| Centre name: | A designated centre for people with disabilities operated by GALRO Limited |
| Centre ID: | OSV-0003255 |
| Centre county: | Laois |
| Type of centre: | Health Act 2004 Section 39 Assistance |
| Registered provider: | GALRO Limited |
| Provider Nominee: | Joe Sheahan |
| Lead inspector: | Eva Boyle |
| Support inspector(s): | Ann Delany; |
| Type of inspection | Unannounced |
| Number of residents on the date of inspection: | 3 |
| Number of vacancies on the date of inspection: | 2 |
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 un-announced and took place over 1 day(s).

The inspection took place over the following dates and times
From: 15 August 2014 09:30   To: 15 August 2014 16:30

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

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
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<tr>
<td>Outcome 08: Safeguarding and Safety</td>
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<tr>
<td>Outcome 12. Medication Management</td>
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<tr>
<td>Outcome 13: Statement of Purpose</td>
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<tr>
<td>Outcome 14: Governance and Management</td>
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<tr>
<td>Outcome 17: Workforce</td>
</tr>
</tbody>
</table>

Summary of findings from this inspection
This follow-up monitoring inspection was unannounced and was carried out by two inspectors over one day. A previous inspection had taken place five weeks earlier but on that day there were no children in the centre. This inspection was scheduled in order to observe children and their interaction with staff. As part of the inspection, inspectors met with managers and staff, observed interactions between children and staff, and reviewed amended policies, procedures and fire records. There had been few changes implemented since the date of the previous inspection. Inspectors did not review aspects of care where the management team identified that no changes had been made.

The centre was located within a town in Co. Laois. It was a detached bungalow with a separate sensory room in the back garden. The statement of purpose and function identified that the centre offered respite care to children who had a diagnosis of autism and or other intellectual disability and who presented with behaviour that challenged, or with a reactive attachment disorder. Thirty eight children were attending the service for respite care and a maximum of five children attended the service at any one time. There were three children in the centre on the day of the inspection.

Inspectors observed warm, attentive and respectful interactions between staff and children. Children participated in activities such as going on an outing, baking and listening to music on the day of the inspection.
Not all fire prevention measures were in place. Inspectors found that all windows and doors within the centre were locked and fire fighting equipment was locked away in one room downstairs. In the event of a fire staff would be required to unlock doors to facilitate an exit. The Authority took the unusual step of issuing an immediate action plan as the centre was not in compliance with Regulation 28 (1). The Authority received assurances from a suitably qualified person in fire safety design and management that the centre was compliant with fire regulations and the provider identified that windows had been unlocked and window restrictors had been fitted. The nominated provider provided assurances that fire extinguishers were placed in a locked box system in the centre.

Governance and management systems were not sufficiently robust. There had been little action in relation to the regulatory breaches identified in the inspection of 08 July 2014. Some policies had been reviewed and amended but they had not been implemented. There was no quality assurance process in place and there was no formal supervision of staff.
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.

<table>
<thead>
<tr>
<th>Outcome 05: Social Care Needs</th>
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<tr>
<td>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.</td>
</tr>
</tbody>
</table>

| Theme: |
| Effective Services |

| Outstanding requirement(s) from previous inspection(s): |
| Some action(s) required from the previous inspection were not satisfactorily implemented. |

| Findings: |
| The management team informed inspectors that there had been no changes implemented in the assessment or personal planning process since the last inspection. Therefore inspectors did not sample further children's files. Inspectors reviewed a draft client update template which had been developed. This form requested updated information from children's parents in relation to any changes in the child's care since there last stay, such as medication, behaviour and restrictive practices. Inspectors found that the restrictive practices section of this template was confined to two examples of restrictive practice - locked doors, and the use of a harness. Regulatory actions from the last inspection have been included in this report due to no changes in practice. |

| 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): |
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Some measures were in place to promote the health and safety of children and staff. However, they were not sufficient.

The management team told inspectors that there were few changes implemented since the last inspection. The risk management policy had not been updated. Infection control practices were not optimal. Fire safety precautions were not adequate and the Authority took the unusual step of issuing an immediate action plan to address the fire safety regulatory breaches.

