

**Health Information and Quality Authority
Regulation Directorate**

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



Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0001465
Centre county:	Co. Dublin
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	St John of God Community Services Limited
Provider Nominee:	Sharon Balmaine
Lead inspector:	Una Coloe
Support inspector(s):	Conan O'Hara
Type of inspection	Announced
Number of residents on the date of inspection:	16
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 compliance with National Standards. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From: 26 March 2015 09:00 To: 26 March 2015 19:30

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 the service. It was an announced monitoring inspection which took place over one day. As part of the inspection, inspectors met with young people, members of staff and the person in charge. Inspectors spoke with family members and observed interactions between staff and the young people in the centre. Inspectors reviewed documentation including care plans, policies and procedures.

The service provided residential services for children attending a school which was located on the same campus as the units. The service catered for children from 7 to 18 years with a diagnosis of a mild intellectual disability. Residential services as well as day care facilities were provided during the school term from Monday to Friday.

The staff team interacted positively with the children and were knowledgeable about their needs. The assessment of children's needs and personal plans were of good quality however additional information was required in relation to planning for transitions. There were policies and procedures in place for risk management but not all risks had been assessed and an immediate action plan was issued regarding one risk identified on the day of the inspection. There were adequate control measures in place regarding infection control and fire prevention. The young people were well cared for but the management of child protection and welfare concerns required review. An immediate action plan was issued regarding one young person whose care required review. The statement of purpose did not reflect the service the centre

intended to provide and the capacity to cater for 16 children was dependent on children sharing rooms. Staffing levels were not adequate and some improvements were required with regard to the management of medication.

These and other findings are discussed within the body of the 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:

The health, personal and social care needs of the children were assessed and there was evidence that the children were actively consulted in their care. Multidisciplinary input was present in some of the files reviewed and although systems were in place to support older children who were transitioning from the service, there was limited documentation to support this.

The assessment templates were comprehensive but not all sections were consistently detailed to provide an adequate overview of needs. There was a number of comprehensive assessment templates to guide the assessment of need. The inspectors reviewed a number of assessments including an individual learning assessment, a social emotional needs assessment and a health passport. On one file reviewed there were issues identified regarding the child's social and emotional needs, but there were limited comments and actions to detail what was required to support the child around this. For example, it was noted that that one child 'did not have many friends' and had 'limited problem solving' but the actions to address such issues and the supports required were not documented. The information contained in the files was repetitive. The assessed needs were not incorporated into a personal plan document which would allow one clear document to guide the care of the children.

There was evidence of some multi disciplinary input but it was not adequate for all the children. The person in charge advised that the organisation had access to a multi disciplinary team including a social worker, psychologist and speech and language therapist. There was some documentation and evidence of input from a psychologist and a speech and language therapist but this was not consistent for all children and further documentation was required to document that professionals were involved in the

assessment of the children's needs.

There were goals identified for the children however some were not specific and measurable. Goals were noted sporadically throughout the files and included independent living skills and social and emotional goals. There was a checklist in place which was signed by the key worker and the child to evidence that work was completed on identified tasks. It was clear that some goals were reviewed by the child and the key worker but other goals had not been reviewed since June 2014. There were specific goals for some children, for example to learn to tie shoe laces however other goals were not as specific such as 'sexuality education'. The time frames to complete actions were not included in some cases and the progression to new tasks was not documented sufficiently.

Some aspects of care had been reviewed but a comprehensive holistic review had not been carried out. The person in charge advised that reviews were due to commence and this was reflected in the minutes of a management meeting. The minutes outlined that two meetings would be scheduled, one with the key worker and following this the parents would be invited to attend. Multidisciplinary input was not outlined as part of this process.

There was an effective transition planning process in place but the documentation to reflect this was not of poor quality. The person in charge advised that when the children turn 16, they attended the vocational training on the campus. A work experience coordinator and a career development officer worked with the children and the focus was on practical skills development. There was a report from a meeting held for one child regarding plans for their future but it was not clear that there were actions or recommendations arising from this meeting. A parent interviewed as part of the inspection described the transition programme in place and was satisfied that his/her child received adequate support with academic and practical skills and advised of meetings attended to discuss the future. There was limited documentation to reflect this aspect of care provision.

There was an effective system to support children to develop skills for independent living. The children were engaged in activities such as cooking and chores and it was clear from the files reviewed that that they were supported to develop skills such as using cooking equipment. One child interviewed as part of the inspection advised that s/he was supported to learn how to cook and clean and gain independence by going to the shop. The parents interviewed confirmed this and acknowledged that work on independent living was completed in the units.

There was regular consultation with the children about their care. There was child friendly documentation in the files reviewed which on occasions were handwritten by the child and/or signed by the child. There was child friendly all about me information which detailed information about the child, their future, interests, communication and family. The inspectors met with the children and they confirmed that they were involved in their care and had to sign documents on their file. There was a weekly meeting with the children to elicit their views and the inspectors observed one of these meeting. It was noted during this meeting that one child was asked to chair the meeting and discussions took place in relation to activities, domestic issues and staff related issues. Inspectors

observed that the children were comfortable and relaxed in the presence of staff. Staff members were respectful and engaged positively with the children.

Family members were consulted regarding the care of their children. Family members interviewed by telephone advised that discussions took place regarding their child's care. Inspectors were advised that there was regular phone contact with staff members and family members. A number of parents advised that they had not attended meetings but stated that they had filled in questionnaires about their child. The inspectors viewed forms completed by parents which were contained within the children's file. There were consent forms on the files for trips, activities and photographs that were signed by parents.

Judgment:

Substantially Compliant

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:

There were policies and procedures in place for risk management but not all risks had been assessed. An immediate action plan was issued regarding one risk identified on the day of the inspection. There were some control measures in place regarding infection control but there was no policy to guide this practice. Adequate fire precautions were in place.

