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A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd

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Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
Centre ID:	OSV-0004692
Centre county:	Limerick
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Daughters of Charity Disability Support Services Ltd
Provider Nominee:	Breda Noonan
Lead inspector:	Eva Boyle
Support inspector(s):	Una Coloe
Type of inspection	Unannounced
Number of residents on the date of inspection:	5
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance 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 inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
13 January 2015 09:00	13 January 2015 18:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 12. Medication Management
Outcome 13: Statement of Purpose
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the first inspection of this service and was carried out for the purposes of monitoring. Seven outcomes were reviewed as part of this inspection. The centre provided a respite service for boys and girls aged from 0-18 years with mild to profound intellectual disabilities, physical disability, communication needs and specific medical needs. The majority of children attended for overnight respite but some younger children attended for day respite. The centre was located in a bungalow in a suburb of Limerick and the provider was St. Vincent's Residential Services which came under the remit of the Daughters of Charity.

As part of the inspection, the clinical nurse manager 2 (CNM 2) who was the person in charge, the clinical nurse manager 1 (CNM 1), staff and four parents were met by inspectors. Documents such as personal plans, policies and procedures and staff files were reviewed by inspectors. Five children who attended the centre on the day of the inspection were observed by inspectors. Staff were observed being kind and supportive to the children and delivering a good standard of care to them. Parents told inspectors that they were happy with the service that their children received and were regularly updated by the staff team. The staff team were aware of what to do if they had concerns in relation to children's welfare and had passed on concerns to the Child and Family Agency. Recruitment processes were in line with the regulations. Staff identified that they received informal support from management. The CNM 1 and CNM2 were aware of their roles and responsibilities and staff were

provided with good leadership within the centre. A six monthly review of quality and safety of the centre had been completed recently and actions were identified for follow up.

Risk management processes were not robust. Inspectors identified three hazards on the day of the inspection that had not been identified or risk assessed. Two of these risks were managed on the day. An immediate action plan was issued in relation to the third risk where the windows had not been risk assessed and there was a risk to children's safety. An appropriate action plan was provided to the Authority within the agreed timeframe.

The statement of purpose and function had a broad admissions criteria and the statement of purpose did not meet all of the requirements of the regulations. Children's needs were not adequately assessed, personal plans were not comprehensive and no goals set for children. There were deficits in the training that were provided to the staff team and not all staff had received mandatory training. No formal supervision or annual appraisals had been completed with staff and it was unclear how the CNM 2 formally reviewed staff's performance.

These and other deficits are outlined in this report.

Section 41(1)(c) of the Health Act 2007. Compliance 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.

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
Children's needs were not adequately assessed. As a result, personal plans were not comprehensive. Parents were involved in the development and review of personal plans, but the involvement of children where appropriate was not apparent. Children did not have a seamless transition between children and adult respite services.

Each resident's health, personal and social care and support needs were not fully assessed. Inspectors found that there was a social work assessment on file, which assessed the need for respite prior to the child's admission, but it was not a comprehensive holistic assessment of children's needs. Some professional reports were held on children's files such as psychological reports. However, the absence of comprehensive, updated assessments meant that all of the young people's needs had not been assessed to inform their personal plan. The lack of a comprehensive assessment also impacted on the staff teams ability to meet the needs of children on a consistent basis.

Personal plans were in place for each resident, but they were not comprehensive. Inspectors reviewed a sample of three personal plans and found that some sections of personal plans were incomplete or had insufficient information in relation to specific needs of children. For example, inspectors found that the section about 'me and my life, special events' was not completed in some personal plans, while in another plan no special event was documented since 2012. A new template for personal plans had recently been introduced but inspectors found that the template was not significantly different to the original template. Inspectors reviewed one of the new templates which had been recently completed. The new template of personal plans had included some

pictures, a section on a social assessment, and had a section on social development planning.

No child friendly copies of personal plans were available, and copies of personal plans had not been provided to parents or guardians. Therefore, parents may not been aware of all aspects of their child's personal plan. The level of ability of children who attended the service varied but it was not clear that children were consulted where appropriate. No specific goals were identified in personal plans, so it was unclear how staff monitored children's outcomes.

Reviews of personal plans had not focused on the effectiveness of the resident's personal plan. Personal plans were reviewed annually or more often if required. However, inspectors reviewed a sample of minutes of respite review meetings and found that there was a focus on medical needs but not on children's social needs. The parents of children were consulted and involved in the reviews. No future goals were identified for the child in the sample of review meetings that were reviewed by inspectors. Therefore, it was not clear that the review meetings were an effective forum where there were clear, achievable plans put in place for the year ahead.

Children's preparation for adulthood was not strongly evident in personal plans. There was evidence that children had opportunities to develop their social skills through their participation in activities in the community and staff told inspectors that children experienced going shopping. However, it was not evident from personal plans how children's life skills were developed with a view to preparation for adulthood.

There were delays in children transitioning to adult services, and there were no definite plans in place in relation to transitions. The CNM2 told inspectors that it was only since Christmas that the service had begun to look at transitions. He/she outlined that children were discussed at the respite committee and that there were no documents in the centre to reflect these transitions. Four children were identified to be turning 17 years during 2015. Inspectors were informed by the CNM2 that there was a waiting list within adult services for respite, but care plans were transferred to adult services, and young people usually had two visits to the adult service prior to transferring to adult services. However, there was no evidence on children's files in relation to this level of planning of transitions and it was not clear that children were supported by staff in regard to moving from the service to adult services.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The health and safety of the young people, visitors and staff was not adequately promoted. Although there were policies and procedures in place in regard to health and safety and some fire precaution measures in place, the inspectors identified a number of hazards and risks that had not been assessed during the inspection. This indicated that the risk management systems in place were not adequate.

The risk management system was not effective and did not lead to all risks being identified, reduced or eliminated. The centre had an organisational health and safety statement dated July 2014 with supporting documentation on local hazards and risks. The inspectors observed a number of safety measures which had been put in place such as chemicals being locked away. However, this assessment had not identified a number of other hazards and risks that inspectors identified on the day of the inspection such as the safety risk of open windows to children had not been risk assessed. An immediate action plan was issued following the inspection as there had been no risk assessment of the windows in the centre. The provider responded with an appropriate action plan within the agreed time frame. The centre risk assessed the situation and window restrictors were fitted to windows in the centre.

