

**Health Information and Quality Authority
Regulation Directorate**

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

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| Centre name: | A designated centre for people with disabilities operated by Praxis Care |
| Centre ID: | OSV-0001913 |
| Centre county: | Meath |
| Type of centre: | Health Act 2004 Section 39 Assistance |
| Registered provider: | Praxis Care |
| Provider Nominee: | Irene Sloan Ringland |
| Lead inspector: | Eva Boyle |
| Support inspector(s): | Orla Murphy |
| Type of inspection | Announced |
| Number of residents on the date of inspection: | 2 |
| 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 inform a registration decision. This monitoring inspection was announced and took place over 2 day(s).

The inspection took place over the following dates and times

From: To:
01 December 2014 09:00 02 December 2014 18:30

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

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| Outcome 01: Residents Rights, Dignity and Consultation |
| Outcome 02: Communication |
| Outcome 03: Family and personal relationships and links with the community |
| Outcome 04: Admissions and Contract for the Provision of Services |
| Outcome 05: Social Care Needs |
| Outcome 06: Safe and suitable premises |
| Outcome 07: Health and Safety and Risk Management |
| Outcome 08: Safeguarding and Safety |
| Outcome 09: Notification of Incidents |
| Outcome 10. General Welfare and Development |
| Outcome 11. Healthcare Needs |
| Outcome 12. Medication Management |
| Outcome 13: Statement of Purpose |
| Outcome 14: Governance and Management |
| Outcome 15: Absence of the person in charge |
| Outcome 16: Use of Resources |
| Outcome 17: Workforce |
| Outcome 18: Records and documentation |

Summary of findings from this inspection

This was an 18 outcome inspection, carried out for the purpose of registration. It was the first inspection of the centre and as part of the process inspectors reviewed policies, records, spoke to the young people, members of the staff and management team and observed the delivery of the service. However, no questionnaires were returned from family members. The centre was located in a large dormer bungalow in the countryside outside of a town in Co. Meath. The centre provided a comfortable home for the young people and their visitors. One child and a young person who was 18 years of age resided in the centre. A placement in an adult centre had been identified for the 18 year old but there was no definite timescale in place for a transition to occur.

The service was provided by Praxis Care who had applied to register the centre as a designated centre for five children up to 18 years of age. The provider was a registered charity with its own Board. Inspectors found that the Board did not receive regular updates on the performance of the centre and it was difficult to ascertain how they were assured about the safety and quality of the care and support being provided to the residents of the centre.

Risk management processes were not robust. There were serious safety issues in the designated centre and inspectors identified three significant risks to the young people:

- all of the young people's needs were not being met
- there were times when one young person was not adequately safeguarded
- water temperatures were measured at 50 degrees Celsius which posed a risk of potentially burning a young person.

The Authority took the unusual step of issuing an immediate action plan and stated that no further admissions were to occur until such time as the Authority were adequately assured about the ability of the centre to safeguard the current residents and meet their needs. The provider took steps to address the issues and responded within the agreed timescale. Further admissions remain on hold until a follow-up inspection had occurred and safe systems are in place to meet the needs of the residents.

Staff members provided warm, respectful care to the young people. The centre was a homely and domestic environment and the young people had opportunities to be involved in the day to day running of the centre and to be involved in the community. The staff team was a relatively new team and at times they were challenged to manage the young people. There was some poor practice in the way some behavioural episodes were managed which impinged on the young people's rights.

These and other deficits are outlined in this report and in the action plan submitted by the provider.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 01: Residents Rights, Dignity and Consultation

Residents are consulted with and participate in decisions about their care and about the organisation of the centre. Residents have access to advocacy services and information about their rights. Each resident's privacy and dignity is respected. Each resident is enabled to exercise choice and control over his/her life in accordance with his/her preferences and to maximise his/her independence. The complaints of each resident, his/her family, advocate or representative, and visitors are listened to and acted upon and there is an effective appeals procedure.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Staff treated the young people with respect and promoted their dignity, although some practices impinged upon their right to information and free movement within the centre. Inspectors observed staff speaking kindly and warmly to the young people. Staff were also observed supervising the young people from a distance, respecting their dignity, safety and also his/her wish to be alone. Young people were able to exercise some choices which were recorded in the notes of the young people's meetings and in their files. Changes were made as a result of suggestions made by young people. However, there were issues discussed at residents meetings which were private and personal to individual young people. While information was provided to young people about their rights it was not user friendly, and there was no access to independent advocates. The operation of the complaints process was not in line with the complaints policy.