The centre had some systems in place to manage health and safety and risk. A designated health and safety representative was in place. However, the risk management policy had not been amended since the last inspection to meet the regulatory requirements. Not all hazards within the centre had been risk assessed. For example, staff identified to inspectors that no risk assessment had been completed of the sensory room, in order to ensure that the equipment used was appropriate to the needs of the children and inspectors also observed a door/window frame in the garden that could potentially have posed harm to one of the children if they had pulled it down on top of themselves. The team leader told inspectors that he/she had not been trained in risk assessment or management.

The infection control practices in place on the day of the inspection were not optimal. Liquid soap and hand drying facilities were not available in bathrooms. The team leader told inspectors that s/he had removed the soap and paper towels as she was concerned that the children would ingest the soap or place the paper towels in the toilet. However, no risk assessment had been undertaken in relation to individual children or the collective risk of having soap in the bathrooms so it was unclear what had informed the team leader’s decision. The team leader placed liquid soap and paper towels in the bathrooms during the inspection. Personal protective equipment such as gloves were also locked away and staff were unable to get timely access to these. Children’s files, staff documentation and children’s clothes were held in the kitchen which was not in line with good practice. Inspectors also observed that mops and buckets, used to clean the centre, were stored in the open outside the back door. There were cleaning schedules in place to inform the cleaning routine of the centre.

Fire safety precautions were not adequate. The centre had a fire compliance certification which was dated 2012. Inspectors found that fire extinguishers were locked in the utility room on the ground floor. This meant that in the event of a fire breaking out staff would be required to go to that room, unlock the door and get the appropriate fire extinguisher. All windows and doors within the centre were locked so fire exits were impeded. Staff identified to inspectors that the front door which was a fire door had three separate locks, a bolt, and two other key locks, one of which did not require a key to open from inside the centre. Staff told inspectors that one of these keys was stored in the kitchen. The team leader told inspectors that staff members had keys for doors and windows on their person at all times, but inspectors found that this was not always the case, as the team leader did not have all keys available. However, it was unclear
whether the qualified person in fire safety design and management had been aware of the practice of locked doors and windows.

Due to these factors, the Authority issued an immediate action plan and requested that a suitably qualified person in fire safety design and management provided assurances that the building was compliant with fire regulations. The Authority received assurances from the registered provider that window restrictors had been fitted to windows, and a suitably qualified person in fire safety design and management outlined that the centre was in compliance with fire safety. Assurances were received from the registered provider that fire extinguishers were no longer stored in a locked utility room, but were stored in a locked box system in the centre.

The centre had no systems in place for daily, weekly and monthly fire checks. Inspectors were advised that the children had on occasions activated the fire alarm, but no record of this was maintained by the staff team.

Staff training records in relation to fire safety were not available in the centre. No fire drills had been held since the last inspection. The team leader outlined that they planned to implement horizontal fire drills for children. However, no specific dates were scheduled, therefore children did not know what to do in the event of fire.

**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
While there had been some work undertaken in relation to child protection and safeguarding policies and procedures since the last inspection there had been no changes to behaviour management plans or restrictive practices. Due to this, inspectors did not review children’s records in relation to these aspects of care. Inspectors observed staff's interaction with children and found them to be attentive and respectful.
There were some safeguarding measures in place, for example recruitment practices and some policies and procedures including keeping safe and bullying. Since the last inspection the staff team had worked on amending safeguarding policies within the centre.

A policy on intimate care had been updated, but was not operational as each child in the centre had not an intimate care plan. The policy provided good guidance in relation to the increased vulnerability of children with a disability to abuse and practical guidelines on communicating with children prior to assisting them with intimate care. The policy gave step by step guidance in relation to the provision of a shower/bath to a child. However, specific guidance was not provided for other forms of intimate care.

The centre had an amended organisational child protection policy. The policy included a reference to Children First (2011), but had not amended references to the Child and Family Agency within the policy. There were gaps in staff's knowledge of child protection. Inspectors found from discussions with staff that they were knowledgeable about the types of abuse, but were not aware of the appropriate steps to take, if they had concerns in relation to a child's welfare. The centre had a designated liaison officer in place. The team leader informed inspectors that there had been no child welfare concerns in the centre since the last inspection and that training in child protection and safeguarding was scheduled for staff for the end of September.