In addition to the immediate risk, inspectors found two other additional risks. Firstly, there was a risk that children could ingest personal protective equipment, as they were stored within reachable height for some children in the kitchen and bathroom. Secondly, there was a risk of injury to children as there were car seats stored in the entrance area. These risks were appropriately mitigated against during the course of the inspection as the level of personal protective equipment was placed out of the reach of children and the car seats were moved.

The centre had risk assessments completed on some risks such as fire, infection, food hygiene, hot water, transportation of service users, lone working, slips and trips and aggressive behaviour. The risk was identified, the impact, the existing controls, additional control measures, persons responsible for action, a due date for completed action and a review date.

The centre had an organisational risk policy that was not in line with all the requirements of Regulation 26. The policy outlined the systems in place for hazard identification, assessment of risk, the measures and actions in place to control the risks identified. The measures and actions in place to control the unexpected absence of a child, accidental injury to residents, visitors or staff, aggression and violence and self-harm were referenced but not adequately described. The policy referenced relevant policies that related to risk such as behaviour management policies, child protection and missing persons policy. However, it did not outline the arrangements for the investigation and learning from serious incidents or adverse events involving residents.

There were systems in place to record incidents and serious events. However it was not clear how any changes were made to practice as a result of incident reports. Incidents were identified, risk rated and notified to management. The incident forms reviewed

related to behavioural incidents and it was not clear that any changes were made as a result of these reported events. There had been no adverse incidents in the centre in 2014.

Procedures in relation to safe practices in areas such as food safety, manual handling, infection control, cleaning schedules, first aid and disability awareness were provided to staff. Inspectors examined a selection of staff training records and these reflected that the majority of staff had completed training in food safety and infection control. Two staff members had not received updated training in manual handling so there was a risk that they could potentially injure themselves when lifting items within the centre. Additional training had been provided for staff in the control of substances hazardous to health, and there was guidance in the centre in relation to products such as detergents which could be hazardous to young people and staff.

There were systems in place in relation to protection against infection, but staff had not received training in hand hygiene. Inspectors found that the centre was clean. A daily, three monthly and six monthly cleaning schedule was in place for areas internally and external to the centre. An audit of hygiene in the centre was completed in 2014 and many of the recommendations that were made were implemented such as the installation of hand lotion dispensers and the colour coded systems for cleaning and food preparation. Pedal operated bins were in use throughout the centre. The temperatures of fridges and freezers were checked daily. Personal protective equipment such as gloves and aprons were available for staff. There was extensive guidance available in the centre in relation to specific diseases and hand hygiene. The CNM 2 told inspectors that hand washing was an issue, that it was recommended in the hygiene audit that an additional hand washing sink was made available to staff, but due to the size of the building that it was not possible to implement this recommendation. However, hand gels were available for staff use throughout the centre. Staff had not received hand hygiene training. Therefore, there was a risk that staff may not be aware of best practices in hand hygiene. There were arrangements in place for clinical waste to be brought to the main campus of St. Vincent's centre for disposal.

There were some fire safety precautions in place but improvements were required. Each child had an individual fire risk assessment which outlined their mobility status, gave direction regarding non-ambulant children, and recorded the level of assistance that children required if they had to be evacuated. However, it did not outline the contingency in place if children could not return to the centre. There were good child friendly directions on the steps to take in the event of a fire on display in the centre. Suitable fire fighting equipment was available such as fire blankets and fire extinguishers, and these had been serviced in February 2014. The fire alarm and emergency lights were serviced in April 2014, which did not meet the requirement of quarterly servicing. Daily checks were completed of the fire systems panel and fire door and weekly checks were completed of the emergency lighting. Monthly checks reviewed the means of escape, smoke alarms, specific rooms of the house and fire fighting equipment. The centre's statement of purpose outlined that monthly fire drills took place. However, there were only two records of fire drills in June and October 2014. One of these fire drills only involved staff members and 4 children in total had experienced a fire drill. Therefore, there was a risk that the majority of children may not know what to do in the event of a fire.

Judgment:
Non Compliant - Major

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There were some measures in place to safeguard children, but the management of behaviour required further development. Staff had a good awareness of their responsibilities in safeguarding children and were warm and respectful in their interactions with children. However, not all staff had been trained in Children First Guidance for the Protection and Welfare of Children (2011) or in the management of behaviours. There was a policy in place for the provision of behavioural support, but the policy was not fully adhered to by staff. The assessment and review of restrictive practices was not robust and it was not evident that the least restrictive practice was considered at all times.

There were some measures in place to keep children safe and protect them from abuse. Inspectors observed staff singing and playing with children and were respectful in all their interactions. The majority of staff had received training in 'Abuse Guidelines', which the CNM 1 described as training on the organisation's policy for adults and children, which incorporated Children First (2011). Therefore, the majority of staff had not received specific training in Children First Guidance for the Protection and Welfare of Children (2011). The CNM 2 had not received training in Children First (2011), but inspectors found that he/she had good knowledge of what to do in the event of suspected abuse.

Staff members knew what abuse was and knew what to do in the event of an allegation, suspicion or disclosure of abuse. Child welfare concerns were reported to the Child and Family Agency and staff participated in related meetings such as child protection conferences. However, staff had not reported the concerns using the standard report form as is a requirement of the organisation's policy and also of Children First (2011), therefore this may have been due to the lack of staff training in this area. Staff on duty knew that the designated liaison officer was the services manager. However, the organisation's child protection policy had not been updated with the details of the

designated liaison officer. Therefore, this key information may not have been available to staff.

The centre had a comprehensive policy in relation to the provision of intimate care in the centre, but intimate care plans were not sufficiently detailed for staff to provide consistent care to children. Inspectors found that it was emphasised in intimate care plans that staff needed to tell children what they were going to do, prior to completing intimate care on the children. Staff had good knowledge of the organisation's policy on intimate care. Inspectors observed that staff members preserved the dignity of children when assisting children with intimate care by ensuring that the door of the bathroom or bedroom were closed. Inspectors reviewed personal plans and found that there was insufficient detail recorded and no consents were in place in regard to the provision of personal care. For example, it recorded that children required full assistance in regard to their intimate care but no specific guidance was provided for staff on providing the care within the plan. Therefore, staff may have been inconsistent in the way in which they provided intimate care to children.