Young people were not aware of all of their rights. Inspectors found that there was information available and on display in the centre about children's rights. However, the information was not user friendly. Young people told inspectors that they would speak to the manager of the centre or staff if they needed something but that they were not aware of their rights. Therefore, there was the possibility that young people in the centre may not be aware of their right to express their views and have them considered by staff. No young people had access to independent advocates. But there was evidence on daily logs that staff advocated on behalf of young people for services such as educational training courses. Access to independent advocates may have facilitated young people's wishes to be further asserted.

Staff members treated residents with dignity and respect. Personal care practices used

by staff were respectful and encouraged the dignity and privacy of young people. Staff members were observed calling out to young people and knocking prior to entering their rooms. Arrangements were in place for young people to have private contact with their family members. Both young people had private access to the centre's telephone to contact family members, and one young person contacted friends by telephone.

There was a good level of consultation with children but the organisation's service user's strategy 2012-2015 had not been fully implemented. The strategy document outlined five different ways that young people would be facilitated to be consulted about their care, which included their participation in service user meetings, service user surveys and participation in care planning meetings. Inspectors found that young people had participated in service users meetings with staff, the development of their personals plans and in meetings in regard to their care plans. However, the young people had not completed service user's surveys.

There was regular consultation with young people on the operation of the centre. The meeting agenda included visits with family members, school, menus, chores, house rules and any other business. Inspectors saw that suggestions made by young people about the menu and activities n the centre were implemented by staff. The young people also drew up the rules of the centre at this meeting. However, some issues discussed at resident's meetings were personal to the young people and were not appropriate for general discussion, for example, training placements and specific arrangements for visits with family members. Discussion on these issues on occasions led to verbal disputes between the young people. This observation was raised with staff, and the manager acknowledged that there had been some conflict between the young people during these meetings.

Young people were facilitated to make choices. Young people told inspectors that they had choices in the films that they went to see, the food they ate and also the clothes they wore. Inspectors observed staff giving a young person the choice of whether they wanted to bake as part of their routine for the day. Resident's were given the choice about whether they wished to attend religious services or not, and this was recorded in personal plans.

Complaints were not well managed. The centre had a complaints policy which was displayed on the notice board in the hall. The complaints officer for the organisation was the director of care. However, neither the young people nor the staff were familiar with this person. The policy outlined that the manager at a local level could resolve some complaints. It also outlined that there were three main stages to complaints and referenced both verbal and written complaints in the first stage of their complaints process. The service had an internal appeals process, and also included that an appeal could be made to the Health Service Executive. No complaints were recorded in the centre's complaints log. However, one young person told inspectors that they had a number of complaints in relation to their experience of living in the centre. Inspectors also found that the young person had talked to staff about their complaints, and they were recorded in their daily log. However, the manager or staff team had not recorded or managed the young person's issues as a complaint, which was not in line with the organisation's policy. Therefore, not all complaints that young people raised were acknowledged or managed as a complaint, recorded, reviewed or analysed.

Opportunities to empower young people by listening to their complaints and making changes as a result of those complaints had been missed as a result of not complying with the policy.

Not all young people had similar opportunities to their peers. One young person was not involved in a full time training programme, so did not have the opportunity to mix with his/her peers on a daily basis. This young person told inspectors that they did not have a personal mobile phone. Staff told inspectors that it was not something that had come up for the resident previously and that they would follow up on this. The lack of these opportunities meant that the young person did not have the same opportunities as their peers to develop their social skills on a daily basis with people of their own age.