Restrictive practices were used in the centre, but there were no formal review systems in place around restrictive practices. There was no policy in place on the use of restrictive procedures. Inspectors found that restrictive practices, such as locked doors and windows and the use of a harness in the car, were used but the log of restrictive practices used in the centre was not available to inspectors on the day of the inspection.

Inspectors did not find that there were systems in place to ensure that every effort was made to identify and alleviate the cause of the child's challenging behaviour, that all alternatives were considered before a restrictive practice was used and that the least restrictive procedure was used for the shortest duration necessary. For example, windows and doors were locked during the day of the inspection, even at times when children were not in the centre. Staff had not received training in the use and implications of restrictive practices. The team leader informed inspectors that they had planned to discuss restrictive practices with staff at the next staff meeting. No quarterly or six monthly notifications of restrictive practices had been notified to the Authority.

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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
There had been some improvements since the last inspection in relation to medication management. The centre had reviewed and amended its medication management policy and improvements had been made in the safekeeping of medication.

The centre's policy on the management and safe administration of medication, dated 27 June 2014, had been amended and inspectors found the policy was more comprehensive in its guidance. The policy referenced the controlled drugs policy for the management, administration and storage of controlled medicines. It outlined the procedures to be taken in prescribing, receiving medication in the centre, storage, administration of medication, medication refusal, as required medication, safe disposal, ethical considerations, responsibilities of staff and the organisation. The process for reporting medication errors to management, and the steps to take in caring for a child where medication was given in error was outlined. However, no review process of medication errors was outlined. Staff had not been briefed on the new policy.

Improvements had been made in the storage of medication within the centre. The management team had installed a locked medicines cabinet, a suitable cabinet for controlled medication and a specific fridge for medication fridge. Inspectors found that food was stored in the medication fridge and the food was removed by the team leader. While the fridge did not have a lock the team leader identified that it was planned to place the fridge in a locked press. Within the medicines cabinet, each child's medication was stored in a plastic container, two out of three containers contained a photo to ensure that the correct child received the correct medication. One child was using homeopathic remedies, and staff were not clear on the reasons for administering this. There was no policy/guidance in place for staff on the use of homeopathic remedies. However, there was no controlled medication register in place though it was referenced in controlled medication policy.

Prescriptions sheets were not in line with good practice as they did not contain the address or photograph of the resident, the name of the GP, and the maximum dosage within 24 hours of as required medications. The administration sheet had been amended since the last inspection and it contained a space to record comments on withholding or refusing medication, and space for staff to give their full signature.

Staff were all trained in the safe administration of medication. However, there were no competency assessments in place to assess staff’s competency in the safe administration of medication. Inspectors found that not all staff were aware of the purpose of the prescribed medication for the children resident in the centre. Inspectors also found that there was no information or reference point to assist staff in researching the reasons for or side effects of medication was available for staff. Staff told the inspectors that they would use the internet for this purpose.
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):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The statement of purpose did not meet all of the requirements of Schedule 1 of the regulations.

The statement of purpose had been reviewed since the last inspection but it remained incomplete and was not in line with Schedule 1 of the Regulations. Inspectors found that it was too broad and was not confined to the provision of respite care to children. It outlined that the centre provided respite care, short term residential placements up to six months, medium term residential placements from 6-24 months and long term residential placements of 24 months plus to children aged form 0-18 years. The care needs of an infant and an adolescent are different, and it was not clear how staff were trained to meet the needs of infants through to young people who were reaching adulthood.

The statement of purpose did not detailed the arrangements for the assessment and development of a child's personal plan, review of personal plans, dealing with complaints, fire precautions and associated emergency procedures in the centre. Nor did it outline the arrangements for respecting the privacy and dignity of residents. Specific therapeutic techniques used in the centre and the arrangements for consultation with and participation of the children in the centre were not sufficiently described.

Judgment:
Non Compliant - Major

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

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**Responsibility for the provision of the service.**

**Theme:**
Leadership, Governance and Management

**Outstanding requirement(s) from previous inspection(s):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
There were defined management structures in place but management systems and oversight were not robust. The management team had progressed few of the regulatory breaches identified at the last inspection.