The majority of children in the centre did not present with behaviour that challenged but no behavioural plans were in place for children who had. The CNM1 told inspectors that one child had behaviour that challenged and had a behaviour support plan in place. However, this file was reviewed by inspectors, and there was no behaviour support plan on file. The last risk assessment in regard to the child's behaviour on file was 15 months old. Therefore, the staff had no up to date guidance to support them in working with the child on the behaviour that challenged. A referral to psychology services was completed, but there was no feedback documented on the file. However, it was not clear that the child's behavioural needs had been assessed on an ongoing basis and appropriate plans were put in place. The child was admitted on his/her own to the centre for respite and inspectors were told that this was due to the the challenges of managing the child's behaviour. However, the practice of the child being admitted on his/her own to the centre was not regularly reviewed and it was unclear how the CNM 2 made decisions in relation to this practice.

The majority of staff had been trained in behaviour management, but staff told inspectors that this training was general training which applied to both adults and children. Therefore, staff may not be aware of best practice in dealing with the management of children's behaviour.

Restrictive practices used in the centre were identified as such by staff. Restrictive practices such as the use of a harness in the car, visual monitoring, locking of internal doors and windows were used in the centre.

The approval and review process for restrictive practices was not robust and it was not evident that the least restrictive practice was always in place. Risk assessments in regard to the use of restrictive practices were not in place for all restrictive practices. Inspectors found one assessment which risk assessed the use of bed rails which was not sufficiently detailed. Nine children's restrictive practices were approved by a multi-disciplinary team but the process of approval was unclear from documents reviewed by inspectors. The use of restrictive practices for other children had been referred to two other multi-disciplinary teams for approval. Therefore, all restrictive practice in use in

the centre had not been approved. This meant that restrictive measures may have been applied routinely by staff rather than on a therapeutic or risk based basis. The CNM1 told inspectors that s/he had met with multi-disciplinary teams and had provided information on restrictive practices to them. There was little evidence in the files reviewed that alternative measures or the least restrictive measure, for the shortest duration had been considered, but the CNM 1 told inspectors that it was considered but not documented. A parent told inspectors that they had received information regarding restrictive practices from the CNM1 and the child's multi-disciplinary team.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There were improvements required in the administration and management of medication. Medication was safety stored, and there were good procedures in place in relation to receiving medication into the centre. Staff had not received training on the safe administration of medication and some medication errors had occurred.

The centre followed an organisational medication policy which was reviewed in October 2014 and met the requirements of the regulations. The policy outlined the process in relation to ordering, storage, administration, recording of emergency prescriptions, drug errors and controlled drugs.

Medication was received from parents on each admission to the centre. Inspectors observed two staff members receiving a child's medication. Staff recorded the child's name, the medication and quantity of the medication that came into the service and this was completed again when the child was leaving respite. Staff checked the medications against the prescription sheet. Each child's medication was stored in a separate section in a locked medication cabinet and a locked fridge was also used if required. Appropriate locked storage facilities were in place for controlled medication. The original labels from the pharmacy were not on all medications received by staff. The CNM1 told inspectors that when children left the respite centre and were going to school prior to going home that their medication was given to the bus escort who was responsible for handing it to the school nurse. There was no discontinued medication stored in the medication cabinet.

There was a controlled drugs register in place, but staff did not consistently adhere to the requirements of the policy. Controlled drugs were monitored at the end of each shift, and also upon the child's admission and discharge to respite as per the policy. However, two members of staff did not consistently sign the drugs register. The CNM1 explained to inspectors that sometimes parents left medication into the centre during the day, and two members of staff were not always on duty, therefore the staff were unable to comply with the requirement of two staff signing in controlled medication.

The centre had prescription sheets but the practice of replacing prescriptions sheets on a six monthly basis carried some risk. All prescription sheets sampled contained the young person's photograph, their date of birth, general practitioner's name (GP's), name of medication, dose, route of and time of administration. A doctor's (GP's) signature was in place for each medication. As required medications (PRN) outlined the maximum dosage.

Administration sheets identified the medications which were prescribed on the prescription sheet. There was a signature sheet in place, so it was possible to track what staff had administered medication. A space was available for staff to record if a child refused or withheld medication. No children had been assessed as being capable of managing their own medication at the time of the inspection.

A number of drug errors had occurred due to parents/guardians not communicating changes in medication to staff. Prescription sheets for children were completed on a six monthly basis by the child's GP, and a copy of the child's prescription which was valid for six months was also held on file. Staff were dependent on family members updating them if there were any changes to medication during the six month period. There were various communication systems in place with families, such as some parents used communication books to pass updates to the staff team, other parents spoke directly to staff either by telephone or by calling into the centre, but there was always a risk that in error updated information may not be passed on.

The centre had systems in place to record and monitor drug errors, but it was not clear how learnings were implemented in practice. Inspectors reviewed records of drug errors from 2014. Five drug errors were reviewed by inspectors and incident forms were completed on each error. Errors were recorded in relation to a child being administered the incorrect dosage of medication, discrepancies between the prescription sheet and actual prescription, medication being administered but not documented and insufficient medication being provided by a family member and staff being unable to source the medication. Some of the medication errors related directly to staff not following the centre's policies on medication management and therefore the lack of training in the safe administration of medication may have contributed to a small number of drug errors. Inspectors found that staff followed the policy in regard to medication errors and contacted the CNM3 on call initially who provided direction for staff. The CNM2 told inspectors that s/he had reviewed the drug errors and that there were no patterns. Medication errors were reviewed by a central committee. However, it was not evident what feedback was provided to the management of the centre and if any changes were made as a result of the analysis of the drug errors. The CNM2 told inspectors that they were developing local guidance in relation to medication audits.

All medication was administered by nursing staff, but staff had not received up to date training. The CNM1 and CNM2 had both received training in medication management for persons in charge during 2014, but no other members of staff had received updated training. No competency assessments had been completed recently with nursing staff. The CNM2 told inspectors that they were planning to provide medication management training for staff. Therefore, staff may not have been up to date in the best practice of administration of medication.

Judgment:
Non Compliant - Moderate

Outcome 13: Statement of Purpose
There is a written statement of purpose that accurately describes the service provided in the centre. The services and facilities outlined in the Statement of Purpose, and the manner in which care is provided, reflect the diverse needs of residents.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The centre had a statement of purpose which was completed in July 2014. However, it did not meet all of the requirements of Regulation 3.

