## Centre Information

| Centre name: | A designated centre for people with disabilities operated by North West Parents and Friends Association |
| Centre ID: | OSV-0001933 |
| Centre county: | Leitrim |
| Type of centre: | Health Act 2004 Section 39 Assistance |
| Registered provider: | North West Parents and Friends Association |
| Provider Nominee: | Evelyn Carroll |
| Lead inspector: | Ann Delany |
| Support inspector(s): | None |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 1 |
| Number of vacancies on the date of inspection: | 3 |
About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.
Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times
From: 19 November 2014 14:00  To: 20 November 2014 14:00

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

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Summary of findings from this inspection
This was the first inspection of this service and was carried out for the purposes of monitoring. Seven outcomes were reviewed as part of this inspection. The service was part of the North West Parents and Friends Association in Sligo/Leitrim and this centre provided a respite service for six children with an intellectual disability within the area. The inspection was carried out over two half days. As part of the inspection the inspector met with the clinical nurse manager 2 (CNM 2) who was the person in charge, staff and a service user. The inspector also observed practice, and reviewed documentation such as personal plans, policies and procedures, staff files and other reports.

This designated centre provided respite support and accommodation for up to and including three children overnight. This included both boys and girls from 13 - 18 years with mild to profound intellectual disability, autism, and physical and sensory disability. Therapeutic interventions were obtained through community and primary care teams, including occupational therapy, physiotherapy and speech and language therapy.

The inspector found that children received a good service of care. Personal plans were in place and staff were very familiar with the children and their likes and dislikes. There were also good communication systems in place with the children's families. However, comprehensive assessments of each child's needs had not been undertaken or, where present, were over three years old. The personal plans had not
been reviewed in line with the regulations. There was limited preparation for transition and independent living as children grew up.

There were effective management structures in place. Staff and managers were aware of their responsibilities and for what they were accountable. Some management systems were in place including policies and procedures and others were in development, such as the risk management, behaviour support and quality assurance policies. The statement of purpose and function had broad admissions criteria and while the current children attending the service received a good service of care by the staff team there was no evidence that the staff team had been developed to have the ability to care for the broad range of needs that the admissions criteria identified. In addition, while children with a physical disability were accommodated in the centre, the bathroom and showering facilities were not suitable.

The health and safety of children, visitors and staff was not adequately maintained. The inspector identified that the water was 47.1 degrees Celsius which posed a risk or burning or scalding a child. An immediate action plan was issued and the provider responded with an appropriate action plan. Overall, risk management systems were not robust.

There were some measures in place to safeguard children but there were improvements required. Staff were observed to be respectful when working with children. However, staff had not received training in Children First (2011) or the behaviour support model. Restrictive practices were in use but were not reviewed to ensure they were as least restrictive as possible.

The workforce were a long standing team who were committed to providing quality care. However, while core training had been provided to the majority of staff, there was no evidence of specialist training for managing behaviour or in key issues of providing a service to children with an intellectual disability. This presented a risk that staff might not be able to provide sound evidence-based practice, but have to rely on individual judgment and their experience. There was no formal supervision process in place which meant that the manager did not have an opportunity to formally identify positive practice, developmental needs or areas of improvement or concern to staff.
Outcome 05: Social Care Needs

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

Theme:
Effective Services

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

Findings:
Children’s needs had not been comprehensively assessed and personal plans did not detail the child's individual needs or their objectives and goals. There was limited evidence that children and their families were being consulted with in the development of the plans. There was limited preparation for transition or independent living.

The inspector found that on a day to day basis children attending the service were well cared for by the staff team. However, up to date comprehensive assessments of need were not in place for all children accessing respite care in the centre. The inspector reviewed three case files and found that an assessment of each child's needs had been undertaken by a nurse using the activities of daily living model of assessment. Some of these were outdated, having been completed in 2011. Considering how quickly children's needs can change as they develop, it was likely that up to date information about the needs of the child would not be available for staff to guide personal care planning.

As a result, personal plans were not comprehensive and were not informed by a multidisciplinary approach. There was no evidence of other professionals being involved in the planning process. There were a number of plans in children's files, for example 'a book about me', 'my personal choices and preferences plan', a nursing plan, the individual education plan, and an emergency egress plan. However, they did not set out the supports needed to maximise the child's personal development or provide information on how to support the child and deliver the required care. The 'book about me' was written in the first person and identified children's likes and dislikes, communication needs and their daily routine but was out of date in one instance. The plans did not set out the goals for the child or the steps and actions required to meet these goals. The care plan and the individual education plan were not integrated to
ensure that all professionals were working consistently with the children. However, staff talked about some short term goals for some of the children including dressing independently and brushing their teeth, but there was no record of this on file to support a consistent approach. The clinical nurse manager acknowledged that the short and longer term goals for children attending the service were not clearly identified in plans. Plans were not formally reviewed. Some parts of the plan were dated as reviewed in 2014 but there was no record that the effectiveness of the plan was reviewed or that it considered any new developments or changes in circumstances. Nor was there a record that the children, as appropriate, or their family had been involved in the review process or received a copy of the plan in an accessible format.

Transition planning was not of a good quality. There were no transition plans in place for any of the children despite the fact that one young person was due to leave the service imminently and another young person was approaching their eighteenth birthday.

Children had limited opportunities to prepare for adult life. The inspector found that the centre was set up for younger children in terms of decor and play equipment and staff agreed that some toys were not appropriate for the children attending the service. There was one young person who was working on independent skills in relation to shaving. Staff also advised that children were brought shopping at weekends from time to time.

**Judgment:**
Non Compliant - Moderate

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**Outcome 07: Health and Safety and Risk Management**

*The health and safety of residents, visitors and staff is promoted and protected.*

**Theme:**
Effective Services

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

**Findings:**
The health and safety of the children, visitors and staff was not adequately promoted. Although there was an organisational health and safety statement in place and some fire precaution measures were also in place, the inspector identified a number of hazards and risks on the day of inspection. This indicated that the risk management systems in place were not adequate.