The centre had a clearly defined management structure which identified the lines of authority and accountability in the centre. Since the last inspection, the team leader (person in charge) had been assigned to the centre on a full time basis. The team leader reported to an area manager who reported to the director of the service. All staff reported directly to the team leader. An informal on-call system was in place with the team leader and or area manager available to staff outside of normal working hours. The sustainability of this arrangement was queried by the inspectors.

However, the team leader (person in charge) had insufficient knowledge of the regulations. For example, at the time of the inspection, no regulatory notifications had been made to the Authority, regarding the use of restrictive practices, or recording of any occasion on which the fire alarm equipment was operated other than for the purpose of fire practice, drill or test of equipment. However, notifications regarding the use of restrictive practices were subsequently made to the Authority.

The management systems within the service were not robust. The team leader informed inspectors of meeting with the area manager and provider nominee. However, there was no formal records of these meetings made available over the course of the inspection therefore it was not apparent how the management team made and recorded decision making. Inspectors found that the majority of the regulatory breaches from the July inspection remained in place and little progress had been made. Some policies had been reviewed but were not fully operational, such as the policies on the management and safe administration of medication and the intimate care policy, and staff were not aware of the amended policies. A staff meeting was scheduled for the end of August to update staff on policy and system changes. The dates on policies had not been amended to reflect policy changes.

No formal management systems were in place to support, develop and performance manage staff. Inspectors were advised by the team leader and area manager that these systems were in the process of being developed within the organisation. Staff told inspectors that they had not received feedback from the team leader on incident report forms that had been completed. There was no protected disclosure policy in place to facilitate staff to raise concerns about the quality and safety of care and support provided to residents.
There were limited monitoring systems in place in the centre. For example, the provider had not arranged for an unannounced visit to the centre on a six monthly basis in order to report on the safety and quality of care and support provided in the centre. This regulatory breach was outstanding since May 2014. No new auditing systems had been implemented. Inspectors were advised that a record of restrictive practices had been completed. However, it was not available for inspectors to review. It was not clear how the management team ensured that practices within the centre were consistent.

No copies of the service level agreements between the organisation and the Health Service Executive were provided for review to inspectors.

**Judgment:**
Non Compliant - Moderate

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**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):**
Some action(s) required from the previous inspection were not satisfactorily implemented.

**Findings:**
Staff were suitably qualified and recruitment practices were generally good. However, some staff were scheduled on occasions to be the lead member of staff for periods of up to 48 hours, there was no formal supervision in place and not all staff had received core training. Staff files were not reviewed by inspectors, as they were not held in the centre.

Staff had qualifications in childcare. However, a new member of staff had commenced in the days prior to the inspection, and inspectors were unable to verify the qualifications of the new staff member as their staff file was not held in the centre. The team leader told inspectors that the centre had an induction process which included the new staff member becoming familiar with the centre's policies and being provided with time to read the children's files. In addition, they worked alongside another member of staff for four shifts. Some core training was also provided and the new member of staff identified that they had completed the online safe administration of medication training. However, the induction process was not documented.
The numbers of staff on duty varied depending on the number of children who were attending or respite care on a day to day basis. There were a large number of staff rostered to work in the centre. Two core members of staff were employed in addition to the team leader and an additional 14 members of staff were rostered to work over a four week period. This meant that there was a potential for children not to receive continuity of care and support due to the ever changing staff cover.

There was a staff roster in place. Inspectors reviewed the actual roster for the month of August. The team leader generally worked from 9am to 6pm Monday to Friday. A lead staff member was identified for each shift and the two core members of staff were identified as the lead staff member when they were on duty. There were two shift periods from 8am-8pm and from 8pm to 8am. The number of staff and length of some staff's shift varied on the 8am-8pm shift and the team leader told inspectors that staffing levels were dependent on the number and needs of children placed in the centre for respite. At night, one member of staff was rostered to be waking, while the second staff member was asleep. Sleepover staff could be called by the waking staff if an issue arose with a child. The centre also had a night steward who was available at night to all of the organisation’s residential centres.