The statement of purpose adequately outlined the facilities for privacy and dignity, the organisational structure, staffing levels and the arrangements for visiting children during respite. It described that the service provided respite to both males and females.

The Statement of purpose was very broad in its criteria for the provision of respite, the centre provided respite care for children under the age of 18 years of age. It outlined that the centre provided care for children with an intellectual disability and who also may have physical disability, communication difficulties, medical needs, epilepsy and social needs. However, it was unclear that staff had access to continuous professional development in regard to the range of children's needs that the centred provided respite to.

The statement of purpose did not adequately describe the following;
- the number of children who could avail of respite at any one time
- the arrangements made for consultation with respite users
- arrangements for children to attend school during respite
- the arrangements for the annual review of personal plans
- the complaints procedures and the complaints officer was not named.

However, the statement of purpose did not meet the requirements of regulation three as there were a number of omissions. For example, the criteria for emergency admissions was not outlined. Other omissions were as follows:
- how children would be facilitated to attend religious services
- details of specific therapeutic techniques used or their supervision
- no dimensions were included on the floor plan
- contingency arrangements were not described in the event of a fire or evacuation of the centre
- arrangements for day care.

The statement of purpose was on display in the front hall of the centre for staff and parents to view but it was not in a format that was accessible to residents. Children and families had not received copies of the statement of purpose.

Judgment:
Non Compliant - Moderate

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was a clearly defined management structure and some systems in place to ensure the centre operated safely but these were not always effective. This included risk management and quality assurance mechanisms which had not identified the significant risk that this inspection found. The CNM 2 who was the person in charge provided good leadership to the staff team.

There was a clearly defined management structure which identified the lines of authority and accountability in the centre. A clinical nurse manager 2 held the position of person in charge (PIC) for this unit and another unit. A clinical nurse manager 1 deputised for the CNM2 in his/her absence. All staff reported to the CNM 2 and were clear about the reporting relationships. The CNM 2 reported to a CNM3 who in turn reported to the assistant director of nursing, who reported to the director of nursing and the services manager. Staff on duty were aware of their roles and responsibilities and who they reported to.

The CNM2 was a suitably qualified and experienced manager, who was appointed to the position in May 2014. S/he held a degree in nursing, had completed management training and completed a range of continuous development courses. The CNM2 had a good knowledge of children attending the centre. The working hours of the CNM 2 was equally divided between the two centres that s/he managed. The CNM 2 told the inspector that s/he met the CNM 3 formally on a monthly basis. Inspectors found from reviewing the minutes of these meetings that issues relating to the children's respite service were discussed and specific actions were identified. However, timescales for actions were not recorded and items discussed at the previous meetings were not always reviewed at the next meetings. Therefore, it was unclear how the CNM2 was held to account by the CNM 3.

There were management systems in place but they were not sufficiently robust. The CNM 2 had good communications systems in place. Staff, the CNM1 and CNM 2 told inspectors that informal discussions took place on a daily basis in regard to specific children and the service. Monthly team meetings took place, and a wide range of issues were discussed such as children, training, health and safety, occupancy of the respite house, practice guidelines and admissions and discharges. There was a system in place where policies, procedures or specific issues were focused on each week by the staff group. For example, on the week of the inspection infection control was focused on by the staff team. In addition, inspectors observed that previous inspection reports completed by the Authority on other children's disability centres were available for staff to read within the centre. An on call system was in place out of hours, and a CNM 3 was available to staff out of hours. Staff members outlined that the CNM2 was accessible and popped into the centre on days when he/she was rostered to work in the other centre. While the CNM2 had a good knowledge of the regulations, not all the requirements of the regulations were implemented.

Other management systems in place included policies and procedures which were available to staff in the centre. These were in place to guide staff but there was no system in place to monitor their implementation. Risk management systems were not robust as they had not identified the risk identified by inspectors within the centre. The CNM 2 also attended a respite committee which reviewed the occupancy rates of the respite centre to ensure that the service provided an efficient service to children. Parents told inspectors that they had experienced no cancellations of respite since May 2014.

There was some monitoring of the overall quality of the service provided to children and their outcomes, but there were no system of regular ongoing audits in place. The CNM 2 and other nominated staff members had undertaken some random audits of the service, for example in regard to the the transfer of information between staff coming on duty and staff ending their shift, infection control and meal times and an analysis of complaints had been completed for 2013. However, a systems of regular audit was not in place and issues such as the quality of children's personal plans had not been audited. A six monthly unannounced visit was completed by the Quality and Risk Officer for the organisation in December 2014 and the service was reviewed under the 18 outcomes of the standards. The report highlighted specific deficits and made recommendations for further actions. Plans were in place to address the identified deficits.

Staff were not formally performance managed. There was a system of staff appraisal in place within the organisation but no staff had an up to date appraisal. The CNM 2 told inspectors that s/he had required a period of time to get to know staff prior to completing appraisals, but planned that appraisals would be completed by May 2015.

There were no formal arrangements in place to ensure that staff exercised their personal and professional responsibility for the quality and safety of the services that they are delivering, but inspectors found evidence that staff raised concerns in relation to the quality of the service. There was no formal protected disclosures policy in place, but inspectors found evidence that staff raised specific concerns with the CNM 2 in regard to a practice issue, the matter was followed up by the CNM 2 and an outcome was reached. Staff members told inspectors that they would raise concerns with the management or senior management of the organisation if they had concerns regarding the safety or quality of care provided to children.

The centre had a service level agreement with the Health Service agreement for 2014, but discussions were taking place in regard to 2015 service level agreement.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There were adequate recruitment processes in place for staff employed by the organisation. Staff had a good awareness of organisational policies and of the Regulations and Standards. Sufficient staff with appropriate qualifications and experience worked in the centre. However, no training needs analysis had been completed to identify the continuous professional development training that staff required. There were gaps in the education and training that was provided to staff and not all staff had mandatory training.

Recruitment processes were adequate. A sample of staff files were reviewed and inspectors found all the requirements of schedule 2 were in place. Staff files contained the names, address, dates of birth, identification, photograph of staff members, qualifications and An Garda Síochána vetting. However, there was no system in place of updating staff vetting. Professional registration certificates were in place up to December 2014 and staff had yet to submit their updated certificates for 2015. Agency staff were used by the centre but no service level agreement was in place with the specific agency. The Acting Services Manager told inspectors that there was no system in place to view the qualifications of agency staff. The CNM 2 told inspectors that the same agency staff were used in order to have continuity. There were no volunteers working within the centre.