Young people retained control over their own possessions. However, the arrangements to support young people with their money was not clear. There was a policy on personal property of young people. Young people had appropriate safe storage space in their rooms, some of which could be locked in order to safeguard their personal property. Young people got pocket money on a weekly basis and one young person used their pocket money to purchase personal items as they wished. The second young person had control of their bank account, and their training allowance was paid into this. The management of young people's monies and their ability to do this was referenced in their personal plans. However, the programme of work that was to be undertaken by staff to support young people to manage their money was not clearly outlined in the goals of young people. A staff member told inspectors that they planned to complete work with a young person about the value of money and developing the young person's awareness about the value of specific euro notes, but this was not reflected in the young persons plan. It was also unclear what work was specifically planned in this area for the other young person. This meant that other members of the staff team did not have a record of planned or actual work undertaken with the young person around this issue.

Young people had opportunities to play and participate in their interests and hobbies. Inspectors observed one resident playing football in the grounds of the centre with a staff member. While another resident had an interest in music and had access to CDs. Both young people were facilitated to do their own laundry with assistance from staff, and this was referenced in their personal plans.

Judgment:

Non Compliant - Moderate

Outcome 02: Communication

Residents are able to communicate at all times. Effective and supportive interventions are provided to residents if required to ensure their communication needs are met.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Young people in the centre had the ability to communicate effectively. None of the young people required the use of assistive technology in their communication.

Staff were aware of the communication needs of the young people. Each of the young people's communication needs were incorporated into their personal plan. For example, in the young person's version of their personal plan, simple English and pictures were used to assist them in following their plans. Pictures were also in place throughout the house to assist young people in their understanding of procedures such as evacuating the house in the event of a fire. Inspectors observed staff members using simple language in their communication with young people, and observed young people questioning the staff on the information provided. This was an effective process for ensuring that young people understood what was being communicated to them. However, the young people did not have a specific communication passport so not all staff members may be aware of the most effective way to communicate with the young people.

Young people had access to radio, television, music systems, limited internet use and telephone. One young person told inspectors that a staff member supervised their use of the internet. The two young people had varying levels of involvement in the local community. Due to this, they had some access to information about the local area and ongoing events through their football club and by their attendance at a local youth club. The staff team and management team had a good knowledge of the local community and had linked the young people in with local organisations, as neither of the young people were originally from the immediate area.

It was unclear how the staff team would meet the potential communication needs of future residents. The centre's statement of purpose outlined that it would provide services to children with a profile of learning disabilities and also referenced acquired brain injury. However, the statement of purpose did not outline what communication needs that the service was in a position to provide.

Judgment:

Compliant

Outcome 03: Family and personal relationships and links with the community

Residents are supported to develop and maintain personal relationships and links with the wider community. Families are encouraged to get involved in the lives of residents.

Theme:

Individualised Supports and Care

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Young people were supported to maintain relationships with family members, and had involvement in activities in the local community. Family members were updated on the resident's progress regularly by staff. Staff encouraged young people to develop and maintain friendships. However, friends of the residents did not visit the centre.

Staff members supported family relationships and there was good quality, frequent contact between the staff and family members. The young people were facilitated to have regular visits with their family which helped maintain important attachments. One young person had overnight and day visits with their family. Another young person's family and family pet visited the centre on a weekly basis and staff supported this visit to take place privately. Both young person told inspectors that they would like more contact with their families. Inspectors reviewed the individual records of young people and found that staff had advocated on behalf of the young people for more visits or visits in different locations with family members. For example, one young person wished to have a visit with their family in Skerries and this was facilitated by staff.

Staff had regular contact with family members and kept them up to date. Inspectors reviewed young people's files and found that there was regular contact such as meeting family members after family visits to formal meetings such as care planning meetings as well as regular telephone contact where staff gave updates on the young people. However, family members had not been given copies of young people's personal plans.

Staff were supportive of the young people developing and maintaining personal relationships, but no friends visited the centre. Both children had attended a local youth club, where they met peers of their own age group. One of the young people had recently attended a friend's birthday party. While the second young person, attended a youth club for young people with disabilities within the local community, and also visited another residential centre, where the resident identified that they had friends. While no friends visited the centre, the manager told inspectors that they would be open to facilitating visits from friends where appropriate.