There was a centre specific risk management policy which contained some of the information required by the regulations. It outlined the roles and responsibilities of frontline staff, line managers, the person in charge, senior management and the regional director of services. It also outlined a risk matrix system and methods of rating risk. The identification of hazards for the centre did not include current risks or hazards. The policy identified possible hazards such as manual handling, dysphasia and restrictive intervention however these were not likely risks considering the children's needs who accessed the service. Risks identified by the inspectors such as access to the building, staffing levels or layout of units were not recorded on the policy. The measures and actions in place to control the risk of unexpected absence of any resident, accidental injury, aggression and violence and self harm were not adequate. There were some precautions listed but they related to how issues would be responded to as opposed to preventative measures. For example, in relation to risk of aggression and violence, the policy referred to the behaviour that challenged policy but the person in charge advised the policy was not applicable for the children in the units due to the nature of their

disability.

There was a risk register for the centre but assessment of all risk was not comprehensive. The inspector's viewed the centre's electronic risk register which outlined risks in the centre and the level of risk attached. The risks were rated by colour and the person in charge advised that risks rated as orange or red were escalated to management at organisational level. S/he advised that there were no high risks recorded on the register at the time of the inspection. Risks were monitored and discussed at management team meetings and this was reflected in the minutes of these meetings.

A comprehensive assessment of risk in the centre had not been completed. Individual risk assessments were completed for the children but there were no environmental risk assessments and some risks in the units had not been assessed. Individual risk assessments for the children included assessed risks such as risk of injury and burns, fire and personal safety. Control measures were in place but the risk assessments were not always specific to the individual. Risks identified during the inspection were not identified or assessed. There were no window restrictors on the windows. The person in charge advised that this was never considered and an immediate action plan was issued to ensure the safety of all residents and staff members. The bathroom on the first floor of the units were not risk assessed and it was observed that the toilet and hand washing facilities were not contained in the same room. Incident report forms reviewed by inspectors detailed how one child burned an arm from a toaster and another child attempted to put a metal chain in a toaster. It was not clear that risk assessments had been completed following the incidents.

There was a log and review process of all adverse incidents in the centre however actions to prevent similar incidents required review. The incidents mainly related to behaviour that challenged and there were some incidents relating to burns, slips and medication errors. The person in charge advised that the reports were discussed at management meetings and if required, placed on the risk register. There were actions attached to each incident however the overall learning from incidents was not clear. The person in charge said hazards and incidents were discussed at team meetings. It was not evident that training needs were identified following an incident. The staff interviewed were aware of the process to follow regarding risk and risk assessments. The person in charge advised that additional training was required for the team in relation to risk management.

There were some procedures in place for the prevention and control of infection but there was no policy in place. The units were clean on the day of the inspection and chemicals were stored appropriately. There was adequate signage on display in relation to hand washing and hand gels were available. There were checklists for staff to complete on a daily, weekly and monthly basis but they were not consistently signed as completed. The majority of the bins were pedal operated however there was one hand operated bin which was not consistent with effective infection control procedures. The storage of mops was not adequate as inspectors observed mops stored in the downstairs bathroom which had not been dried sufficiently.

There were adequate precautions in relation to fire and regular fire drills were

completed. There was sufficient fire equipment in the units including fire extinguishers, fire blanket and a fire alarm. Fire extinguishers were serviced in November 2014 and fire detection equipment and the alarm had been serviced in February 2015. An external service carried out an inspection regarding fire recently and the report following the inspection stated that additional emergency lighting was required. Numerous fire drills were completed with the participation of the children and staff. One deep sleep fire drill was carried out in February 2015. The person in charge advised that s/he assisted with this drill. The records evidenced that one child was disorientated and required guidance during drill but the records of the fire drills showed children were evacuated within one minute. There was detailed personal emergency evacuation plans in place for the children which were adequately detailed. Not all staff members had completed fire training.

Judgment:

Non Compliant - Moderate

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:

The management of safeguarding issues was not effective. There were no behaviour management plans in place for the children and the policy regarding behaviour was not sufficient to guide practice. The children were cared for in a respectful manner and there was an effective complaints procedure in place.

There was a detailed policy on, and procedures in place for, the prevention, detection and response to abuse. The inspectors reviewed the organisation's draft policy and procedure for safeguarding vulnerable people, dated October 2013. This policy described the types and indicators of abuse and guidelines to recognise abuse. The role of the designated liaison person was described but it did not document who the designated liaison person was. There were procedures outlined to guide staff should child abuse be suspected, and these procedures were in-line with Children First: National Guidance for the Protection and Welfare of Children (2011). Some aspects of the policy were not up to date as the Health Service Executive (HSE) was referred to as the statutory body and this required updating to reference the Child and Family Agency

(CFA). There was a designated liaison person (DLP) and a deputy designated liaison person (DDL) for the centre. Staff members were aware of the designated liaison officer for the centre and the correct reporting procedures.

Training in Children First (2011) was not up to date. The training records reviewed by the inspector's outlined that 8 members of the team had not completed Children First training. Inspectors were advised by the DDL that Children First training had been incorporated into the organisation's safeguarding training. However, s/he was not sure if all staff members had attended specific Children First training and this was reflected in the training records. A staff member interviewed by inspectors advised that they had not attended this training.

The management of child protection and welfare concerns was not adequate. Inspectors issued an immediate action plan in respect of one child who's care required review. The inspectors discussed referrals to the CFA with the person in charge and s/he had limited information on the extent of referrals. The inspectors met with the DDL and discussed a number of child protection and welfare concerns regarding the children attending the service. Some appropriate referrals had been escalated to the CFA. The inspectors issued an immediate action plan regarding one child to ensure a comprehensive assessment was completed and any necessary referrals completed. The inspectors noted concerns on one child's file regarding acting out behaviour, sexualised references and suicidal ideation. Although some of the concerns had been discussed with the child and the child's parent, there was no evidence that appropriate referrals had been completed for the child to mental health, psychology or child protection and welfare social work services. Previous referrals were made to the CFA regarding this child and the inspectors reviewed responses from the statutory agency which stated that intervention was not required at that time.