There was sufficient staff with the right qualifications and experience to meet the assessed needs of residents at all times. The service was staffed by nursing staff who held a qualification in intellectual disability nursing or children's nursing, and one health care assistant was on the staff team. Additional agency health care assistant staff were rostered if required. Two members of household staff were on the roster and student nurses also worked in the centre. Many of the children who attended the centre had significant medical needs and it was appropriate that nursing staff were employed in the centre, this was in line with the centre's statement of purpose. Inspectors observed staff interaction with children and found them to be respectful and timely in their provision of care to children.

Copies of the actual and amended rota were held in the centre. The rota was difficult to follow, the 24 hour clock was not used. The system in place to indicate a sleepover was not always clear as sometimes it was marked by s/o to indicate a sleepover, and on other occasions a number was included in an untitled box at the end of the week. Therefore, there was not consistency in how sleepover were indicated on the rota and new or agency staff may find it difficult to follow.

There were sufficient staff rostered on duty on the day of the inspection. The rostering of staff during the day was dependant on the needs of the children on respite and two or three members of staff worked during the day. A nurse was rostered on waking night duty from 20.00 until 08.15, and a second member of staff was in the centre on sleep over so there were sufficient staff in place to care for children at night time.

There were gaps in the provision of training to staff and not all staff had received mandatory training. No training needs analysis had been completed. This meant that the training provided to staff did not fully reflect the training and development needs of the staff team as it was not informed by the needs of the young people attending the service. Two staff members had not up to date fire training or manual handling but training in these areas were scheduled for staff in February 2015. The training provided to staff on behaviour that challenged had not been specific to managing children's behaviour. This training was key in order that staff had the right skills to effectively manage children. Additional training had been provided to some staff in areas such as infection prevention and control, food safety and person centred planning.

No formal supervision was provided for staff and no supervision policy was in place. Staff spoke of receiving good informal guidance from the CNM 2 if required. However, staff did not have formal support by the manager or an opportunity for the manager to formally identify good practice or areas which required improvement.

Staff had a good awareness of the organisation's policies and procedures, and of the relevant legislation, Regulations and Standards. Copies of the regulations and standards were available for staff in the centre. Inspectors found from interviews with staff members that staff had a good knowledge of the Regulations and Standards.

Judgment:
Non Compliant - Moderate

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Eva Boyle
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Daughters of Charity Disability Support Services Ltd
Centre ID:	OSV-0004692
Date of Inspection:	13 January 2015
Date of response:	27 March 2015

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance 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.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Comprehensive holistic assessments were not completed prior to children's admission to respite services.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:
Under Regulation 05 (1) (a) you are required to: 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 prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

A complete comprehensive holistic assessment will be completed for all children prior to admission. The Person in Charge, key worker (Registered Nurse) and relevant MDT members will review the assessment tool to ensure that it meets the assessment needs of each child in the areas of health, personal and social care needs.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not evident that children needs were re-assessed.

2. Action Required:
Under Regulation 05 (1) (b) you are required to: 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 as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
All children attending the centre will have their needs reassessed and any changes in their needs will be reflected in the assessment. Actions arising from the reassessment will have plans of care developed to support those needs identified. Going forward each child's care plan will be reviewed by their key worker (Registered Nurse) no less than ever twelve months. If there are any changes in a child's circumstances, these will be reviewed more regularly.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Personal plans did not contain all information in relation to children's needs.

3. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

All children attending the centre will have their updated assessment reviewed to ensure that all the information in relation to the child's needs will be documented. The Person in Charge, staff team and relevant MDT members will review the assessment tool to ensure that it meets the assessment needs of each child in the areas of health, personal and social care needs. Actions arising from the reassessment will have MDT review and the care plan will be updated.

Proposed Timescale: 30/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Review of respite did not adequately reflect children's social as well as medical needs, and no goals were identified.

4. Action Required:
Under Regulation 05 (7) you are required to: Ensure that recommendations arising out of each personal plan review are recorded and include any proposed changes to the personal plan; the rationale for any such proposed changes; and the names of those responsible for pursuing objectives in the plan within agreed timescales.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

All children will have included in the reviews of the plan of care a person centred plan. This Person centred plan will focus on the educational and social needs of each child and identifying goals with the child and their family. A clear action plan will be in place for each goal to be achieved with regular review dates. The goals identified will be meaningful to the child and will be quality of life focused. These goals will be reviewed at each yearly review meeting and any changes and rationale for those changes are documented.

Proposed Timescale: 15/06/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No child friendly version of personal plans were available for children.

5. Action Required:
Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.

Please state the actions you have taken or are planning to take:
A new child friendly version of the care plan has been developed and made available for each child. Parents and Families will be involved in the completion of the new child friendly version care plan. This new child friendly version will commence on the next child admission to the respite centre. This care plan will be reviewed as part of the overall yearly care plan review.

Proposed Timescale: 14/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence that children participated in the review of their personal plans where it was appropriate.

6. Action Required:
Under Regulation 05 (6) (b) you are required to: Ensure that personal plan reviews are conducted in a manner that ensures the maximum participation of each resident, and where appropriate his or her representative, in accordance with the resident's wishes, age and the nature of his or her disability.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

This Person centred plan will focus ensuring that all children and their families are included in the review of the personal plans and identifying goals with the child and their family.

Proposed Timescale: 15/07/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Reviews of personal plans did not review the effectiveness of the current plan.

7. Action Required:
Under Regulation 05 (6) (c) and (d) you are required to: Ensure that personal plan reviews assess the effectiveness of each plan and take into account changes in circumstances and new developments.

Please state the actions you have taken or are planning to take:
The Person in Charge and key workers (Registered Nurse) will review the current personal plan and make changes to ensure it's effective in meeting the needs of each child in the areas of health, personal and social care needs. A formal meeting will be held yearly to review and reflect the effectiveness of each plan. The chairperson will reflect on the old plan and create a new plan for the coming year.

Proposed Timescale: 18/12/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Transitions were not planned and it was not clear how children were prepared for transition to the adult services from children's files.