Inspectors found from reviewing staff rosters, that on two occasions over a two week period, two members of staff were rostered as the lead staff member to work four shifts in a row, including two overnight shifts. Therefore they were rostered as the lead member of staff for 48 hours. One of the staff members, had worked four overnight shifts out of the five overnights rostered on the week of the inspection. Staff may have not been at their optimum given the length of their working hours, which may impact on the care of children.

No formal process of supervision had been implemented since the last inspection. The team leader told inspectors that they were in the process of finding suitable training in the area of supervision. The absence of formal supervision meant that staff did not have formal confidential support by the manager or an opportunity for the manager to formally identify positive practice or development needs or areas of improvement or concern to staff.

Staff had not received all mandatory training such as child protection, manual handling, fire training and first aid, however some training was scheduled. The team leader had no records available of whether staff had received training since the last inspection. However, training in child protection and safeguarding was scheduled for staff in September 2014.

**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
Provider’s response to inspection report

<table>
<thead>
<tr>
<th>Centre name:</th>
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<tr>
<td>Centre ID:</td>
<td>OSV-0003255</td>
</tr>
<tr>
<td>Date of Inspection:</td>
<td>15 August 2014</td>
</tr>
</tbody>
</table>

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:
Children’s needs were not holistically assessed.

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.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
Prior to first admission PIC will ensure a comprehensive assessment is done with the parents with the participation of the child where practicable. Care plans will be drawn up within 28 days of the initial assessment. We will also request a copy of update reports from other professionals and Multi-Disciplinary Teams (if any) from the parents to have on the child’s file. PIC will set up a meeting with members of the MDT involved, parents and the child (where possible) to ensure an inclusive input into the care plan and a meeting to review the care plan with MDT, parents and child (where possible) will be held annually or more regularly where required.

Proposed Timescale: 26/08/14 to commence contacting relevant parties re MDT meetings and to have all parties contacted by 30/10/14. 30/09/14 – commence the first of the MDT meetings. 19/12/14 – to have all relevant parties invited and the meetings concluded.

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**Proposed Timescale:** 19/12/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
No formal process of reviewing personal plans was in place.

**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:**
Personal Plans will be reviewed prior to every admission with the client update form. PIC will facilitate an annual meeting with the child, parents and MDT to formally review the personal plans. Where there is a change in circumstances or needs of the child the meeting will be held as required.

Proposed Timescale: Completed by 19/12/2014

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**Proposed Timescale:** 19/12/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
No multi-disciplinary reviews of personal plans was taking place.

**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:
Currently all plans are being revised and our psychologist is making contact with all professionals from other services working with the children. Care Planning Review Meetings are being arranged with the Multi Disciplinary Team and the Parents and this will be reflected in the revised Care Plan.
Proposed Timescale: Completed by 19/12/2014

Proposed Timescale: 19/12/2014
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Children and young people were not routinely participating in contributing to their personal plan where appropriate.

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:
We will endeavour to include the children in the initial assessment, care plan and annual review of their personal plan in so far as is practicable. In circumstances where the child is unable to participate, the review will take place in conjunction with the parents. Staff will draw up an accessible child friendly version of the care plan in picture format and where possible, in conjunction with the child. This Care plan will be a live document that will be updated as needs and preferences change. Currently the PIC is making contact with parents and children to invite them to a Care Plan Review.
Proposed Timescale: Due to commence with admissions as of 26/08/14 and with all admissions thereafter. Contact with the children and their parents has commenced 26/08/2014.

Proposed Timescale: 26/08/2014
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Specific goals were not identified in personal plans for children.

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 reviewed respite care assessment will identify realistic goals specific to each child in conjunction with parents and child. Subsequent to the initial assessment these goals will be reviewed in conjunction with input from the MDT. These goals will then be incorporated into the child’s care plan. For all new assessments for future admissions we will have reviewed our assessment template to incorporate a goals setting section. For all existing children on our database we are in the process of revising the Care Plan to include a goal setting section. Proposed Timescale: 1/10/2014 for children booked in. 29/08/2014 for new admissions.

**Proposed Timescale:** 01/10/2014

### 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 risk management policy did not include the measures and actions in place to control the risks identified within the centre.

**Action Required:**
Under Regulation 26 (1) (b) you are required to: Ensure that the risk management policy includes the measures and actions in place to control the risks identified.