There was one child who had an allocated social worker from the CFA. Inspectors discussed this child's situation with the DDL and it was evident that there was correspondence with the CFA. The centre had passed on a number of concerns however, there was no formal response from the CFA regarding the most recent referral and there was little evidence that the child's situation had changed in a positive way since a referral in 2013. The DDL advised that s/he liaised regularly with the allocated social worker and had requested a multidisciplinary meeting to discuss the case. This had not been scheduled at the time of the inspection.

Safeguarding measures to protect children regarding internet use required review. There was a concern regarding the negative impact of accessing inappropriate online material on the children. The centre had some effective interventions in place for the children such as group work programmes which focused on relationships and sexual education, feelings work, internet safety and rights. The DDL described a child's inappropriate use of the internet, access to numerous social media sites and the child uploading inappropriate images on the internet. The most recent concern came to the attention of the school principal who was shown images of a sexualised nature of the child on the internet. This occurred after the child's eighteenth birthday and the DDL advised that previous concerns of a similar nature were not deemed as requiring escalation to the CFA. The inspectors were advised that limited intervention took place with the child in the last year. A parent interviewed as part of the inspection identified concerns

regarding content shared on social media sites between the children attending the units and said s/he had discussed this with staff at the centre.

There were some systems in place to ensure that there was learning following incidents in the centre but this process needed to be enhanced. Incident forms and reflection sheets recorded details of the issue but recommendations to prevent similar issues was not consistently recorded. The inspectors reviewed an incident that described an inappropriate verbal exchange between a staff member and a child. During the incident, the child referred to a previous allegation that a staff member had hit him. This allegation had been notified to the Authority and there was appropriate follow up at the time. It was recorded that the supervisor discussed the issues with the child but it was not clear that there was follow up with the staff members involved.

The management of complaints was effective. There was a complaints policy and a child friendly complaints procedure which was drafted by the children during a focus group in 2014. The inspectors reviewed a number of compliments and complaints about the service. One complaint included concerns from a staff member regarding single staff cover at night in respect of one child presenting as aggressive. This was followed up appropriately and the minutes of the meeting reviewed stated that the outcome was that the child decided s/he no longer wanted to avail of the service. There were a number of complaints from the children accessing the service. They included for example, the requirement to sign forms, rules that were too strict and issues with other residents. The inspector reviewed the complaints and noted that they were resolved appropriately.

Adequate supervision of the children was limited due to staffing ratio's. The recommended staff to child ratio of 2:6 during the day and 1:6 at night time was not always met. This will be outlined in more detail later in the report. There was a child friendly approach in the centre and inspectors observed children freely accessing all units and all areas of the unit including the staff office. Although there were no restrictions on children's movement, appropriate supervision of all the children was not always maintained. The inspectors reviewed an incident report which outlined that a child from another unit accessed a child's bedroom and barricaded the door. The staff members managed the situation but the assurance that the privacy of all children was maintained was not clear.

There was an organisational policy on intimate and personal care dated 2009. The person in charge said that individual intimate care plans for the children were not required as they had independence in this area. This was confirmed by a staff member who advised that a plan was in place for one child in the past and the child's skills were developed to ensure s/he no longer required assistance.

There were no restrictive practices in use in the centre. The person in charge advised that as there was no restrictive practices in use in the centre, a policy was not required.

The organisational behaviour management policy was not applicable to the children accessing the service and there were no behaviour management plans in place. The person in charge provided the inspectors with evidence that a draft policy specific to the centre was being compiled. There were no behaviour management plans in the files

reviewed. The person in charge advised that there was a plan for one child but stated that it was not applicable as it was formulated in the child's home and a new plan needed to be drawn up. S/he advised that behaviours and event reflection was used to manage behaviour whereby the incident was reviewed with the child and stated that a system of sanctions was not used in the centre. The person in charge advised that an assessment regarding behaviour was being developed and a focus group with the children was scheduled on the day of the inspection to elicit the views of the children regarding this. The inspectors observed this group and noted that the children were actively engaged regarding policy development, the format of assessments and consulted regularly about the running of the service. There were two forms of training provided in behaviour management and therefore there may be an inconsistent approach to managing behaviour.

There were some systems in place to ensure residents were safe and protected from abuse but additional work was required to ensure the children were protected from peer abuse. A number of groups were set up for the children to attend to ensure learning and education on safeguarding issues such as a relationships group and rights group. However, there were a number of incidents reported regarding challenging behaviour between residents at the units. There was an anti-bullying policy but this was not specific to the childcare service. The person in charge advised that there were difficulties with behaviour that challenged between two boys in particular at the centre. S/he stated that there was a meeting on the day prior to the inspection to discuss this issue and advised that it is likely that both children will be offered alternative weeks instead of weekly accommodation to manage the situation. The minutes of this meeting had not been compiled at the time of the inspection. Behaviour management plans had not been developed for these children.

There was a system in place to ensure there were no barriers to disclose abuse and a protected disclosure policy was in place. Staff member's interviewed did not have sufficient awareness of this policy. The person in charge advised that all staff were required to read the policy but it was not clear that staff members had sufficient knowledge of this process.

Judgment:

Non Compliant - Major

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:

The management of medication was not adequate in the centre. There was a policy on medication management to guide practice and all staff members were sufficiently trained to manage medication. However, the prescription and administration sheets were not adequate and learning as a result of medication errors and completed audits was not clear.

There was a comprehensive organisational policy on medication management. It outlined guidance in relation to the prescribing, ordering, storage, crushing and disposal of medication. There was clear guidance in relation to self-medicating however the procedure for the administration of medication was not clear.