8. Action Required:
Under Regulation 25 (3) (b) you are required to: Provide support for residents as they transition between residential services or leave residential services, through the provision of training in the life-skills required for the new living arrangement.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

A transitional Plan has since the inspection been developed. This is currently being piloted with a pilot group to ascertain its effectiveness. Any changes required will be made and the final transitional plan will be implemented for each child.

TRANSITION PLAN FROM CHILDREN'S RESPITE TO AUDLT RESPITE

•Once Seventeen, the C.N.M.1 or 2 of Children's Respite Service contact the family and inform them of the application process for Adult Respite Services. Highlight that the process takes six months, and therefore, applications should commence six months prior to the person turning eighteen. This contact is logged on a "Tracking Sheet". Application forms are available from Children's Respite Service C.N.M. 1 or 2. This form is completed and returned to the "Chairperson" of Respite Committee.

•Following on from above contact and family; Children's Respite Service C.N.M. 1 or 2 make contact with Social Work and inform them that said family have been contacted re' Adult Respite Application. This contact is logged on a "Tracking Sheet" between Children's Respite Service and Social Work.

•Children's Respite Service C.N.M. 1 or 2 contact Adult's Respite Service and inform them of above communication.

•Tracking Sheets for Communication.
1) Children's Respite Service ‥Social Work
2) Adult's Respite Service ‥Social Work
3) Adult's Respite Service ‥Children's Respite Service
4) Children's Respite Service ‥Family and Child
5) Adult's Respite Service ‥Family

•Tracking Sheets for Orientation e.g.
— Family Visits / Service User Visits
— P.M. Respite / Day Respite
— Overnight Commenced

•Handover Tracking Sheets
E.g. Handover from:
— Children's Respite Service to Adult's Respite Service
— Social Work to Adult's Respite Service (Adult's Respite Service C.N.M. 1 or 2 arrange meeting with Social Work).
— School to Adult's Respite Service (Adult's Respite Service arrange meeting).
— Any other area of attendance to Adult's Respite Service e.g. Day Service (Adult's Respite Service arrange meeting).

Proposed Timescale: 01/04/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The measures and actions in place to control the unexpected absence of a child was referenced but not sufficiently described.

9. Action Required:
Under Regulation 26 (1) (c) (i) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the unexplained absence of a resident.

Please state the actions you have taken or are planning to take:
The risk management policy has been updated and includes the measures and actions in place to control the unexplained absence of a resident. These measures include that all service users with a history of absconding now have a Missing Person Profile in their Care Plan and a risk assessment completed. There is a risk management policy specific to absconding in place in the centre. The missing person's profile is also completed for those service users who do not have a history of absconding. All measures and actions are now in place to control the unexpected absence of a child. All staff are made aware of the updated policy through their PIC/ Deputy line manager, intranet and signing sheet which is required by the service whereby staff sign off on reading / reviewing the updated policy.

Proposed Timescale: 01/04/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy referenced the measures and actions in place to control accidental injury to residents, visitors or staff were referenced but not adequately described

10. Action Required:
Under Regulation 26 (1) (c) (ii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control accidental injury to residents, visitors or staff.

Please state the actions you have taken or are planning to take:
The risk management policy DOCs 052 has been revised. The revised policy has been signed by the service CEO and distributed to all centres. The risk management policy now includes actions and measures to be taken to ensure controlling accidental injury to residents, visitors and staff. These measures include the following:
Safety Statement is completed in the centre which includes risk assessments on all identified hazards for staff, service users and visitors. Standard Operating Procedures in relation to the service Incident and Accident Reporting system. Incidents and near misses are investigated by the centre safety officer or nominated personnel and statistics are monitored, audited and trended through the health and Safety committee/ challenging behaviour monitoring group/ Infection Control Committee. Availability of first aid and out of hours GP and on call services for another employee who has witnessed the incident, or support by the line manager. All staff are made aware of the revised policy through their PIC/ Deputy line manager, intranet and signing sheet which is required by the service whereby staff sign off on reading / reviewing the updated policy.

Proposed Timescale: 20/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy referenced the measures and actions in place to control aggression and violence, but was not sufficient.

11. Action Required:
Under Regulation 26 (1) (c) (iii) you are required to: Ensure that the risk management policy includes the measures and actions in place to control aggression and violence.

Please state the actions you have taken or are planning to take:
The risk management policy DOCs 052 has been revised. The revised policy has been signed by the service CEO and distributed to all centres. The measures and actions in place to control aggression and violence are now described in the policy and include the following: All staff are trained and utilize the Guidelines in supporting persons with challenging behaviour, risk assessments are completed and positive behaviour support plans are developed to support service users who have potential to display aggression and violence or where aggression and violence part of an individual's history.
Safety Statement completed in relation to challenging behaviour outlining procedure
Reducing exposure to known risk factors for people who may display aggression and violence through providing a range of person centred living, leisure and educational opportunities within the service from early childhood through to old age, depending on the individual needs of the person.

All people who may display aggression and violence are reviewed by the MDT and have regular review to the psychiatric team within the centre. Emergency response protocols are in place to respond to such incidents where staff have pagers and an alarm system to alert staff to respond to areas that require extra support. Appropriate skill mix with staff that have qualifications that enable them to work with service users who display aggression and violence. Staff to have knowledge of de- escalation and distraction techniques. On call support from senior nurse management. Pregnancy risk assessments are completed for staff working with people who display aggression and violence. Referral to G.P services/ Hospital services for assessment with follow up if required. Referral to Occupational Health for staff if required. All incidents are reported using the Service Incident Reporting Policy. Incidents and near misses are investigated by the centre safety officer or nominated personnel and statistics are monitored, audited and trended through the health and Safety committee/ challenging behaviour monitoring group. All staff are made aware of the revised policy through their PIC/ Deputy line manager, intranet and signing sheet which is required by the service whereby staff sign off on reading / reviewing the updated policy.

Proposed Timescale: 20/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy referenced the measures and actions in place to control self-harm but did not outline them in sufficient detail.

12. Action Required:
Under Regulation 26 (1) (c) (iv) you are required to: Ensure that the risk management policy includes the measures and actions in place to control self-harm.