**Please state the actions you have taken or are planning to take:**
We are reviewing our risk management policy to include the measures and actions in place to control the risks identified in the centre through risk assessments. We have amended environmental risk assessment relating to the use of window restrictors. Risk assessment/management training took place on 16th September.
Proposed Timescale: Training complete 16/09/14; Policy reviewed 31/10/2014

**Proposed Timescale:** 31/10/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The arrangements to deal with adverse incidents were not outlined in the risk management policy.

**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:**
We are reviewing our risk management policy to ensure it includes arrangements for...
the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents. Staff were informed at staff meeting 27/08/2014; by staff memo circulated signed by staff; and at staff supervision. Risk assessment /management training took place on 16th September.
Proposed Timescale: Training completed 16/09/14; Policy reviewed 31/10/2014.

**Proposed Timescale:** 31/10/2014

**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 measures and actions to control the risks identified due to the unexpected absence of any resident.

**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:
We are reviewing our risk management policy to ensure it includes measures and actions in place to control the risks identified due to the unexpected absence of a resident. We have installed window restrictors, window alarms and an additional security gate. We have updated our absent management plan. Staff were informed at staff meeting 27/08/2014; by staff memo circulated and signed by staff; and at staff supervision. Risk assessment /management training took place on 16th September.
Proposed Timescale: Window restrictors fitted 26/08/14. Training 16/09/14
31/10/2014 to review risk management policy.

**Proposed Timescale:** 31/10/2014

**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 the measures and actions in place to control accidental injury to residents, visitors or staff.

**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:
We are reviewing our risk management policy to ensure it includes the measures and actions in place to control the accidental injury to residents, visitors or staff. Risk

<table>
<thead>
<tr>
<th>Proposed Timescale: 31/10/2014</th>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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</table>

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The risk management policy did not include the measures and actions in place to control aggression and violence.

**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:**
We are reviewing our risk management policy to ensure it includes the measures and actions in place to control aggression and violence. Risk assessment/management training took place on 16th September. Challenging behaviour training part 1 & 2 to be completed by 31/10/14. Proposed Timescale: Risk assessment training completed 16/09/14. Challenging behaviour training to be completed 31/10/14. Policy reviewed 31/10/2014.

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<th>Proposed Timescale: 31/10/2014</th>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Personal protective equipment such as gloves were locked. Staff did not have timely access to these. Mops were unclean and were stored outside the back door of the centre.

**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:**
A separate storage unit is in place for storage of mops, buckets and cleaning products. Mop heads are regularly checked by the PIC and replaced at least every three months. Our infection control policy has been amended to include the requirements as stated in the National standards for the prevention and control of healthcare associated infections. PIC to ensure staff are familiar with and apply the procedures set out in the
policy. Staff have received training in infection control.

**Proposed Timescale:** 03/10/2014

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## Outcome 08: Safeguarding and Safety

**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
A log of restrictive practices was not available.

**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:
We have reviewed our restrictive practice policy and it is in accordance with the National Policy and evidence based practice for restrictive practice. We now have a log of restrictive practices in place in the centre. All staff have completed restrictive practice training and work within the guidelines that where restrictive procedures are applied the least restrictive practice for the shortest duration is applied.


**Proposed Timescale:** 31/10/2014

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Restrictive practices had not been reviewed to ensure that the least restrictive practice was used.

**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:
Each child’s needs with regards to the use of any restrictive practices will be assessed on admission. The assessment will investigate to identify the cause of any challenges
for the child and in the first instance try to identify measures in consultation with parents and multi-disciplinary team to alleviate the challenges without implementing restrictive practices. In the event that the assessment will identify certain measures including restrictive practices that need to be put in place, we will ensure that these measures and practices are appropriate and least restrictive, taking account of the rights and safety of each individual child. We will also ensure that specific restrictive practices will be used for the shortest duration possible and these practises will be reviewed at each admission. Risk assessment/management training was carried out on the 16/09/14. Staff received training in restrictive practice on 03/09/14.

**Proposed Timescale:** Risk assessment/management training was carried out on the 16/09/14. Staff received training in restrictive practice on 03/09/14. Assessment and consultation to identify cause of challenges and identify measures to alleviate the cause is in operation at present 27/08/2014.