Storage of medication was adequate. The medication was stored in a locked press and the children's medication was stored in individual containers on separate shelves. There was a photograph of the children on the box that contained the medication.

The prescription sheets did not contain all of the required information and were not of good quality. The prescription sheets were handwritten in some cases. The sheets did not contain a photograph of the child and this had the potential for the wrong medication to be administered to the wrong child. There were numerous prescriptions on some files and it was not clear which were current. One prescription sheet had discontinued medication crossed off and it had not been updated to reflect the changes. Some prescriptions were out of date, for example in one case a number of medications were prescribed in April, May and October 2014 and re-issued in May, June and November 2014 respectively. The medications were not consistently reviewed and new prescriptions sought after 6 months. They did not detail the route and time of administration or a signature of the prescribing G.P. The maximum dosage was not stated for all as required (PRN) medications.

The administration sheets did not contain all of the required information. There was no space on the administration sheets to record if a child refused the medication. There was a signature of the staff member who administered but the inspectors did not observe a signature sheet. There was a signature of the child on the administration sheet. On one file reviewed it was noted that the medication listed on the prescription sheets were not being administered and the reason for this was not clear. This had the potential for errors to occur.

A comprehensive medication audit was completed in April 2014 by a quality advisor for the service. The audit measured compliance with the regulations and the findings reported poor scores regarding the administration and recording of medication, self administration, controlled drugs and medication systems. It was not clear that improvements in the management of medication had occurred since the audit, as the deficits identified during the audit were evident on the day of the inspection. For example, medications not labelled and no signature sheet. It was noted in the childcare management meeting minutes that a medication audit was scheduled for March 2015 but this was not completed.

There were no assessments of the children's capacity to self medicate in the sample reviewed. The minutes of a childcare management meeting outlined that one child

requested to self medicate. It was noted that relevant forms were submitted and the supervisor was due to seek guidance from the programme manager to follow up on this.

Medication errors were recorded and reviewed but additional work was required to ensure learning from the incidents to prevent reoccurrence. Some medication errors were recorded and there were some actions following the incidents. There was a drug receipt recording form and a handwritten log of medication returned to the pharmacy. Inspectors noted errors on the medication stock control record which were amended by writing over the initial figure and this could have led to further errors. A number of medication errors were reviewed by the inspectors including incorrect dates logged, a tablet dropped on the floor and observations of additional or missing medications. Actions following the errors were noted and included for example, a requirement to read the medication policy. A serious incident occurred in December 2014 where a staff member was unclear if a medication had been administered to a child. The action following this noted that the staff member could not administer medication until s/he attended refresher training in medication. The training records reviewed documented that all staff members had completed training in medication management. The person in charge identified the need for one staff member to be retrained in medication management however learning and improvements required following deficits in the audit and as result of errors was not clear.

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 statement of purpose met some of the requirements of the regulations.

The statement of purpose outlined a comprehensive overview of some aspects of the service. It included detailed information on assessments required, services to meet the care needs and the support provided to children. It also included information regarding complaints, fire safety and emergency procedures. It was documented that the centre had the capacity for 16 children but there was only 12 bedrooms in total in the three units. The capacity to cater for 16 children was dependent on children sharing rooms. This was not in line with good practice for safeguarding children. The statement of purpose referred to four houses however only three houses constituted the designated

centre. The exclusion criteria was not specific. Details of the person in charge was not referenced in the staffing compliment. There was no reference to an advocacy service.

The premises was not suitable for all potential referrals and this was not reflected in the statement of purpose. The units were not wheelchair accessible as all of the bedrooms were on the first floor and the layout of the unit was not appropriate for children with physical disabilities. The person in charge advised that the centre had planned to carry out an accessibility assessment as the units were not assessable for people with physical disabilities.

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 were some management systems in place to ensure that the service provided was safe, appropriate to the residents' needs, consistent and effectively monitored.

Two unannounced visits had been completed to assess the safety and quality of care and support provided in the centre but an annual review of the service was not completed as required by the regulations. A comprehensive action plan was devised following the unannounced visit in April 2014 and it was evident that some of the recommendations were adhered too. However, some of the actions remained outstanding at the time of the inspection such a a review of residents access to the internet and an accessibility audit. Some actions had been marked as completed however the inspectors noticed the same deficits on the day of the inspection including for example medication not labelled. The unannounced visits did not document all of the deficits identified by inspectors including a lack of environmental risk assessments and ongoing review of risk.

The person in charge had sufficient experience and training for the role and was aware of his/her statutory responsibilities. The person in charge was assisted by a supervisor in the provision of management support to the staff team on day to day issues. The

supervisor was newly appointed to the role. There were some arrangements in place to ensure staff exercised their personal and professional accountability for the quality and safety of services delivered. The person in charge advised that the team had responsibility for the children's personal plans and risk assessments. S/he described some difficulties for the team adjusting to recent changes regarding the requirements of the regulations and incorporating the additional paperwork with their direct work with the children.

Team meetings were held on a regular basis but some gaps remained to ensure a comprehensive overview of service provision was explored. Team meetings occurred monthly and the inspector reviewed minutes of meetings held in November and December 2014 and January 2015. The minutes were detailed and outlined that a range of issues were discussed. Examples of this included roles and responsibilities, use of forms, risk assessments, statement of purpose and policies and good practice standards. The care provision, learning from incidents and overview of the children's needs or presentation was not incorporated in the team meetings.

Management meetings were regular and attempts to improve the quality of service provision were evident. Management meetings were attended by the person in charge and the supervisor. The inspectors were provided with the minutes of these meetings from November 2014 to March 2015. The minutes from the meeting in March 2015 were detailed and included an action plan, the person responsible to complete the action and date for completion. Items discussed included staffing levels, supervision, training needs, child related issues audits and health and safety. The meeting held previous to this were called internal quality committee meetings and were not as detailed but there was reference to policies, risk and audits. Three copies of minutes provided had no details of discussions and referred to an action plan for details however the effectiveness of this meeting could not be assessed or the follow through from previous meetings.

