents and that they received continuity of care and support.

The inspector read and was told that by staff and the management team that residents required consistent and familiar staff. However, there were four permanent whole-time equivalent vacancies which were covered by relief and agency staff.

The inspector reviewed the planned and actual rotas for February, March, April, May, and June 2024. The rotas showed a very high use of relief and agency:

- The February, March, and April 2024 rotas showed that over 20 relief and agency staff worked approximately 85 shifts per month.
- The most recent May 2024 rota indicated that 19 relief and agency staff will have worked approximately 80 shifts during the month.
- The planned June 2024 rota showed that 15 relief and agency staff were to work approximately 89 shifts.

The social care leader tried to minimise the risks to residents' continuity of care. For example, a permanent staff member was always on duty during the day. However, the high use of relief and agency staff did promote continuity of care and support for residents, and the inspector found that the overall quality of the service provided to them was being adversely. For example:

- The inspector read that a resident's community-based hobby had been cancelled twice (in March and April 2024) due to staffing deficits.
- One resident's daily notes recorded that on 5 May 2024 they could not go swimming as planned due to staffing deficits. And on another three occasions in April 2024, the resident could leave the centre due to "staffing issues".
- Residents' feedback in the 2023 annual review also noted that they did not like when there was not enough regular staff working in the centre to facilitate their activities.

Judgment: Not compliant

Regulation 16: Training and staff development

Permanent staff were required to complete a suite of training as part of their professional development and to support them in the delivery of appropriate care and support to residents. The training included safeguarding of residents, administration of medication, human rights, manual handling, emergency first aid, infection prevention and control, positive behaviour support, and fire safety. The staff training log viewed by the inspector showed that they were up to date with their training requirements.

The provider had also ensured that agency staff working in the centre were trained in mandatory areas such as in the safeguarding residents from abuse.

The social care leader provided informal support and formal supervision to permanent staff in line with the provider's supervision policy. Formal supervision was carried out four times per year, and records of the meetings were maintained. The social care leader had also arranged for the provider's psychology department to deliver a four-week resilience programme to support staff in managing the increased demands in the centre. The provider's social work department had also met with staff to provide them with guidance and support.

Judgment: Compliant

Regulation 23: Governance and management

The registered provider had endeavoured to ensure that the centre was adequately resourced, governed, and monitored to ensure the delivery of safe and consistent care and support to residents. However, deficits were found in the resourcing of the centre, and in aspects of the quality of the service provided to residents.

The provider had responded to concerns about the quality and safety of the service provided in the centre, such as the changing needs of residents and incompatibility issues. For example:

- Following recent safeguarding concerns, the provider's quality and safety team had reviewed residents' care plans and the use of restrictive practices.
- A service improvement team (which included members of the senior and local management team) had formed to improve aspects of service, particularly with regard to the ongoing staffing and incompatibility issues.

However, their efforts were limited in effectiveness, as shown through the recurring safeguarding incidents, staff and management concerns, and deficits in the staff arrangements. These matters are discussed further in the report under the respective regulations.

There was a clearly defined and effective management structure with lines of authority. The person in charge was full-time, but also had responsibility for a day service operated by the provider. The centre was managed on a day-to-day basis by a social care leader. They had commenced in their role in December 2023, however had previously worked in the centre as a social care worker, and was very familiar with the residents' needs. The social care leader was based in the centre, and their duties included supervising staff, managing rotas, and organising rotas. The person in charge visited the centre weekly, and met the social care leader for a formal meeting. The inspector viewed the minutes of the meetings which noted discussions on residents' changing needs and issues affecting the operation of the centre such as staffing.

The person in charge reported to a senior manager (who in turn reported to a director of service). They met monthly (with the social care leader), and the inspector read their meeting minutes, which were found to be wide in scope. Monthly quality and safety data reports were also shared with the management team to support their oversight of the centre. The inspector found that the management team were well-informed on the residents' individual personalities, and on the service to be provided to them.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had prepared a written statement of purpose containing the information set out in Schedule 1.

The statement of purpose was available in the centre to residents and their representatives. It had been recently revised to ensure that it was up to date, and parts of it had been prepared in an easy-to-read format to make it more accessible to residents.