The risk management system was not effective and did not lead to risks being reduced or eliminated. The centre had an organisational health and safety statement dated November 2014 but there was no supporting documentation on local hazards and risks and how they were being managed. A risk assessment audit had been undertaken on 13
November 2014. The audit looked at 10 aspects of health and safety but did not identify all of the hazards and risks found on the inspection. The inspector observed a number of safety measures which had been put in place such as the installation of window restrictors, sockets protected with covers, safety catch in place where blinds were in use. However, the inspector identified a number of other hazards such as very hot water in the taps. The CNM 2 had identified the risk the day before the inspection, maintenance staff had been called on the morning of the inspection and the CNM 2 told the inspector that the temperature had been reduced. However, there was no evidence that the CNM 2 had made staff aware of the hazard or had rechecked the temperature. The inspector recorded the temperature at 47.1 degrees. This was higher than accepted norms and posed a risk of burning or scalding the children. An immediate action plan was issued the day after the inspection. The provider responded with an appropriate action plan within the agreed timeframe. The inspector noted some other hazards such as missing tops from taps, no handrails in the bath, a ligature in the sensory garden, wardrobes not fixed to the walls, and children had easy access to the main road.

There was a draft risk management and emergency planning policy and procedures but these were not compliant with regulation 26 and did not provide sufficient guidance for day to day practice. For example, it did not include guidance on hazard identification and assessment of risk throughout the designated centre, and how to put measures in place to control identified risks. While there was some guidance in relation to managing the unexpected absence of a child, accidental injury, self harm and aggression and violence, the policy did not state how to control these specific risks.

Effective systems were not in place to identify, assess, manage and monitor all risk. While the centre had an incident report form, the CNM 2 identified that following recent risk management training it had been identified that the form did not meet the organisation’s requirements. All incidents were reviewed by the organisation’s quality, safety and risk management committee who were responsible for trending incidents, indentifying areas for improvement, compiling and updating the risk register. There were two risks identified on the organisation’s risk register - the unsuitable building and medication errors. Staff told the inspector that they did not always receive feedback when they completed incident reports and so could not improve practice in the service or learn from mistakes.

Training records reviewed by the inspector identified that with the exception of one member of staff all of the team was up to date on manual handling training. Staff identified that equipment used within the centre and for transport were included in the manual handling training. The majority of staff were up to date with first aid training.

The maintenance system was not robust. The CNM 2 maintained a maintenance book for any items referred to the maintenance team. However, on reviewing the book the inspector could not identify that all repairs had been completed in a timely manner as there was no sign off date of completion.

The inspector also observed that the two vehicles used to transport the children were insured, taxed and had national car testing certificates.

There were some measures in place in relation to infection prevention and control but
these were not sufficient to prevent infection. There were adequate hand washing facilities and signage on how to clean your hands properly. Training records identified that the majority of staff had been trained on basic food safety and hand hygiene in September and December 2013. Pest control was in place and a sanitation system was available though in one bathroom this was placed in the shower. The management of the centre’s mop system was not optimum. A colour coded system was in place for bathrooms and kitchens but there was no identified colour code for the bedrooms and other living areas. The inspector observed that the mops and buckets were stored outside the front door and there was no system in place for cleaning and changing the mop heads. There were no schedules in place to guide staff on the procedures for cleaning and what product to use. Staff did complete a tick box when the room was cleaned and this was monitored by the CNM 2. There was no appropriate sluice for staff to empty water buckets and bins. Personal protective equipment was limited to single use gloves. There were a number of soft toys available in the centre but there was no system for washing them. There was a system in place to dispose of clinical waste in the local community hospital if required.

There were some fire safety precautions in place but improvements were required. The centre had a serviced fire alarm (which was sounded during the inspection) and fire equipment and emergency lighting had been serviced in November 2014. There had been two fire drills in June and August of 2014. The majority of staff had received fire safety training in the last 12 months. The fire alarm was tested weekly. The fire alarm was tested weekly. Emergency contact numbers and contact details for next of kin were accessible in the event of a fire or emergency. The front and back door were locked at all times with staff carrying keys. The sensory garden was the identified assembly point and staff were very familiar with this. The CNM2 was appointed as the fire warden but had received no additional training in relation to this role. The record of the fire drills undertaken did not name who had been involved - staff or service users, it just identified numbers. On one of these incidents it was recorded that staff had ‘difficulty using fire blanket on bed’ and the action identified was ‘carry out fire drills more regularly’ but only one further drill had occurred and there was no evidence of any further training on the use of evacuation sheets. The inspector found that the weekly fire checks had only commenced on the week of 17 November 2014 and no daily checks were undertaken which meant that fire safety issues were not being identified and fire safety control measures were not being monitored regularly for their effectiveness in line with good practice. Cleaning mops and buckets were observed at the evacuation point (outside front door) and could impede children and staff in the event of an emergency.

Judgment:  
Non Compliant - Major

Outcome 08: Safeguarding and Safety

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

Theme:
Safe Services

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

Findings:
There were some measures in place to safeguard and protect children in the centre from abuse but there were no behaviour support plans for children with behaviour issues. There were some restrictive practices in use though not all of these had been identified as such.

The centre had some effective safeguarding measures in place, for example policies in relation to recruitment, intimate care, lone working, and children missing from care. The inspector observed staff interacting with a young person in a positive manner. Staff were observed engaging in a caring and respectful way and had awareness of the young person's likes and dislikes. Staff also spoke about the children in a very respectful way.