Judgment:

Non Compliant - Minor

Outcome 04: Admissions and Contract for the Provision of Services

Admission and discharge to the residential service is timely. Each resident has an agreed written contract which deals with the support, care and welfare of the resident and includes details of the services to be provided for that resident.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Admissions processes were not robust. Both residents admissions were emergency admissions, and the criteria for emergency admissions were not outlined in the statement of purpose. Contracts for the provision of care for young people were in place, but the details of charges was not outlined and specific services provided were not fully described.

The admission system was not comprehensive and the mix of residents at the centre was unsafe at times. The centre had an admissions policy, and the statement of purpose outlined the admissions process in broad terms. The admission process did not consider the wishes, needs and safety of the young people in the house. New referrals were discussed by an admissions panel which was made up of the management of the Child and Family Agency, the manager and assistant director of Praxis Care, and the social worker with responsibility for the child. Following the admissions panel meeting the relevant multi-disciplinary team meet to assess the collective risks associated with the current residents and the potential new admission. This group report back to the admissions panel who make the final decision.

Inspectors found that this process was not always followed. The first admission to the centre took place in April 2014 and was an emergency admission. However, the risk assessment for this admission was dated November 2014. The second admission, went through a process that was in line with the admission process. However, the collective risk assessment completed was not sufficiently detailed, to provide a comprehensive overview into the risks and how they precisely impacted on both young people. It was therefore not apparent that the staff team had an overview of all of the risks associated with both young people and this had impacted on the level of care that was provided to the young people on a number of occasions.

Both young people had complex profiles. Incident reports and minutes of team meetings outlined there had been an escalation in significant incidents in the centre since the second resident was admitted. Despite the documented concerns of the manager and staff team, there was a proposal to admit a third young person to the centre. The multi-disciplinary collective risk assessment meeting for the proposed new admission was scheduled for the day prior to the proposed date of a third young person moving into the centre. No information was given to inspectors about a further meeting of the admissions panel whose purpose was to review the risk assessment and make a decision if the third child was appropriate to be admitted to the centre. Inspectors were concerned about the assessment of the current needs of the young people, and how a further admission with complex needs would impact on the current young people and issued a directive for no further admissions.

Contracts for the provision of care were completed within one month of admission. The young people's contracts were signed by the young people and the placing agency, but the manager had only signed one of them. However, the contract did not provide a sufficient description of the specific services provided to young people or details of any charges. In addition the wording of the contract was legalistic and not user friendly and was difficult for the young people to understand. This meant that the young people, or

their families did not have sufficient information about the service to be provided.

Judgment:
Non Compliant - Major

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:
Not all young people's needs were sufficiently assessed and arrangements were not in place to meet all of the needs of each resident. The translation of the personal plan into 'my support plan' needed further work to ensure that the 'my support plan' consistently reflected the main actions of the personal plan. The input of family members and the full multi-disciplinary team was not evident in personal plans. Some goals were in place, and these goals were regularly reviewed by staff. Reviews of personal plans had taken place.

Not all young people's needs were identified and comprehensively assessed. The manager used a combined assessment and planning document to undertake the assessment. Young people's needs were assessed around seven outcomes including improved health, improved quality of life, making a positive contribution, exercise of choice and control, freedom from discrimination or harassment, economic wellbeing, personal dignity and personal needs but not all needs were identified. However, for one young person there was no assessment of their mental health incorporated into the assessment. In addition, the area of friendships, adulthood or adjustment to living away from family was not assessed in the section on emotional and behavioural development, yet these were significant needs that the young people had. The manager told inspectors that the young people's social workers and families were consulted when assessing young people's needs. The absence of comprehensive, updated assessments meant that all of the young people's needs had not been assessed to inform their personal plan and ensure all of their needs were met. The lack of a comprehensive assessment also impacted on the staff teams ability to meet the needs of both children on a consistent basis.

As a result, personal plans were not comprehensive and were not informed by a multi-

disciplinary approach. The manager, staff of the centre, young people and their social workers were directly involved in drawing up their personal plans but no other professionals were involved. Elements of the statutory care of one young person was incorporated into their personal plan in areas such as training and family contact, this was positive as it illustrated consistency in the provision of care in these areas.