The person in charge monitored the service but did not have sufficient knowledge of some issues in the centre. The person in charge advised that s/he monitored the service by regularly visiting the units. Both the supervisor and the person in charge were based on the same site. The person in charge advised that s/he worked irregularly hours to ensure monitoring of the service at various times during the day and evening. S/he stated that s/he worked later shifts two days a week. The person in charge did not have sufficient knowledge of child protection and welfare issues in the units and some risks were not identified such as the impact of staffing levels on the care and supervision of the children. The actions following a medication audit had not been consistently completed and deficits identified in the audit were evident on the day of the inspection. Some risks identified on the day of the inspection had not been assessed.

There was an on call system in place to provide support to the team outside of normal working hours. The person in charge advised that s/he provided on call support four nights a week. S/he felt this was effective and sustainable and stated that this support was not required on a regular basis. There were effective provisions in place for when the person in charge was not on duty and the supervisor was the named individual to provide cover during such times. The staff members interviewed were aware of the lines of accountability and authority in the organisation. A child spoken with as part of the

inspection could identify the person in charge. S/he also identified recent changes and stated that staff had to spend more time on paperwork and therefore less time engaging in activities. S/he also identified that the person in charge was more available in the past and did not have regular contact recently.

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:

Staffing levels in the units were not adequate to ensure sufficient supervision of the children. There was a planned and actual rota in place but there was an over reliance on relief staff to cover shifts. The core training needs of some staff members had not been met.

There was a planned and actual rota in place however the actual rota was not consistently completed. The inspectors reviewed the rotas and the actual rota was not fully completed for the week the inspection took place. Day and night shifts were included but there were no times of shifts recorded and there was no handover time allocated or referenced on the rota. It was unclear why there were changes from the planned and actual rota. The actual rota was not accurate. The inspectors noted that it was recorded on the rota that one staff member had worked both the day and night shift for three consecutive days in one week and for two consecutive days the following week.

There was insufficient staff to provide adequate cover in the units. The rotas reviewed by inspectors highlighted that two staff were scheduled to work day shifts and there was single staff cover at night time. A staff member interviewed advised that lone working at night was sufficient in some of the units but said it was not adequate for one unit in particular. S/he also advised that the recommended ratio of two staff per unit for day shifts was not always maintained and staff members may be transferred from one unit to another leaving one staff to cover a day shift alone. Inspectors reviewed the rotas and on six occasions a staff member had to cover shifts in another unit, leaving one staff member alone in a unit which was not good practice for safeguarding and

supervision of the children. The person in charge advised that the current relief panel were covering core shifts on a full time basis due to absences for maternity leave. Inspectors reviewed the rotas and there was a reliance on relief workers to cover core shifts as twenty eight out of the eighty nine shifts were covered by relief staff. Staff on duty confirmed that relief staff were required on a full time basis to cover core shifts. The inspectors observed two relief workers covering the day shift in one unit. However, there was consistency provided for the children as the same staff team were scheduled to work in the units. The person in charge stated that the person in charge and the supervisor covered core shifts when required and said a recruitment drive was necessary to employ additional relief workers. The inspector reviewed self evaluation questionnaires completed by family members and there was a suggestion to have two staff to cover night shifts. It was also noted on the minutes from the childcare management meetings that a recruitment process has commenced for additional relief workers as the current staffing compliment was not as specified in the statement of purpose.

The documents as required by Schedule 2 of the Regulations were in place in the sample of staff files reviewed. It was noted however, that Garda Vetting disclosures for some staff members were not completed in recent years as some had not been updated since 1996 and 2006. There was no volunteers in the centre.

Mandatory training for the staff team was not up to date. The inspectors reviewed the training overview which referred to seventeen staff members. The full staff team had completed training in the safe administration of medication. Training in fire and manual handling was outstanding for some staff members. The training overview outlined that 9 staff members had completed training in Children First (2011) in 2013. The DDLP advised that the Children's First (2011) training was condensed into the organisation's safeguarding vulnerable people training which was attended by sixteen staff. Two forms of behavioural support training was provided to the team. The training records outlined that eleven of the team had completed a specific model of behavioural management and fifteen had completed training in positive behavioural support. This could lead to inconsistencies in the approach to managing behaviour that challenged. First aid training was completed by the majority of the team and two were scheduled for a refresher training. The inspectors were provided with a training schedule for 2015 which included for example food safety, safeguarding, infection control and induction training. There was no training needs analysis completed for the centre.

Supervision was provided to the team but this was not always consistent. The person in charge advised that supervision is provided to the staff team every 6 to 8 weeks. S/he acknowledged that the time frames needed to be reviewed as the supervision had not occurred as often as intended. The inspectors were provided with three supervision records which contained some detailed information on discussions however additional information was required to ensure there was evidence of support and supervision regarding the direct work with the children. From the records provided it was not possible to ascertain the regularity of supervision provided. The person in charge advised that annual appraisals occurred for the staff team and the inspectors reviewed a number of appraisals from 2014 and 2015. Minutes of appraisals were contained in some staff files but this was not consistent and the inspectors noted that 2 out of 5 files

reviewed contained an appraisal. The appraisals reviewed listed tasks completed under a number of headings such as motivation and commitment, team work, communication and core knowledge skills but it was not clear if the staff members strengths and weaknesses were discussed. Objectives and targets were documented but there was limited information regarding interactions and interventions with the children. The person in charge advised of a new system to be put in place for reflective learning which incorporated a journal as part of their continuous professional development. This was identified as a new system and the effectiveness of this had not been reviewed.