There was no evidence in the children's files reviewed, that children were being supported to develop knowledge, self awareness, understanding and skills needed for self care and protection. There were no intimate care plans in place. With the exception of one child, all children who attended the service required intimate care. Staff reported that they provided intimate care based on their knowledge of each of the children attending the service. The absence of intimate care plans meant that staff, particularly new staff, did not have sufficient guidance in relation to bathing and showering each of the residents in a safe way.

The centre also had a draft prevention, detection and response to abuse policy called 'safeguarding children policy'. However, the policy did not provide sufficient guidance for staff as it did not contain the details for the designated person or their role and it was not clear who should contact the family in the event of an allegation. Not all staff were trained in child protection or the role of the designated liaison person. This meant that staff may not report allegations of abuse appropriately and in line with national guidance. Staff were knowledgeable about abuse including issues for vulnerable children who could not communicate verbally. Two reports of child protection concerns were made to the Child and Family Agency in the last 12 months and these were still under consideration. However, relevant notifications to the Authority had not been reported at the time of inspection but following a request were received following the inspection.

Adequate systems were in place to manage the children's pocket money and protect them from financial abuse. Children's pocket money was stored securely and the staff team maintained a log of children's money. Monies received and spent were recorded and signed by one staff member and there was a record of what the monies had been spent on. The manager audited the log but on an infrequent basis which meant that any potential inaccuracies may not have been identified in a timely way.

The majority of children in the centre did not present with behaviour that challenged.
The staff team utilised a positive behaviour support model. There was a draft behaviour support and use of restrictive practice policy. However, this policy described a different behaviour support model and did not provide guidance to staff on managing behaviour that challenges. In addition staff had not been trained on the model described within the policy. The manager identified that they were introducing a new model of behaviour support and training was being planned for this model before the end of the year. There were no behaviour support plans in place and the team did not have access to multidisciplinary supports.

Restrictive practices were used to manage behaviour within the centre and there was a draft policy which identified that restrictive practices should not be used without endorsement from senior managers except in an emergency. The inspector found a number of restrictive practices which were mainly environmental. These included use of bed rails, lap belts, locked front and back door but also physical intervention. The inspector found an occupational therapist had approved the use of a lap belt, tilted chair and bedrails for one child in May 2013, 17 months previously. There was no evidence in the files reviewed that alternative measures, or the least restrictive measure for the shortest duration, had been considered for other restrictive practices. Nor was it evident in files reviewed that senior managers had endorsed the restrictive practice. This meant that restrictive measures may have been applied routinely by staff rather than on therapeutic or a risk based basis. The CNM 2 and staff identified that a number of these practices were used as safety measures and they had not considered that they restricted some children’s rights. On the first day of the inspection when a child was in the centre, the inspector observed that the front and back door were locked at all times with the key removed, even though this child did not attempt to leave the centre. No audits had been completed on the use of restrictive practices and not all of the restrictive practices had been reported to the Authority on a quarterly or half yearly report.

**Judgment:**
Non Compliant - Moderate

### Outcome 12. Medication Management

*Each resident is protected by the designated centres policies and procedures for medication management.*

**Theme:**
Health and Development

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

**Findings:**
Medication management systems did not fully protect residents. Prescribing of medication was not in line with good practice, but medications were administered safely.

An organisational medication management policy was in place dated April 2014.
However, it did not fully inform the practice in the centre. The policy outlined the ordering, storage, administration and recording of medication. It also covered emergency prescribing. However, the procedure for routine prescribing was not clearly outlined within the policy. The inspector found that while the policy identified that medication should be returned to the family when the child was returning home, in practice certain medications were retained within the unit. Not all over the counter medication was labelled for the child.

The centre had a combined prescription and administration sheet, but prescriptions were not in line with good practice. For example, one prescription for ‘as required’ medication was prescribed in the regular prescription section. Another medication newly prescribed for a child had been inadvertently signed off as discontinued. This meant that a child may not get the required medication at the appropriate time. General practitioners (GPs) had initialled prescriptions when a signature was required. The CNM 2 had made many efforts to rectify and safeguard children and staff administering the medication through written requests to GPs, that medication prescriptions be legible, state maximum dose, route of administration, including a written example of what was required but this had not always been successful in the prescriptions reviewed.

Inspectors found that medications were well administered. Nursing staff took responsibility for administering medication and were observed administering medication safely. The majority of staff who administered medication had completed an online medication management training course in 2014. However, their competency had not been assessed recently and no audits of medication management had been undertaken.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The centre had a draft statement of purpose. However, it had broad admissions criteria and while the current children attending the service received a good service of care by the staff team, there was no evidence that the staff team had been developed to have the ability to care for the broad range of needs that the admissions criteria identified. While the statement of purpose identified that children with a physical disability could be cared for, the centre did not have suitable bathing or showering facilities to do this.
The statement of purpose did not meet the requirements of Regulation 3 as there were a number of omissions. For example, it did not clearly describe the specific care needs the service intended to meet, or the services to be provided to meet those needs. Other omissions included:

- criteria used for admission, including emergency admissions
- the gender of residents
- the size of rooms
- the arrangements for reviewing residents personal plans
- supervision of specific therapeutic techniques
- arrangements for consulting with, and participation of, residents in the operation of the centre.

In addition, there was not sufficient information on how children could engage in social activities, hobbies and leisure interests, the arrangements for dealing with complaints and the fire precautions and associated emergency procedures.

**Judgment:**
Non Compliant - Moderate

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**Outcome 14: Governance and Management**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
There was a clearly defined management structure and some systems in place to ensure the centre operated safely but other processes such as risk management and quality assurance were at an early stage of development.