Judgment: Compliant

Quality and safety

This section of report focuses on two regulations (Regulation 5: Individual assessment and person plan, and Regulation 8: Protection) related to the quality and safety of the care and support provided to residents in the centre. Overall, the inspector found that residents' assessed needs were not being met in the centre, and this was having an adverse impact on their wellbeing and safety. For example, there were recurring safeguarding issues due to the incompatibility of residents.

The person in charge and provider had ensured that residents' needs were assessed. The assessments of residents' needs were reviewed on an ongoing basis and were used to inform written care plans. The inspector reviewed two residents' assessments and care plans, including those on communication, positive behaviour support, mental and physical health, intimate care, nutrition, relationships, and safety. The plans were up-to-date and readily available to guide staff practice. They also reflected involvement from a wide range of multidisciplinary professionals, including nursing, dietitian, psychiatry, occupational therapy, and psychology.

The provider had determined through multiple sources, including a recent compatibility assessment with input from multidisciplinary professionals, that residents were not compatible to live together due to their varied and complex needs. The incompatibility of residents was adversely impacting on the quality and safety of the service provided to them. The compatibility assessment also noted that residents required consistent staff. However, as discussed in the capacity and capability section of the report, there was a high use of relief and agency staff in the centre. Additionally, some residents' health needs had changed, and the premises were deemed to be no longer meeting their full needs.

There were arrangements in place for the safeguarding of residents from abuse. For example, there was a written safeguarding policy and staff had received relevant training. The inspector also found that safeguarding incidents had been reported, and safeguarding plans were in place. However, the safeguarding arrangements were not fully effective, and this was seen through recurring incidents and ongoing concerns expressed by staff, the management team, and residents.

Regulation 5: Individual assessment and personal plan

The registered provider had not ensured that the centre was suitable or that appropriate arrangements were in place to meet the assessed needs of each resident.

The provider had assessed residents' needs and determined that they were not all compatible to live together due to their complex individual needs. The incompatibility issues were having an adverse impact on some residents' lived experience. For example, safeguarding concerns persisted despite the efforts of staff and the provider to safeguard residents. Concerns about residents' incompatibility were highlighted in multiple sources, including staff and management meeting minutes, care plans, risk assessments, written assessments by multidisciplinary professionals, and audits such as the annual review. The recent compatibility assessment also highlighted that residents' complex needs were difficult for staff to manage.

The provider had also determined, through a nursing assessment, that the physical environment was no longer suitable to meet the changing needs of one resident. Their environment was limited in space, and they could no longer use an area that helped them to self-regulate their behaviour. The management team had referred

the resident for an internal transfer, however no appropriate alternative options had been identified yet.

In addition to the aforementioned matters, residents were also assessed as requiring familiar and consistent staff. However, the staffing arrangements in place were not meeting this need.

Judgment: Not compliant

Regulation 8: Protection

The registered provider had implemented systems to safeguard residents from abuse, which were underpinned by a written policy.

Staff had completed safeguarding training to support them in the prevention, detection, and response to safeguarding concerns. The policy and associated procedures were also discussed at monthly team meetings to ensure that staff were adequately informed on these matters.

The inspector found that safeguarding concerns had been appropriately reported and notified to the relevant parties. Safeguarding plans had also been prepared, as required, which outlined the measures to protect residents from abuse. Staff spoken with were familiar with the safeguarding measures and the procedures for reporting any concerns. The provider's social work department had oversight of the safeguarding plans, and had also carried out an audit of the centre in November 2023.

Most safeguarding concerns in the centre stemmed from the incompatibility of residents. Staff and the management team told the inspector about how residents were being affected. For example, at times they were upset and frightened due to the behaviours of others. The inspector also read similar concerns in documentation, such as the the annual review, compatibility assessments, and meeting minutes. The incompatibility issues remained unresolved, which were resulting in an ongoing risk to residents' safety and wellbeing in the centre. For example, in 2024, 17 notifications of allegations of abuse were submitted to the Office of the Chief Inspector of Social Services.