Judgment:

Non Compliant - Major

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:

Una Coloe
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 report¹

Centre name:	A designated centre for people with disabilities operated by St John of God Community Services Limited
Centre ID:	OSV-0001465
Date of Inspection:	26 March 2015
Date of response:	22 May 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:

The assessed needs of the children were not incorporated into a personal plan.

Action Required:

Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects

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

the resident's assessed needs.

Please state the actions you have taken or are planning to take:

The comprehensive assessment of needs has been collated with each young person. From this the DPIC in consultation with Key Workers and young people a personal plan will be developed which will identify the needs and supports required for the young person and how the centre plans to meet these needs. This plan will be used to support the young person in identifying goals which they will work on. The PIC will review each PCP on an annual basis, as well as auditing a sample of PCP's on a monthly basis to ensure the quality of documentation.

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:

There was some multidisciplinary input however it was not evident that care reviews were carried out.

Action Required:

Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.

Please state the actions you have taken or are planning to take:

A new care review template has been developed and implemented by the PIC; dates have been agreed upon by the DPIC for case reviews. MDT input will be sought where applicable. On completion of review, these will be shared with MDT and be used in future planning with the young person

Proposed Timescale: 11/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was no formal review of the personal plans.

Action Required:

Under Regulation 05 (6) you are required to: Ensure that residents' personal plans are reviewed annually or more frequently if there is a change in needs or circumstances.

Please state the actions you have taken or are planning to take:

A new care review template has been developed and implemented by the PIC; dates have been agreed upon by the DPIC for case reviews. MDT input will be sought where applicable. Reviews will take place at least annually and more frequently should there be a change in needs or circumstances.

Proposed Timescale: 11/05/2015

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The documentation to reflect the work completed on transitioning children was not of good quality.

Action Required:

Under Regulation 25 (4) (c) you are required to: Discharge residents from the designated centre in accordance with the resident's assessed needs and the resident's personal plans.

Please state the actions you have taken or are planning to take:

A template to be developed by the PIC and DPIC in consultation with the school career's development officer to reflect the work completed with and for children preparing to leave the service.

New care file review includes plans, considerations and recommendations for the future. Care review outcomes will be shared with future services, with consent of young person and their representatives.

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:

Although some planning had taken place for childrens discharge from the service had occurred it was not clear if this was discussed with the children.

Action Required:

Under Regulation 25 (3) (a) you are required to: Provide support for residents as they transition between residential services or leave residential services through the provision of information on the services and supports available.

Please state the actions you have taken or are planning to take:

A discharge template will be developed by the PIC and DPIC and used for all young people being discharged from the service. Discharge plan will be discussed with young person and their representatives. Records of discussion to be kept.

Proposed Timescale: 11/05/2015

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:

Assessment of risk in the centre was not comprehensive. There were no restrictors on the windows in the units.

Action Required:

Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:

All windows have been fitted with restrictors. Advice to be sought from Occupational Health and Safety Advisor and a comprehensive assessment of risks in the centre to be carried out. Adverse Incidents and Risk Assessments will be reported to the Program Manager and Regional Director through the monthly and bi-monthly reporting mechanisms, they will also be recorded on the departments directory of residence and reviewed on a monthly basis by the PIC and Deputy PIC. Adverse Incidents and Risk Assessments will be discussed at the monthly staff team meeting to ensure learning takes place. Person In Charge to develop a sweep of audit tools to identify review and manage environmental risks.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The risk management policy did not include hazard identification and assessments of all risks specific to the centre.

Action Required:

Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:

PIC and DPIC to review the risk management policy to ensure that the policy includes hazard identification and assessment of risks throughout the designated centre.

Proposed Timescale: 30/07/2015

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 risk of accidental injury to residents, visitors or staff were not adequate.

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:

PIC and DPIC to review the risk management policy to ensure that measures and actions in place to control the risk of accidental injury to residents, visitors or staff are adequate.

A review of adverse incidents to take place at weekly house meetings which will be minuted. Learning from incidences to be included on the agenda for monthly team meeting. When appropriate, a root cause analysis template will be used to review and learn.

Timescale: 31/5/15 (review of adverse incidents at house meetings) 31/7/15 (review of risk management policy)

Proposed Timescale: 31/07/2015

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 risk of the unexpected absence of a resident were not adequate.

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:

A standard operating procedure is in place for dealing with unexpected absence of a resident, including escalating measures for when an incident occurs. All residents have a risk assessment identifying the hazards and actions in place to control the risk of unexplained absence. All risk assessments will be reviewed by the PIC and DPIC to ensure measures are adequate.

A review of the risk management policy by the PIC to take place to ensure that the measures and actions in place to control the risk of the unexpected absence of a resident are adequate.

A positive Behaviour Support Policy to be developed and implemented by the PIC and DPIC in consultation with the MDT team. Behaviour Report Forms to be implemented

in department where unexplained absences will be recorded. These will be forwarded to Positive Behaviour Support Committee by the DPIC on a monthly basis. These will also be discussed at the monthly team meeting so that learning can take place.

Proposed Timescale: 31/07/2015

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 risk of aggression and violence were not adequate.

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:

PIC and DPIC to review the risk management policy to take place to ensure that the policy includes adequate measures and actions in place to control the risk of aggression and violence. A local positive Behaviour Support Policy to be developed and implemented by the PIC and DPIC in consultation with the MDT team.

All residents will have behavioural assessment and where indicated behaviour management plans will be put in place by Key Workers and DPIC, which will detail supports needed on an individual basis.

Behaviour Report Forms to be implemented in department. These will record instances of aggression and violence. These will be forwarded to Positive Behaviour Support Committee on a monthly basis by the DPIC, for trend tracking. These will also be discussed at the monthly team meeting so that learning can take place.

Proposed Timescale: 31/07/2015

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 risk of self-harm were not adequate.