The centre was adequately managed for the current service users. There was a management structure in place. The CNM 2 and the service manager were also responsible for operating other aspects of the organisation. The inspector found that the CNM 2 was suitably qualified and experienced to manage the centre. S/he was also the person in charge for another designated centre on the same grounds as the children’s respite service. S/he provided good leadership to the team and had a very good
knowledge of the children attending the service. S/he had knowledge of the legislation and of some of his/her statutory responsibilities. The CNM 2 told the inspector that s/he met the service manager formally but also that the service manager was available as required. Minutes of the management meetings were reviewed by the inspector and reflected that issues relating to the children's respite service were discussed and actioned including the physical premises, child protection and risk management training. However, it was unclear from the minutes if items actioned from a previous meeting were discussed/followed up at the following meeting. A suite of organisational policies and procedures were in place to guide and support staff though some of these were in draft format and had not been implemented. Others as previously identified did not provide sufficient guidance for staff.

The service was a medical model with a qualified nurse on duty for the majority of day shifts. The rationale for this was not clear as the majority of the children attending the service did not have nursing needs. The allocation of nurses to the centre appeared to be historic and was not necessarily a good use of resources. As outlined in outcome 13 the development of the staff team to meet the needs of future service users, as identified in the broad admissions criteria in the statement of purpose, was not sufficient to ensure that the staff would have the knowledge, skills and competencies to meet the needs of those children.

The provider had identified physical infrastructural deficits with the centre to meet the needs of the children and had liaised with the Health Service Executive (HSE) in relation to a capital project. The CNM 2 informed the inspector that the provider had some plans developed for a new building but that the funding of the project was with the HSE.

Nursing and care staff all reported to the CNM 2 and all staff spoken to were clear about their reporting relationships. An on call system was available to staff out of hours, with the nurse on duty for the site being the first on call and the CNM 2 and service manager providing alternate on call arrangements. The CNM 2 set the roster and could authorise additional resources if required to meet the needs of the children. Staff reported that they could approach the CNM 2 at any time and that his/her door 'was always open'. However, team meetings for all staff were not held regularly and there was no formal supervision so it was unclear how decisions were effectively communicated to all staff. Staff reported that memos were circulated and the CNM 2 kept them informed about different decisions.

Staff were not formally supported or performance managed. The centre did not have a supervision policy and it was unclear how staff performance was managed in order to ensure that the service was continually improving and that staff could exercise their professional responsibility for the quality and safety of services delivered. While a protected disclosure policy was in place not all staff who spoke to the inspector were aware of the policy.

There was some monitoring of the overall quality of the service provided to children and their outcomes. The CNM 2 had undertaken some audits of the service, for example health and safety. A system of regular audits was not in place for issues such as the quality of children's personal plans. The organisation was in the process of applying for an accreditation which they hoped to achieve by the end of 2015. However, the provider
had not carried out an unannounced visit to the centre on a 6 month basis to assess the safety and quality of care and support or an annual review as required by the regulations.

**Judgment:**  
Non Compliant - Moderate

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<th><strong>Outcome 17: Workforce</strong></th>
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<tr>
<td>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.</td>
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**Theme:**  
Responsive Workforce

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**Findings:**  
There were sufficient staff on duty to provide the service and the centre was generally staffed with a registered nurse and social care staff. The recruitment process was not robust and the CNM 2 was not in compliance with Schedule 2 of the regulations. Not all care staff were qualified and there was no formal staff supervision taking place. In general staff had received core training but little other professional development. The inspector found that the service was dependent on the commitment of staff and their long term knowledge of the children to run a safe service.

Staff files were not complete. A sample of staff files was reviewed and the inspector found that they did not contain all the requirements as outlined in Schedule 2. For example, there were gaps in the employment history, references were not available for all staff, one member of staff’s evidence of qualification was not on file and there was no record of the number of hours the person worked each week included for a number of staff. The inspector reviewed a comprehensive induction programme that was ongoing at the time of the inspection.

There were sufficient staff members on duty on the first day of the inspection and no children were scheduled for admission on the second day. The inspector examined the staff rosters and found that one nurse and one social care staff were on duty when there were children in the centre with the exception of Sunday when two social care staff were rostered. The CNM 2 identified that a nurse from the nearby adult service was available to the social care staff if required. One care staff was scheduled on night duty with the nurse from the adult service also on call for them. In total 12-14 staff worked in the centre providing care for the six children who attended the service. The nurse was the identified shift leader on the roster to provide accountability and management for
the shift. Not all social care staff were professionally qualified.

There was no supervision policy in place and staff were not formally supervised. While there was some informal supervision, the absence of formal supervision meant that staff did not have formal support by the manager or an opportunity for the manager to formally identify positive practice, developmental needs or areas of improvement or concern to staff.

Most staff had received core training in manual handling, fire safety, food safety and hygiene. While the provider provided a copy of a training needs analysis that had been prepared for 2015 for the organisation it was unclear how the needs of the children using this service had informed the analysis. There was no evidence in training records of specialist training for managing behaviour or in key issues in the provision of services to children with intellectual disability. Staff members confirmed this to be the case. There was a risk that staff members would not be informed by best practice when caring for children as the quality of the service was dependent on individual judgment and experience of the staff.

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:

Ann Delany
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority
Provider’s response to inspection report

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<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by North West Parents and Friends Association</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0001933</td>
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<tr>
<td>Date of Inspection:</td>
<td>19 November 2014</td>
</tr>
<tr>
<td>Date of response:</td>
<td>6 February 2015</td>
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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:
There was no comprehensive assessment of the health, personal and social care needs or each resident completed prior to admission.

Action Required:
Under Regulation 05 (1) (a) you are required to: Ensure that a comprehensive

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
All children attending the Service now have an up to date nursing assessment based on the Roper Logan Tierney model of nursing. A comprehensive assessment of need will be completed on each child attending the respite service. The Admission Policy will be reviewed at NWPF’s Quality, Safety and Risk Management Committee (QSRM) which is scheduled for the 17th February 2015. The PIC will ensure that the updated Admission Policy will be implemented ensuring that a comprehensive Assessment by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to any new admission to the designated centre.