<table>
<thead>
<tr>
<th><strong>Proposed Timescale:</strong> 16/09/2014</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Safe Services</td>
</tr>
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</table>

**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).

**Action Required:**
Under Regulation 08 (7) you are required to: Ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and response to abuse.

**Please state the actions you have taken or are planning to take:**
We have reviewed our training schedule and training is scheduled to commence before 30/09/2014 and it is envisaged that all training will be completed by 31/10/2014.

**Proposed Timescale:** Children First training to be complete 31/10/2014.

<table>
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<tr>
<th><strong>Proposed Timescale:</strong> 31/10/2014</th>
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<tbody>
<tr>
<td><strong>Theme:</strong> Safe Services</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The policy on intimate care was not operational, and the policy did not give specific guidance on the provision of all aspects of intimate care.

**Action Required:**
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.
Please state the actions you have taken or are planning to take:
Training in intimate care has been completed which includes guidance in the provision of all aspects of intimate care in accordance with the Guidance for Designated Centres in Intimate Care. Each child’s intimate care plan is updated on each admission and the parents have received an intimate care plan questionnaire in relation to their child’s needs which will be integrated into their care plan. Staff have received Children first training and work in accordance with policy to ensure that the children’s dignity and integrity are upheld at all times.

Proposed Timescale: 31/10/2014

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:
No controlled drugs register was in place.

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:
We now have a controlled drugs register in place. The GALRO registered staff nurse has trained staff how to fill in the register and will monitor its use.
Proposed Timescale: Completed 06/09/2014.

Proposed Timescale: 06/09/2014
Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff were not aware of the amended medication management policy.

Action Required:
Under Regulation 29 (4) (a) 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 any medicine that is kept in the designated centre is stored securely.
Please state the actions you have taken or are planning to take:
An amended management policy is in place. This was brought to the attention of staff at a meeting on 27th August 2014. At that meeting discussion took place around the importance of the new medication management procedures and a short training session followed which emphasised the procedure. PIC conducts medication administration competency assessments with staff every three months. The PIC monitors staff performance with regard to the administration of medication monthly at a minimum. The PIC successfully completed a two day training programme in Responsible & Safe Medication Management Training Programme with Joe Wolfe Associates and has also successfully completed Safe Administration and Management of Medication Training. Proposed Timescale: Completed 27/08/2014.

Proposed Timescale: 27/08/2014

**Outcome 13: Statement of Purpose**

<table>
<thead>
<tr>
<th>Theme: Leadership, Governance and Management</th>
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</thead>
<tbody>
<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>The draft statement of purpose was not in line all the requirements of schedule 1.</td>
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<tr>
<td>Action Required:</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
</tr>
<tr>
<td>The Purpose and Function is revised in line with Schedule 1 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.</td>
</tr>
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</table>

**Proposed Timescale: 29/08/2014**

<table>
<thead>
<tr>
<th>Theme: Leadership, Governance and Management</th>
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<tbody>
<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
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<tr>
<td>The statement of purpose was under the process of review, was in draft and incomplete.</td>
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<tr>
<td>Action Required:</td>
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<tr>
<td>Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.</td>
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</tbody>
</table>
Please state the actions you have taken or are planning to take:
Statement of Purpose revised.
Proposed Timescale: Complete 29/08/2014.

Proposed Timescale: 29/08/2014
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Children and their representatives had not received a copy of a statement of purpose for the service.

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 made available to the children and their families.
Proposed Timescale: Copies to be furnished to families by 31/10/14.

Proposed Timescale: 31/10/2014

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:
Inspectors did not find robust management systems in place in the centre.