Please state the actions you have taken or are planning to take:
The risk management policy DOCs 052 has been revised. The revised policy has been signed by the service CEO and distributed to all centres. The revised policy now includes measures and actions place to control self harm. These include the following: All staff are trained and utilize the Guidelines in supporting persons with challenging behaviour, risk assessments are completed and positive behaviour support plans are developed to support service users who have potential to self harm or where self harm is part of an individual's history. All people who may self harm are reviewed by the MDT and have regular review to the psychiatric team within the centre. Emergency response protocols are in place to respond to such incidents where staff have pagers and an alarm system to alert staff to respond to areas that require extra support. Appropriate skill mix with staff that have qualifications that enable them to work with service users who self harm. Staff to have knowledge of de- escalation and distraction techniques. On call support from senior nurse management. Referral to G.P services/ Hospital services for assessment with follow up if required. All incidents are reported using the service Incident Reporting Policy. Incidents and near misses are investigated by the centre safety officer or nominated personnel and statistics are monitored, audited and trended through the health and Safety committee/ challenging behaviour monitoring group. . All staff are made aware of the revised policy through their PIC/ Deputy line manager, intranet and signing sheet which is required by the service whereby staff sign off on reading / reviewing the updated policy.

Proposed Timescale: 20/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not outline the arrangements for the investigation and learning from serious incidents.

13. Action Required:
Under Regulation 26 (1) (d) you are required to: Ensure that the risk management policy includes arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

Please state the actions you have taken or are planning to take:
The risk management policy DOCs 052 has been revised. The revised policy has been signed by the service CEO and distributed to all centres. The risk policy now includes arrangements for the investigation and learning from serious incidents. All incidences and near misses are reviewed by the Person in Charge and staff team in the centre at each monthly team meeting to discuss what occurred, how a situation was managed and what could be improved on, with a view to encourage learning and quality care improvement. All incidences and near misses are also reviewed by the Person in Charge/ Deputy with the CNM3 on call as they have occurred which is then communicated to the Nominee Provider. All incidences and near misses are again reviewed by the Person in Charge and the link CNM3 to the centre each month to evaluate the incidences; learning achieved to ensure quality indicators are being followed through in the prevention of further incidences. Incidents and near misses are investigated by the centre safety officer or nominated personnel and statistics are monitored, audited and trended through the health and Safety committee/ challenging behaviour monitoring group/ Infection Control Committee. All staff are made aware of the revised policy through their PIC/ Deputy line manager, intranet and signing sheet which is required by the service whereby staff sign off on reading / reviewing the updated policy.

Proposed Timescale: 20/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The contingency plan for children if they needed to be evacuated in the event of fire was not documented.

14. Action Required:
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

Please state the actions you have taken or are planning to take:
A contingency plan for each child is now documented if they need to be evacuated in the event of a fire. Children will be evacuated – parents or secondary contact will be contacted to take the individual child home or failing this to premises in the main residential centre arranged by the nominee provider. The emergency planning risk assessment will be updated to reflect the above.

Proposed Timescale: 31/03/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Two members of staff had not up to date fire training.

15. Action Required:
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
One staff has completed the mandatory fire training and one staff is scheduled to complete the training.

Proposed Timescale: 27/04/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No behaviour support plans were in place. Risk assessments in relation to the use of restrictive practices were not comprehensive and it was not evident that the least restrictive practice was for the shortest duration was considered.

16. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
All restrictive practices are being reviewed with relevant MDT in children's services to ensure that the least restrictive practice for the shortest duration for each child has been considered. Risk assessments will be updated to reflect the outcome of the review. Behaviour support plans are being developed for individual children in consultation with children services and the individual child's parents. Where new a child is being admitted to the centre, a risk assessment is to be completed in conjunction with the MDT where it will be formally reviewed, agreed and signed off. The risk assessment will look at the causative behavioural factors for the child and alternative measures looked at prior to any restrictive practice being implemented. Currently 5 children identified have had their behaviour support plans completed with MDT meeting due to occur for team ratification.

Proposed Timescale: 30/06/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The systems in place for the approval and review of restrictive practices were not robust.

17. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

All restrictive practices for each child is reviewed by their individual child's MDT and once ratified a copy is returned to the centre. All restrictions are discussed in detail and all other possibilities are explored for the child and alternative measures looked at prior to any restrictive practice being implemented. A copy of the restrictive practice agreement will be retained in the centre and a copy will be sent to the parents/ guardians of each child the restriction is for their agreement and also with the child where feasible.

Proposed Timescale: 15/05/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
A standard report form had not been completed to forward concerns of child welfare to the child and family agency.

18. Action Required:
Under Regulation 08 (5) you are required to: Ensure that the requirements of national guidance for the protection and welfare of children and any relevant statutory requirements are complied with where there has been an incident, allegation or suspicion of abuse or neglect in relation to a child.

Please state the actions you have taken or are planning to take:
Staff will complete any concerns of child welfare to the child and family agency on the standard report form provided from the Children's First policy.

Proposed Timescale: 20/03/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in Children First (2011).

19. Action Required:
Under Regulation 08 (8) you are required to: Ensure that where children are resident, staff receive training in relevant government guidance for the protection and welfare of children.

Please state the actions you have taken or are planning to take:
The service is currently sourcing an outside contractor to deliver Children's First training which will be provided on 15/05/2015.

Proposed Timescale: 15/05/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The organisation's policy on child protection had not been updated with the details of the current designated liaison person.

20. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
Organisations Policy on Child Protection has now been updated to include the current designated liaison person.

Proposed Timescale: 20/03/2015

Outcome 12. Medication Management

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The drugs register was not consistently signed by two staff members.

21. Action Required:
Under Regulation 29 (4) (d) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that storage and disposal of out of date, or unused, controlled drugs shall be in accordance with the relevant provisions in the Misuse of Drugs Regulations 1988, as amended.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

The PIC/deputy will ensure the drugs register is consistently signed by two staff members on a daily basis.

Proposed Timescale: 20/03/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There had been a number of medication errors and it was not clear what learnings were implemented as a result. There were some risks attached to the practice of prescription sheets and copies of prescriptions.

22. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
Control measures are in place to reduce or eliminate risks identified in the prescription sheets of medication. This includes the PIC/ Deputy cross referencing the prescription sheet/ kardex with the family initially, then every 3 months with the child's pharmacist. Contact with the Child's GP also occurs where there is a query about a child's medication. Where a child's medication is not prescribed on a kardex or prescription sheet, the child will not be admitted to the centre. All drug errors and near misses are recorded in the service incident reporting system and forwarded to the CNM3 on call. The DOCs 015 medication policy in relation to reporting and investigation of medication errors will be discussed with staff at their house meeting. The CNM3 reviews the drug errors with the nominee provider and reverts back to the Person in Charge/ Deputy as they have occurred to ensure safety of the resident and to follow through on any actions that are required. All dru errors and near misses are again reviewed by the Person in Charge and the link CNM3 to the centre each month to evaluate the incidences; learning achieved and ensures quality indicators are being followed through in the prevention of further incidences. Drug Errors and near misses are investigated by the centre safety officer or nominated personnel and statistics are monitored, audited and trended through the Service Drugs and Therapeutics Committee. Medication Management training for staff is in place. All medication errors will be brought up at Unit Meetings with a view to learning and ensuring there are no further incidents. All medication issues and incidents are discussed at the service Drugs and Therapeutics Committee and actions for learning from the Drugs and Therapeutics Comittee with a view to reducing drug errors are communicated back to the PIC by the Nominee provider.

Proposed Timescale: 13/04/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose was not in line with the requirements of Regulation 3.

23. Action Required:
Under Regulation 03 (1) you are required to: Prepare in writing a statement of purpose containing the information set out in Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Please state the actions you have taken or are planning to take:
Statement of Purpose has been amended to ensure it is in line with Regulation 3.

Proposed Timescale: 24/03/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Families and children had not received copies of the statement of purpose.

24. Action Required:
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

Please state the actions you have taken or are planning to take:
Copies of the Statement of Purpose will be sent to families and children.

Proposed Timescale: 15/05/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The management systems in place in the centre were not sufficiently robust.

25. Action Required:
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she

can ensure the effective governance, operational management and administration of the designated centres concerned.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

There is a CNM1 and CNM2 in the centre to monitor and ensure quality care practices. Both post holders work full time. There is a daily communication with the CNM3 on call to update the Person on call on any issues or concerns relations to the residents in the centre. Each day the PIC is on duty, he/she will contact the deputy in the centre via the phone or a visit to the centre to be appraised of the status of the residents and to discuss any organizational issues or decision making processes that arise. The CNM2 reports to the CNM3 and there are monthly formal meeting to raise and address all aspects of care delivery in the centre. The CNM3/ PIC also meet with the nominee provider to inform and discuss any issues or concerns arising. The PIC and Nominee provider also meet formally as required but not least 4 times a year. There will be actions detailed and time frames identified for completion of action from this meeting which will be recorded in the minutes. These will be reviewed by the CNM3 with the CNM2 to ensure completion.

The CNM2 will be responsible for the completion of a number of audits within the centre, these audits will include identifying any risk with care practices and putting in place control measures to reduce/ eliminate these risks. Where there are actions from the audits, the CNM2 and CNM1 will delegate to relevant staff for completion. There will be monthly staff meetings in the centre chaired by the CNM2 to ensure all care practices are reviewed and discussed and that staff are informed and aware of any changes or alterations to care methods and practices.

The CNM 2 will ensure that all staff have an annual appraisal completed on a yearly basis.The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

Proposed Timescale: 30/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No annual review of the safety and quality of the service had been completed.

26. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
An annual review will be completed in compliance with the regulations

Proposed Timescale: 08/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No annual review of safety was completed, and therefore there was no consultation process with children or their families in relation to this.

27. Action Required:
Under Regulation 23 (1) (e) you are required to: Ensure that the annual review of the quality and safety of care and support in the designated centre provides for consultation with residents and their representatives.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

An annual review will be completed in compliance with the regulations.
Consultation process with children or their families in relation to safety will be completed after the review of safety. There are meetings held in the centre with the children and safety is discussed with them at this meeting.

Proposed Timescale: 30/06/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
No staff appraisals had been completed.

28. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
Staff appraisals will be completed each year. The PIC will give each staff member their employee self appraisal form along with the date for their appraisal. The PIC will meet with the individual staff member on the scheduled date and complete the appraisal. A copy of the appraisal is given to the staff member and the original copy is held in the employees HR file in the residential service.

Proposed Timescale: 30/05/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
While some audits had been undertaken, there were no ongoing audits of the quality of children's assessments or personal plans.

29. Action Required:
Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

An audit of the quality of all children's assessments or personal plans will be completed by the PIC and the linked CNM3. The PIC will complete an audit of the children's assessment and personal plans to ascertain their effectiveness and the quality of work of the child's key worker (Registered Nurse).

Proposed Timescale: 30/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no protected disclosure policy in place.

30. Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

The organisation does not have a protected disclosure policy in place however it is included in DOC 062 Child Protection Policy and Procedure 2015 and staff are obliged to report any concerns they have under this policy.

However, a protected disclosure policy is currently being developed by the organizations human resource department.

Proposed Timescale: 30/07/2015

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Only one report was available following the one six monthly report that was completed in December 2014.

31. Action Required:
Under Regulation 23 (2) (a) you are required to: Carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.

Please state the actions you have taken or are planning to take:
Monthly unannounced visit and report will be completed.

Proposed Timescale: 28/05/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
It was unclear how the staff team were provided with continuous professional development that reflected the needs of the broad criteria of children who could access respite services.

32. Action Required:
Under Regulation 15 (1) you are required to: 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.

Please state the actions you have taken or are planning to take:
Training Needs Analysis completed. Training will be provided for all staff with specific focus on training to support individual children's needs such as stoma care, CPR, PEG/ Naso Gastric Feeding, Challenging Behaviour.

Proposed Timescale: 30/11/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
No training needs analysis had been completed. Not all staff had received mandatory training and there were gaps in the provision of training.

33. Action Required:
Under Regulation 16 (1) (a) you are required to: Ensure staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.

Please state the actions you have taken or are planning to take:
Training Needs Analysis has been completed. Training and refreshers will provided for staff as required. I staff is currently outstanding on fire training and 3 staff outstanding on Children's first. All scheduled to attend the required training in the coming weeks.

Proposed Timescale: 15/05/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not receiving formal supervision.

34. Action Required:
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

Staff to receive formal supervision through regular individual meetings with their line manager which will be linked to individual staff appraisals. The service HR is currently developing a template for PICs to conduct formal supervision with staff and training will be provided for PICs to complete the supervision.

Proposed Timescale: 16/10/2015