Proposed Timescale: 28/02/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no comprehensive assessment of need completed for each child to reflect changes in need or circumstances or no less frequently than an annual basis.

Action Required:
Under Regulation 05 (1) (b) you are required to: Ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.

Please state the actions you have taken or are planning to take:
The PIC will ensure that a comprehensive assessment is completed annually or more often if required to reflect changes in need or circumstances of children attending the respite service.

Proposed Timescale: 28/02/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not reflect all the needs of the children.

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 the resident's assessed needs.
<table>
<thead>
<tr>
<th><strong>Please state the actions you have taken or are planning to take:</strong></th>
<th>The PIC will ensure that the comprehensive assessment when completed will inform the personal plan for each child, together with input from the MDT/family, prioritising goals and supports needed for the child. The PIC will ensure that for any new admissions, a personal plan will be developed within 28 days of admission outlining goals and supports required.</th>
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<td><strong>Proposed Timescale:</strong></td>
<td>13/03/2015</td>
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<tr>
<td><strong>Theme:</strong></td>
<td>Effective Services</td>
</tr>
<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>Personal plans were not made available in an accessible format to the children and/or their family.</td>
</tr>
<tr>
<td><strong>Action Required:</strong></td>
<td>Under Regulation 05 (5) you are required to: Ensure that residents' personal plans are made available in an accessible format to the residents and, where appropriate, their representatives.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>The PIC will ensure that personal plans will be made available in an accessible format to the children and their family, following the development of the personal plans.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong></td>
<td>27/03/2015</td>
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<td><strong>Theme:</strong></td>
<td>Effective Services</td>
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<tr>
<td><strong>The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:</strong></td>
<td>Personal planning was not undertaken by the multidisciplinary team.</td>
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<tr>
<td><strong>Action Required:</strong></td>
<td>Under Regulation 05 (6) (a) you are required to: Ensure that personal plan reviews are multidisciplinary.</td>
</tr>
<tr>
<td><strong>Please state the actions you have taken or are planning to take:</strong></td>
<td>The PIC has written to family, school and MDT members requesting attendance at a review for each child to ensure their input into the personal plan prioritising goals and supports for each child.</td>
</tr>
<tr>
<td><strong>Proposed Timescale:</strong></td>
<td>13/03/2015</td>
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<tr>
<td><strong>Theme:</strong></td>
<td>Effective Services</td>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans were not reviewed annually or more frequently if there was a change in need.

**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:**
The PIC will ensure that personal plans will be reviewed annually or as required to reflect changes in need and circumstances of each child attending the Service.

**Proposed Timescale:** 28/02/2015

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Children, as appropriate or their families were not included in personal plan reviews.

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

**Please state the actions you have taken or are planning to take:**
The PIC has written to the child and their family requesting their attendance at a review, in order that they are involved in developing the personal plan which will outline priority goals and supports for the child.

**Proposed Timescale:** 13/03/2015

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews did not take account of the effectiveness of the current plan, changes in circumstances or new developments for the child.

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

**Please state the actions you have taken or are planning to take:**
The PIC will ensure that the current personal plan is reviewed comprehensively annually, or more frequently if necessary and that consideration is given to any change in circumstances and new developments.

**Proposed Timescale:** 13/03/2015  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
Personal plan reviews were not recorded to include proposed changes to plan, the rationale for the change or the names of those responsible for pursuing the objectives in the plan within agreed timescales.

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

**Please state the actions you have taken or are planning to take:**  
The PIC will ensure that all recommendations made at the review will be recorded, will include any proposed changes to the personal plan, the rationale for such proposed changes, the names of those responsible and the time frame.

**Proposed Timescale:** 13/03/2015  
**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
The personal plan did not outline the supports required to maximise the child's personal development.

**Action Required:**  
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident’s personal development in accordance with his or her wishes.

**Please state the actions you have taken or are planning to take:**  
The PIC will ensure that the recommendations from the planned reviews will be documented in the child’s personal plan, and will include the supports required to maximise the child’s personal development in accordance with his/her wishes.
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<td><strong>Theme:</strong> Effective Services</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were no transition plans in place for young people preparing to leave the service.

**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:**
The PIC will ensure that the transition plans will be discussed in detail at the review with the child/family/MDT in order to identify supports needed for any child preparing to leave the Service. The PIC will ensure that the information on the services and supports available will be discussed and documented at the review. The recommendations from the review will be facilitated and supported through the respite Service.

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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There were limited opportunities to prepare for adult life.

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

**Please state the actions you have taken or are planning to take:**
The PIC will ensure that training in life skills required for the new living arrangement will be identified and prioritised at the review, and be documented in the Personal Plan, and carried out and recorded while in the care of the respite service.

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**Outcome 07: Health and Safety and Risk Management**

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The draft risk management policy did not identify hazards and did not include an
assessment of risks.

**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:**
Training was provided on risk management for NWPF personnel on 14/11/14. A working group was set up and met on the 21/01/15. Terms of reference were agreed, the first being to review the risk management policy which is now completed. This policy now includes hazard identification and guidance on assessment of risks. The second meeting of this group was held on the 4/02/15 to populate the risk register. The registered provider will ensure that this policy is made available to the PIC. The PIC will ensure that this policy will be included on the agenda for staff meetings and the importance of its implementation re-enforced to all staff.

**Proposed Timescale:** 17/02/2015

**Theme:** Effective Services

The registered provider is failing to comply with a regulatory requirement in the following respect:
The draft risk management policy did not detail measures and actions in place to control risks identified.

**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:**
The registered provider has ensured that the risk management policy states the measures and actions in place necessary to control the risks identified outlined in roles and responsibilities within the policy. The registered provider will ensure that this policy is made available to the PIC. The PIC will ensure that this policy will be included on the agenda for staff meetings and the importance of its implementation re-enforced to all staff.