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:
We have reviewed our management systems and the designated Person in Charge is now designated solely to the centre in order to ensure the effective governance, operational management and administration of the designated centre. The PIC is now rostered to work at least one day over the weekend when the centre is open. We have an effective management system in place. Our objectives with regards to our services are clearly stated in our policies and target issues are addressed. The Person in Charge has a relevant professional background in social care with supervisory management experience. She also receives inhouse mandatory training and training in best practice.
Arrangements are in place for all Team Leaders to be trained and certified a minimum FETAC Level 6 Supervisory Management in our organisation. The Person in Charge oversees the daily operation of the centre and arranges for an on-call management back up in the event of her absence. The Person in Charge attends regular management meetings and convenes team meetings with centre staff in the centre to assess progress, highlight concerns, revise and implement new plans. Decisions are made following broader consultation with families, professionals and staff and decisions are communicated at formal scheduled meetings. The minutes of these meetings are recorded and any action plan required will identify the person responsible and the time for completing the action. Staff receive informal supervision on a daily basis and have regular contact with the PIC. Formal supervision takes place every three months. Staff appraisal interviews are conducted every six months. Evaluations and internal reviews in accordance with statutory requirements have commenced and a written report has been completed. PIC and staff are implementing actions required as set out in the report.


**Proposed Timescale:** 31/10/2014  
**Theme:** Leadership, Governance and Management

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

No formal management systems were in place to support, develop and performance manage staff.

**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:**

Manager will hold staff appraisal to support, develop and performance manage the staff team every six months. Staff will have supervision every three months. Staff training on performance management will be carried out.

Proposed Timescale: Performance management training will be completed by 31/10/2014. Supervision commenced: 27/08/2014 Appraisals: will have commenced 30/09/14

**Proposed Timescale:** 31/10/2014  
**Theme:** Leadership, Governance and Management
The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no protected disclosures policy in place.

**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:**
We have formulated a protected disclosure policy. Staff to be informed at staff meeting on 24/09/14 by staff memo circulated and to be signed by staff; and at staff supervision.

Proposed Timescale: Disclosure Policy formulated 05/09/2014. Staff to be informed at staff meeting on 24/09/14.

**Proposed Timescale:** 24/09/2014

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were limited formal monitoring systems within the centre.

**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 new evaluation tool which looks at the 18 outcomes has been designed and implemented. An unannounced visit was conducted at the centre on 9th, 10th and 19th September. Staff will be informed of the outcome of these visits and of actions that are required. During these visits 12 of the 18 outcomes were examined to ensure that the service provided was safe and appropriate to the resident’s needs. There will be regular six month unannounced visits to formally monitor the quality and provision of care.


**Proposed Timescale:** 30/09/2014

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The provider nominee or nominated person had not arranged for an unannounced visit to the centre on a six monthly basis in order to report on the safety and quality of care.
and support provided in the centre.

**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:**
An unannounced visit has been conducted internally and an external body was engaged to carry out an unannounced visit as part of training. A written report on the findings from the visit has been compiled and distributed to the PIC and Area Manager on Friday 3rd October 2014. A planning meeting will take place on 13/10/14 to ensure actions required are implemented.


**Proposed Timescale:** 13/10/2014

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### Outcome 17: Workforce

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There were two core members of staff and a large number of additional staff were rostered to work in the centre.

**Action Required:**
Under Regulation 15 (3) you are required to: Ensure that residents receive continuity of care and support, particularly in circumstances where staff are employed on a less than full-time basis.

**Please state the actions you have taken or are planning to take:**
Staff are rostered to ensure consistency of staff. To this end there are two permanent key workers that work with all the children on occasion. Other key workers are assigned to specific children depending on their individual needs. The pool of staff working in the service is a consistent pool and the numbers are kept to a minimum. The PIC manages the unit and because the respite service is part-time she may be rostered at weekends to ensure continuity and consistency.

Proposed Timescale: Complete

**Proposed Timescale:** 27/08/2014

**Theme:** Responsive Workforce
The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had access to appropriate training, as part of their continual professional development programme.

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:
In-house and external training is conducted for staff. All staff attend mandatory training i.e. SAMM’s, Fire Safety Training, Children First, Manual Handling, Health and Safety and Basic First Aid. Additional professional development training such as Intimate Care, Risk Assessments and Risk Management, Restrictive Practises, Challenging Behaviour, Infection Control, Food Hygiene, Supervision Leadership and Management is offered to staff on an ongoing basis.
Proposed Timescale: Complete 31/10/2014

Proposed Timescale: 31/10/2014

Theme: Responsive Workforce

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

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 training for management is scheduled. This will ensure quality of supervision. The Person In Charge will have formal supervision with individual staff every three months as per the supervision policy. Formal supervision has commenced with staff 27/08/14.

Proposed Timescale: 31/10/2014