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:

PIC and DPIC to review the risk management policy to ensure that the policy includes adequate measures and actions to control the risk of self-harm.

A positive Behaviour Support Policy to be developed and implemented by PIC and DPIC in consultation with the MDT team. All residents will have behaviour management plans which will detail supports needed on an individual basis.

Behaviour Report Forms to be implemented in department. These will record incidences of self-harm. These will be forwarded to Positive Behaviour Support Committee on a monthly basis by the DPIC for trend tracking. These will also be discussed at the weekly house meetings so that a review of supports can take place and also monthly team meeting so that learning can take place. MDT input will be sought.

Proposed Timescale: 31/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no policy to guide practice in relation to infection control. The storage of mops was not appropriate and hand washing facilities were not present in all toilets. Cleaning rotas were not consistently filled in.

Action Required:

Under Regulation 27 you are required to: Ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections published by the Authority.

Please state the actions you have taken or are planning to take:

Infection control policy will be developed and implemented by the PIC and DPIC . DPIC will carry out audits to ensure that cleaning rotas are consistently filled in. A referral has been made to maintenance department for building work to be carried out to ensure hand-washing facilities are present in toilets. A review of storage of mops by the PIC in consultation with the maintenance department, will take place, to identify appropriate storage area within the designated centre

Timescales:

Infection Control Policy development 30/07/2105

Building works for hand washing facilities 30/7/15

Audits and review of storage area: 30/5/15

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Additional emergency lighting was required in the units.

Action Required:

Under Regulation 28 (2) (c) you are required to: Provide adequate means of escape, including emergency lighting.

Please state the actions you have taken or are planning to take:

Referral sent to maintenance on 11/5/15. Advice to be sought from Organisation's Health and Safety Officer regarding additional lighting, in consultation with fire safety contractors and works completed.

Proposed Timescale: 30/07/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Not all staff members had completed fire training.

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:

3 staff nominated to attend fire training on the 17th June. Two staff on maternity leave and will be nominated to attend training on their return

Proposed Timescale: 30/11/2015

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:

Training in a specific model of behaviour management was not consistent for the staff team.

Action Required:

Under Regulation 07 (2) you are required to: Ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.

Please state the actions you have taken or are planning to take:

Two remaining staff to attend training on Positive Behaviour Support. Advice to be sought, by the PIC, from the Callan Institute on an appropriate model and approach to the management of behaviours that challenge.

Proposed Timescale: 31/07/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There were no behaviour management plans in place for the children.

Action Required:

Under Regulation 07 (3) you are required to: Ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and review these as part of the personal planning process.

Please state the actions you have taken or are planning to take:

The comprehensive assessment of needs will be collated and will include a behaviour assessment piece for each young person. From this a personal plan will be developed, by the key worker and DPIC, which will identify the needs and supports required for the young person, including behaviour management plans. The Positive Behaviour Supports Policy to be developed for the department by the PIC and DPIC and Behaviour Report Forms to be implemented. This to be forwarded to the Positive Behaviour Supports Committee on a monthly basis in order to track trends and a review of behaviour to take place at monthly team meetings to ensure learning takes place.

Proposed Timescale: 31/07/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The policy on behaviour that challenged was not applicable for the children accessing the service.

Action Required:

Under Regulation 07 (1) you are required to: Ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.

Please state the actions you have taken or are planning to take:

Local policy on behaviours that challenge to be developed and implemented, by the PIC and DPIC, for the young people accessing the service. Advice to be sought from the Callan Institute on an appropriate model and approach to the management of behaviours that challenge.

Proposed Timescale: 31/07/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

Some children were accessing inappropriate content on the internet.

Action Required:

Under Regulation 08 (1) you are required to: Ensure that each resident is assisted and

supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection.

Please state the actions you have taken or are planning to take:

An internet safety awareness programme will be developed in consultation with the MDT and implemented PIC, for all young people availing of the service. Due to the closure of the service from June 26th to August 31st this program will not be in place until September 2015. This programme will be reviewed by key workers with each young person to assess the learning that has taken place and any additional supports required. Any incidents of inappropriate internet use will be forwarded to the MDT team and will be discussed with young people's representatives. Supports and learning will be offered to young people and their representatives; these will be recorded in the young persons PCP by the Key Worker.

Proposed Timescale: 30/09/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

The management of child protection and welfare concerns required review. Some details outlined in the child protection and welfare policy were not up to date. Adequate safeguarding measures were not in place for a child presenting with challenging behaviour, inappropriate sexual references and suicidal ideation. The concerns were not assessed effectively and supports had not been put in place for the child.

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:

Regarding the Safeguarding Policy, the organisation is in the process of revising its interim policy document in line with the recent HSE Safeguarding Vulnerable People at Risk of Abuse; National Policy and Procedures 2014, incorporating services for elder abuse and for persons with a disability. This is currently with Group CEO and Organisations Safeguarding Committee.

All young people, in consultation with their key worker and representatives, will complete a behaviour review on an annual basis. From this a personal plan will be developed which will identify the needs and supports required for the young person, including the safeguarding measures and how the centre plans to meet these needs. These will be reviewed by the PIC prior to their implementation.

All safeguarding concerns are forwarded to the Designated Liaison Person. A tracking system has been developed to track safeguarding issues and their status. This will be reviewed on a weekly basis with the PIC and DPIC and on a monthly basis with the Prog Manager.

Multi-Disciplinary Team meeting held on the 30/03/2015, to discuss concerns for a child, minutes available upon request. Educational Support Team (EST) meeting arranged for 15/04/2015, parent of the child was invited, and recommendation to be made for parent to raise suicidal ideation with his link psychiatrist. Referral to Callen institute, for a positive behaviour supports assessment, will be made on the 15/04/2015 following EST meeting.