**Proposed Timescale:** 17/02/2015

**Theme:** Effective Services

The registered provider is failing to comply with a regulatory requirement in the following respect:
The draft risk management policy did not include the measures and actions in place to control the risk of accidental injury to residents, visitors or staff.
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<tr>
<th>Action Required:</th>
<th>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.</th>
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<tbody>
<tr>
<td>Please state the actions you have taken or are planning to take:</td>
<td>The registered provider has ensured that the risk management and emergency planning policy now includes the measures and actions in place to control accidental injury to residents/visitors/staff. The registered provider will ensure that this policy is made available to the PIC. The PIC will ensure that this policy will be included on the agenda for staff meetings and the importance of it’s implementation re-enforced to all staff.</td>
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<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
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<td>Please state the actions you have taken or are planning to take:</td>
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<td>Please state the actions you have taken or are planning to take:</td>
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planning policy has included measures and actions in place to control self harm. The registered provider will ensure that this policy is made available to the PIC. The PIC will ensure that this policy will be included on the agenda for staff meetings and the importance of it’s implementation re-enforced to all staff.

**Proposed Timescale:** 17/02/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The draft risk management policy did not include detailed arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

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

**Please state the actions you have taken or are planning to take:**
The registered provider has ensured that the risk management and emergency planning policy and procedure includes detailed arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents. Incidents/adverse events will be monitored and reviewed at the Quality, Safety & Risk Management Committee (QSRM) and the learning from serious incidents/adverse events will be communicated back to staff at staff meetings.

**Proposed Timescale:** 17/02/2015

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
An adequate system had not been implemented for the assessment, management and on-going review of risk, including a system for responding to emergencies.

The temperature in the sink of one bathroom was recorded at 47.1 degrees. This posed a risk of burning or scalding the children in the designated centre.

**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:**
Immediate action plan response:
The necessary valves to allow the water to come out of the hot water cylinder and all the taps have been fitted with temperature controlling mixing valves on 24th November 2014. The cylinder temperature is 60 degrees and the hot water pipe work leaving the cylinder is 50 degrees via the mixing valve heading to all taps. At each tap there is another mixing temperature valve fitted with water temperature at 41 degrees at tap outlet. Water temperatures will be checked on a regular basis using an accurate thermometer and recorded. The shower at the time of inspection has been decommissioned and a Safeguard Care Pumped Thermostatic Shower is being delivered on Thursday 27th November, 2014 and will be fitted immediately.

Subsequent response: The registered provider will ensure that the Risk Register is repopulated by the established working group. This Risk Register will be circulated to all areas to ensure that all risks in NWPF Services are identified. Risk Assessments will be carried out on all risks identified. The Risk Register will be reviewed on an ongoing basis by the QSRM and will be updated accordingly. The Registered provider will ensure that the updated site specific registrar is circulated to each area. The PIC will ensure that feedback on the Risk register is provided at staff meetings and that any new risks identified in each area are included and managed. The Registered Provider will ensure that the Policy for Emergency Planning for NWPF is available to all staff.

**Proposed Timescale:** 30/04/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The draft risk management policy did not include the measures and actions in place to control the risk of the unexplained absence of a 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:**  
The Registered Provider has ensured that the policy on Risk Management and Emergency Planning now includes measures and actions in place to control the risk of the unexplained absence of a resident.

**Proposed Timescale:** 17/02/2015  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
Measures and procedures consistent with the standards for the prevention and control of infection had not been adopted in 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:
The Registered Provider will ensure that the colour coded system for the centres mops will now include a code for bedrooms and other living areas, that adequate storage will be in place for storage of mops and buckets and that a system will be in place for the changing of mop heads. The registered provider will ensure that cleaning schedules will be developed to guide staff on the procedures for cleaning and what products to use, to include a system for washing soft toys. Alginate bags are available onsite. All PPE required will be provided. The Registered Provider will request that all staff receive necessary vaccines.

Proposed Timescale: 28/02/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre did not have adequate arrangements in place for testing fire equipment.

Action Required:
Under Regulation 28 (2) (b)(ii) you are required to: Make adequate arrangements for reviewing fire precautions.

Please state the actions you have taken or are planning to take:
Daily and weekly checks are carried out and logged. The fire alarm is sounded and recorded on a weekly basis by an appointed staff. Fire equipment is serviced and tested quarterly by the certified company and logged. The PIC will monitor the effectiveness of all of the above arrangements. All staff have been made aware by the PIC of the need for fire checks.

Proposed Timescale: 28/02/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Adequate arrangements for the evacuation of all children in the designated centre were not in place.
**Action Required:**
Under Regulation 28 (3) (d) you are required to: Make adequate arrangements for evacuating all persons in the designated centre and bringing them to safe locations.

**Please state the actions you have taken or are planning to take:**
All children have a personal emergency egress plan outlining the procedure specific to each child. The registered provider has directed the PIC or a staff member nominated by the PIC to put a plan in place to ensure that all children can be safely evacuated, and that all staff working in the respite Service will partake in the evacuation process for all children attending the respite service. Children and Staff will be named on the Fire evacuation report. This plan will be in place in the Respite Service and the PIC will ensure compliance with same. Fire drills will be scheduled quarterly to involve evacuation of all children thereafter, the PIC will ensure that the plan is communicated verbally and in written format to all staff working in the respite Service.

**Proposed Timescale:** 28/02/2015
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had received training in fire prevention and emergency procedures.

Fire wardens had not received appropriate training for the role.

**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:**
11 staff completed fire warden training on 21/01/15. The remaining staff are scheduled for Fire Warden training on the 23/02/15. All staff have received training in fire training and emergency procedures.

**Proposed Timescale:** 23/02/2015
**Theme:** Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Fire drills were not completed at regular intervals to ensure all staff and children were aware of procedures to be followed in the case of fire.