Intimate care plans had been prepared to support staff in delivering care to residents in a manner that respected their dignity and bodily integrity.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Quality and safety	
Regulation 5: Individual assessment and personal plan	Not compliant
Regulation 8: Protection	Substantially compliant

Compliance Plan for Garvagh House OSV-0002348

Inspection ID: MON-0043550

Date of inspection: 23/05/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 15: Staffing	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: • Backfilling staff vacancies within the centre remains a priority • A specific recruitment campaign is in the end stages and shortlisted candidates are scheduled to be interviewed on the 2nd of July. • A full-time relief staff member is assigned to the Designated Centre commencing on the 1st of July. • The Centre continues to Block Book Agency to Maintain Continuity of Care until the recruitment Campaign has been Completed • A new Person in Charge has been identified and will be rostered both Frontline and Administrative Duties from the 01/07/2024. • The centres' Statement of Purpose will be updated to reflect the appointment of the new Person in Charge and corresponding governance structures.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • A new PIC has been Identified and will be rostered both frontline and administrative duties from the 01/07/2024. This will provide stronger oversight on the day-to-Day Management of the centre and to identify any Deficits with regard to the Quality of Service provided to the Residents of the designated Centre. • The Terms of Reference for the Service Improvement team will be Reviewed by the Director of Adult Service and Service Manager to Include Members of the Multi-	

disciplinary team and actions will be assigned in a SMART manner.
• A follow up compatibility assessment will be commissioned by the Director of Adult Services and SMART actions will accompany this assessment for action by the PIC/Service Manager and service provider on a whole.
• Updated residential profiles for all residents within the designated centre will be completed by the PIC/Keyworker/Service Manager and forwarded to internal residential approvals committee for consideration and discussion.
• A follow up meeting will be scheduled with the Local Safeguarding Team to escalate the on going concerns.
• A meeting will be arranged with the relevant Health Region through IMR escalation to discuss the concerns of compatibility within the centre.

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:
• A follow up compatibility assessment will be commissioned by the Director of Adult Services and SMART actions will accompany this assessment for action by the PIC/Service Manager and service provider on a whole.
• Updated residential profiles for all residents within the designated centre will be completed by the PIC/Keyworker/Service Manager and forwarded to internal residential approvals committee for consideration and discussion.
• A follow up meeting will be scheduled with the Local Safeguarding Team to escalate the on going concerns.
• A meeting will be arranged with the relevant Health Region through IMR escalation to discuss the concerns of compatibility within the centre.
• A specific recruitment campaign is in the end stages and shortlisted candidates are scheduled to be interviewed on the 2nd of July.
• A full time relief staff member is assigned to the Designated Centre commencing on the 1st of July.
• The Centre continues to Block Book Agency to Maintain Continuity of Care until the recruitment Campaign has been Completed
• A service Improvement team meeting was held on the 7th of June and Actions arising from this meeting are being completed by the PIC and Service Manager with the support of relevant members of management and MDT members.
• The PIC and key workers within the centre will continue to ensure that residents assessed needs and community integration continues to be at the forefront of service delivery.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
• A follow up compatibility assessment will be commissioned by the Director of Adult Services and SMART actions will accompany this assessment for action by the PIC/Service Manager and service provider on a whole.
• Updated residential profiles for all residents within the designated centre will be completed by the PIC/Keyworker/Service Manager and forwarded to internal residential approvals committee for consideration and discussion.
• A follow up meeting will be scheduled with the Local Safeguarding Team to escalate the on going concerns.
• A meeting will be arranged with the relevant Health Region through IMR escalation to discuss the concerns of compatibility within the centre.

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	31/12/2024
Regulation 15(3)	The registered provider shall ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.	Not Compliant	Orange	31/12/2024
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to	Substantially Compliant	Yellow	31/12/2024

	ensure the effective delivery of care and support in accordance with the statement of purpose.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/12/2024
Regulation 05(2)	The registered provider shall ensure, insofar as is reasonably practicable, that arrangements are in place to meet the needs of each resident, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	31/12/2024
Regulation 05(3)	The person in charge shall ensure that the designated centre is suitable for the purposes of meeting the needs of each resident, as assessed in accordance with paragraph (1).	Not Compliant	Orange	31/12/2024
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	31/12/2024