Proposed Timescale: 30/07/2015

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was no centre specific policy on peer abuse.

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:

Policy on peer abuse to be developed and implemented by the PIC in consultation with the MDT team and the Student Focus Group. Due to the closure of the Designated Centre from June 26th to August 31st this policy will not be in place until September 2105.

Proposed Timescale: 01/09/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

There was no evidence that an allegation of verbal abuse by a staff member had been followed up with the accused staff member.

Action Required:

Under Regulation 08 (3) you are required to: Investigate any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers abuse.

Please state the actions you have taken or are planning to take:

The supervisor spoke with the staff member and a reflective learning piece was completed. The DLP was informed who was the link worker for the young person.

All allegations of verbal abuse will be reported to Designated Person and Person in Charge. A tracking system has been developed to track safeguarding issues and their status. This will be reviewed on a weekly basis with the PIC and DPIC and on a monthly basis with the Programme Manager.

Proposed Timescale: 12/05/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The training records outlined that the full staff team had not been trained in Children First: National Guidance for the Protection and Welfare of Children.

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:

All staff will receive Safeguarding or Children's First training, the content will be following consultation with the HSE and will therefore reflect the most recent legislative changes.

Proposed Timescale: 30/07/2015

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 manage of medication was not effective. Some medication was not labelled adequately and some prescription and administration sheets did not contain the required information.

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:

All medication received and returned is recorded and stock control is completed on a weekly basis. All medication to be labelled. Where medication is not labelled, medication will be returned to the parents of the young person.

Monthly audits are carried out by frontline staff and reviewed by supervisor to ensure compliance. Feedback of audits will be discussed at monthly quality meeting with Prog manager, Person in charge and supervisor.

Additionally, a new standardised kardex will be developed and implemented for all young people commencing 01/09/15.

Timescale for kardex: 1/9/15

30/5/15

Proposed Timescale: 01/09/2015

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Assessments of the children's capacity to self medicate were not completed.

Action Required:

Under Regulation 29 (5) you are required to: Following a risk assessment and assessment of capacity, encourage residents to take responsibility for their own medication, in accordance with their wishes and preferences and in line with their age and the nature of their disability.

Please state the actions you have taken or are planning to take:

New assessment tool gives consideration to capacity to self-medicate. Where it is felt that there is capacity, the young person and their representatives will be asked to complete self-assessment tool for review with MDT.

Proposed Timescale: 30/09/2015

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 did not detail all of the requirements outlined in Schedule 1 of the Regulations and did not reflect the service it intended to provide.

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:

Person in charge to review Statement of purpose and function to ensure it meets the requirements outlined in Schedule 1 of the Regulations.

Proposed Timescale: 30/06/2015

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 actions required following the unannounced visits were not all completed.

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:

PIC and DPIC to review and action reports from unannounced visits.

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:

Staff members were not fully aware of the protected disclosures policy.

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:

All staff will be trained on the protected disclosures policy. All staff will be provided with the policy and will sign to confirm they have read and understood it.

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:

The person in charge did not have adequate information regarding child protection and welfare issues. Comprehensive risk assessments had not been completed. Actions following audits of the service had not been consistently implemented.

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:

A tracking system has been developed to track safeguarding issues and their status. This will be reviewed on a weekly basis with the PIC and DPIC and on a monthly basis with the Programme Manager.

Internal audits, reviews and actions taken will be reviewed by the PIC to ensure implementation.

Where behaviours of concern present, a risk assessment will be conducted by staff and

measures identified will be implemented, in consultation with the DPIC. These will be agreed with the PIC prior to their implementation. Advice to be sought from Occupational Health and Safety Advisor and a comprehensive assessment of risks in the centre to be carried out. Adverse Incidents and Risk Assessments will be reported to the Program Manager and Regional Director through the monthly and bi-monthly reporting mechanisms, they will also be recorded on the departments directory of residence and reviewed on a monthly basis by the PIC and Deputy PIC. Adverse Incidents and Risk Assessments will be discussed at the monthly staff team meeting to ensure learning takes place. Person In Charge to develop a sweep of audit tools to identify review and manage environmental risks.

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:

An annual review of the service had not taken place.

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:

Programme Manager will develop annual review of the service

Proposed Timescale: 30/07/2015

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

The actual rota was not consistently completed and was not accurate.

Action Required:

Under Regulation 15 (4) you are required to: Maintain a planned and actual staff rota, showing staff on duty at any time during the day and night.

Please state the actions you have taken or are planning to take:

Planned roster is filled out in advance, by the DPIC. Actual roster is filled out at the end of the week. DPIC to review rosters on a weekly basis.

Proposed Timescale: 30/05/2015

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:

There was an insufficient number of staff to provide appropriate support and supervision for the children. There was an over reliance on relief workers and the required staff to child ratio was not always met.

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:

Specified purpose contracts will be offered in the future to cover periods of leave, such as maternity leave. The relief panel will be expanded to support short term gaps, such as sick leave

Proposed Timescale: 30/08/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Garda Vetting disclosures were in place for the staff members but some were not current.

Action Required:

Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:

There will be an organisational review of the garda vetting timeframes and recommendations will be implemented.

Proposed Timescale: 30/07/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Supervision was not consistent for the team and did not take place as often as planned.

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:

Supervision will take place quarterly inclusive of an annual appraisal. Schedule to be set by supervisor. Pro forma will be used to minute supervision and appraisal sessions

Proposed Timescale: 12/05/2015

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:

Mandatory training had not been provided to all staff members. The team were not consistently trained in the same model of behaviour management.

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 calendar will be used by the PIC and DPIC to identify training needs and will be populated by the DPIC to reflect training completed for all staff. Two remaining staff to attend training on Positive Behaviour Support. Three staff nominated to attend fire safety training on June 17th. Children's First training planned for July 2015

Proposed Timescale: 30/06/2015