**Action Required:**
Under Regulation 28 (4) (b) you are required to: Ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, as far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.

**Please state the actions you have taken or are planning to take:**
The Registered Provider will ensure that all staff are aware of procedures to be followed in the event of fire, have been trained and that fire drills are carried out at regular intervals and logged, to include all children/staff in the respite Service.

**Proposed Timescale:** 28/02/2015

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**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:**
The draft behaviour support and use of restrictive practice policy did not provide sufficient guidance to staff on managing behaviour that challenges. There were no behaviour support plans in place.

**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:**
The Positive Behaviour Support and Restrictive Practice Policy and procedure is ready to be signed off at QSRM on the 17/02/15. The Registered Provider has sourced training which will be provided by an external consultant to NWPF staff on the 2nd, 3rd & 4th March 2015 on Positive Behaviour Support. A further days training has been scheduled in April to give staff the skills in developing the positive behaviour support plans, and to give staff knowledge and skills in de-escalation techniques. The training will inform and provide guidance to staff to respond to Behaviour that that is challenging and to support children to manage their behaviours. The PIC will ensure that each child requiring a Positive Behaviour Support plan will have one developed following training in March/April to be completed by 30 April 2015.

**Proposed Timescale:** 30/04/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff were not trained in the behaviour support model outlined in the draft behaviour support and use of restrictive practice policy.
**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:**
7 staff have now completed Studio III training. A schedule of training has been provided to the Service from the HSE for Studio III to the year end and remaining staff will be scheduled to partake in this training. The PIC will ensure that until all staff have completed Studio III training, there will always be one staff on duty who has completed Studio III, dependant on the needs of the children.

**Proposed Timescale:** 30/06/2015
**Theme:** Safe Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some restrictive practices used in the centre were not viewed by the team as restrictive practices and therefore procedures were not applied in accordance with national policy and evidenced based practice.

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

**Please state the actions you have taken or are planning to take:**
The Positive Behaviour Support and Restrictive Practice Policy and procedure is ready to be signed off at QSRM on the 17/02/15. The training on Positive Behaviour Support scheduled for March/April and Studio III training will guide and inform staff in relation to the use of restrictive practices to ensure compliance with National Policy. Restrictive Practices will be on the agenda for all Staff Meetings ensuring that all staff are clear on what is appropriate and what is not.

**Proposed Timescale:** 30/06/2015
**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no evidence in the files reviewed that alternative measures of intervention or the least restrictive measure for the shortest duration had been considered.

No audits had been completed on the use of restrictive practices and therefore attempts to identify and alleviate the causes of the residents challenging behaviour were not clear.
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:
Every effort will be made to identify and alleviate the cause of a child’s behaviour. All alternative measures will be considered before restrictive procedures are used and enabling plans, where required will be developed in consultation with the residents Multidisciplinary team and family to be discussed at the review meetings. The PIC will ensure that audits are carried out in order to attempt to identify and alleviate the causes of the child's challenging behaviour. Any restrictive practice being considered will be agreed and signed off by the MDT and the PIC will ensure all that all staff are made aware of the outcome of the reviews. Recommendations will be documented in the child's positive behaviour support plan.

Proposed Timescale: 31/03/2015
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Children in the centre were not assisted and supported to develop knowledge, self-awareness, understanding and skills needed for self-care and protection.

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:
The Registered Provider shall ensure that the child’s assessed needs and personal plan includes goals and supports to enable the child to develop the knowledge, self-awareness understanding and skills needed for self-care and protection appropriate to the needs of the individual child, to include intimate care plans, communication systems, a keyworker and individual risk management plans.

Proposed Timescale: 13/03/2015
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The centre had a draft ‘safeguarding children’s policy’. This policy did not provide sufficient guidance to protect residents from all forms of abuse.
The financial management of the children's pocket money was audited on an infrequent
**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:**
The draft “safeguarding children’s policy” will be completed and distributed to all staff giving guidance relating to all the different forms of abuse. This Policy will give clear guidance to the roles & responsibilities of the Designated Liaison Person (DLP) Specific training for DLP’s will be provided by Tusla. The financial management of the children’s pocket money is now audited on a weekly basis.

**Proposed Timescale:** 31/03/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Safeguarding measures in relation to the provision of personal intimate care were not adequate. The centre did not have intimate care plans in place for the children.

**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:**
Intimate care plans are now in place for all children and will be monitored by the PIC

**Proposed Timescale:** 28/02/2015

**Theme:** Safe Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Not all staff members were trained in child protection and safeguarding residents, including the prevention, detection and response to abuse.

**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:**
Training continues to be sourced through the Tusla in Children First . The PIC will ensure that all staff have received training by the end of February 2015. The remaining
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff and the designated liaison person had not received training in relevant government 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 training is line with Children First 2011, delivered by Tusla. 3 staff awaiting training which is scheduled for 27th February 2015. The Registered provider contacted Tusla on the 21/11/14 regarding training for the designated liaison person. Tusla have advised that the HSE is currently developing a training strategy for Children First training for HSE staff and HSE contracted Services which will include the identification of training for DLP's NWPF are included on the Tusla log and we will be contacted with a timeframe for the role-out of the training.

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**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 medication management policy did not provide sufficient guidance for staff on routine prescribing. Practice was not in keeping with the policy as all medication was not returned to the families when children were discharged. Prescription sheets were not in line with best practice, with as required medication prescribed under the routine medication section.

**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:**
Medication management policy was reviewed in April 2014. The PIC will ensure that the
policy is reviewed again to include guidance for staff on routine prescribing. Practices will be reviewed to ensure compliance with policy. The PIC/Nurse on duty will continue to engage with GP's to ensure that kardex's are completed in line with best practice. Families have been contacted to inform them that medication will be returned to them on discharge of their child from respite, and this practice has been implemented.

Proposed Timescale: 31/03/2015

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 organisation had a draft statement of purpose which did not contain all the information as set out in Schedule 1 of the regulations. Staff had not been developed to accommodate the broad admissions criteria identified in the statement

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:
The Statement of purpose will be reviewed and revised to reflect the current needs of the children attending and will include information in relation to new admissions to the Service. The registered provider will ensure that staff will continue to receive training based on the needs of the Service Users.

Proposed Timescale: 31/03/2013

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose while reviewed in November 2014 remained a draft document.

Action Required:
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.

Please state the actions you have taken or are planning to take:
The Statement of Purpose will be finalised and made available to families.
### Proposed Timescale: 31/03/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no evidence to suggest that the statement of purpose had been made available to the residents and their representatives.

**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:**
When finalised, the Statement of Purpose will be made available to residents and their families, and will be on display in the Centre.

### Proposed Timescale: 31/03/2015

### 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:**
There was no annual review of the safety and quality of the care and support provided in the centre.

**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:**
The Registered Provider has prepared an annual review based on audits, staff meetings, observations, meeting with families and staff suggestions covering the period from February 2014 to February 2015.

### Proposed Timescale: 12/02/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no six monthly review of the safety and quality of care and support provided within 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:**
A six monthly review of the safety and quality of care and support provided within the centre has been completed 22/01/15.

**Proposed Timescale:** 22/01/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no effective arrangements in place to support, develop and performance manage all members of staff to exercise their professional responsibility for the quality and safety of the services they delivered.

**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:**
The Registered Provider will ensure the training needs analysis reflects the training needs of all staff to meet the needs of the Service Users. Policies and Procedures will effectively guide staff and inform good practice. Formal staff supervision will be implemented to facilitate staff to discuss performance and any concerns. Staff appraisals will be completed by the PIC by March 2015.

**Proposed Timescale:** 31/03/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Arrangements were not in place to facilitate staff to raise concerns about the quality and safety of care.

**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:
A Protected Disclosures of Information policy is in operation since April 2011, this policy has been reviewed and will be signed off at QSRM on 17/02/15. The Registered Provider will ensure that this policy is distributed to each area and the PIC will ensure that this Policy is on the Agenda for staff meetings.

Proposed Timescale: 17/02/2015
Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The allocation of nurses to the centre appeared to be historic and was not necessarily a good use of resources.

There was no effective risk management system in place and quality assurance systems were at an early stage of development.

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

Please state the actions you have taken or are planning to take:
The Registered Provider will ensure that the reviewed risk management policy will be in compliance with regulation 26 (1). The PIC and the Senior Staff Nurse have received training in Risk Management on the 14/11/14, are involved in a working group across the Services on Risk Management and population of a risk register, which will include risks in relation to staffing levels.
An annual audit plan will be developed to standardise audits presently in operation. PQASSO Quality Assurance System is progressing well for the organisation. This covers planning, governance, leadership & management, user centred services, managing people, learning & development, managing money, managing resources, communications and promotions, working with others and monitoring and evaluation. 8 areas are completed and it is hoped to apply for accreditation by year end.
The QSRM meets every 6-8 weeks whose role includes
Overseeing the development, implementation, monitoring and review of the annual Quality Improvement Plan for Quality, Safety and Risk Management (QSRM).
Compiling, reviewing and updating the risk register.
Compiling, reviewing and updating the safety statement.
Developing an audit plan for the service.
Reviewing results of clinical audits.
Reviewing results of safety audits.
Reviewing incidents, identifying trends and identifying areas of risk and areas for improvement.
Reviewing complaints, identifying trends and identifying areas for improvement.
Providing guidance to staff on implementing effective safe systems of working.
Monitoring compliance with National Standards and Regulations (Health
Identifying and responding to policy gaps.
Ensure that an infection prevention and control programme is in place and infection risks are managed.
Reviewing results of environmental hygiene and hand hygiene audits.
Ensuring the Protected Disclosure of Information Policy is adhered to.

**Proposed Timescale:** 31/03/2015

### Outcome 17: Workforce

#### Theme: Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Fourteen staff worked in the centre on a part time or as required basis.

**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:**
A keyworker system is in place where each child has a keyworker to co-ordinate the implementation of the child’s care plan and to consult with family on a regular basis.

The Registered Provider will ensure that a core group of staff with the necessary skills will be assigned to the respite service in so far as is reasonably possible. Rosters will be kept under review.

**Proposed Timescale:** 31/03/2015

#### Theme: Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Staff records did not contain all of the information as required in schedule 2 of the regulations.

**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:**
Staff files have been reviewed and all the information and documents as specified in schedule 2 are now in place.
Proposed Timescale: 06/03/2015
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff did not have access to appropriate training as part of their continuous 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:
A formal training needs analysis is in place and is available at the registered providers head office. Training is provided on a continuous basis as the needs are identified. One new member of staff on the day of inspection was not trained in manual handling, this training has been scheduled for the 10/02/15. Refresher training is provided for all mandatory training.

Other training undertaken by staff includes
- Preparation for HIQA
- Medication Management
- Health & Safety Awareness Training
- Instruction in the use of the hydraulic lift
- Positive Behaviour Support Planning
- Risk Management Training
- Administration of Buccal Midazolam by Care Assistants.

Additional Training needs highlighted through appraisals/staff supervision/ staff meetings will be provided where appropriate and contingent on resources.

The PIC continuously monitors the training calendar, together with the Registered Provider and scheduling of training is ongoing.

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Proposed Timescale: 28/02/2015
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Formal staff supervision was not taking place.

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:
A Policy on Supervision is now in draft form. Training will be sourced for designated staff who will be involved in Staff Supervision. Following this, a plan for staff supervision will be implemented and monitored.

**Proposed Timescale:** 30/06/2015