The personal plan template was good but the quality of information within the plan was insufficient to maximise the young person's personal development or provide information on how to support the young person and deliver the required care. The template of the assessment and planning document had sections for the young person's needs, risks involved, and the specific supports required to meet these needs, desired outcomes and a time frame. However, the specific risks, supports required and identified actions were not always appropriately described. Both young people's personal plans were examined by inspectors and found to have insufficient detail. For example, in relation to medication management needs for one young person there was a risk identified of the young person not swallowing their medication. The identified desired outcome was that the young person's prescribed medication would be reduced during the following month. However, it was not clear of the medical input that guided the desired outcome or time frame.

Each young person had a young persons version of their personal plan, which was called' my support plan'. This plan used a combination of photographs and text, but the quality of these varied. Three goals were identified for each of the young people. However, inspectors found that the level of clarity for each of these goals varied which meant that young people may not understand each step of the prescribed goal and how they would achieve it. In one young person's 'my support plan' there was a section 'finance'. However, this section had not outlined whether the young person could manage their money themselves, and what specific work would be completed with the young person in relation to their money. In the other young person's plan, the goals and the language used were more adapted to the ability of the young person but were confined to practical tasks, such as cleaning their bedroom and bathroom and washing clothes. The goals were evaluated monthly and staff evaluated the young person's progress. Inspectors observed one of the young people accessing a copy of their personal plan during the inspection.

The manager told inspectors that copies of personal plans had not been provided to parents/guardians of the young people. Therefore, families may not have been aware of the goals that young people were working on.

Personal plans had not been reviewed when there was a change in the circumstances of a young person. In one personal plan, it was outlined that the young person would move to an adult service following their eighteenth birthday and would be discharged from the Child and Family Agency, but there was no review scheduled of the personal plan following the young person's eighteenth birthday.

The planning for young people to transition to other services was poor. A young adult was living in the centre, and there was no definite timescale or transition plan in place for a move to an identified adult placement. The manager outlined that it may occur in March 2015. One positive step that had been put in place was that a temporary team leader had been appointed as keyworker for the young person who would be

transitioning and it was planned that the staff member would move to the adult service along with the young person.

Young people required further support and guidance in life skills to enable them to live as independently as possible. There was a focus on the development of practical skills such as cooking, laundry and cleaning. Young people participated with staff in grocery shopping and shopping for personal items. However, the staff team needed to develop care plans further to ensure that the young people were provided with opportunities to provide life skills and take increasing levels of responsibility in line with their age, ability and stage of development.

Judgment:

Non Compliant - Moderate

Outcome 06: Safe and suitable premises

The location, design and layout of the centre is suitable for its stated purpose and meets residents individual and collective needs in a comfortable and homely way. There is appropriate equipment for use by residents or staff which is maintained in good working order.

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The centre was a spacious dormer bungalow, which was homely and well-maintained and was surrounded by a large garden. None of the young people used assistive equipment, but the centre had sufficient areas for the storage of assistive equipment.

The design and layout of the centre was in line with the statement of purpose and met the needs of the residents. The centre held a disability access certification which was granted by the local authority in November 2010. The centre had been painted in the weeks prior to the inspection. There was suitable heating, lighting and ventilation. The centre had sufficient and comfortable furnishings and fittings. The layout of the kitchen and dining room was open plan, which lead into a large sitting room. There was sufficient space for young people to have private space with visitors. The kitchen was appropriately equipped with cooking facilities. Inspectors observed both young person using the kitchen facilities to prepare food. There were six en-suite bedrooms, five of which were designated as young people's bedrooms. Two of the bedrooms were upstairs, and one of these was used as the staff sleep over room and also served as an office and the other was a young person's bedroom. The young people showed inspectors their rooms which were personalised and had sufficient storage for their personal items. The young people told inspectors that they could personalise their rooms with posters and other personal photographs. There was an adequate number of

toilets and showering facilities in the centre.

There was a large garden area outside the centre which was suitable for children to play in. Inspectors observed one resident playing football with staff. There were high external walls and a gate, which was not closed at all times.

None of the young people who lived in the centre currently required assistive equipment. However, given the statement of purpose, assistive equipment may be required for future residents. The centre was spacious and it would be possible to make storage arrangements for assistive equipment.

Judgment:

Compliant

Outcome 07: Health and Safety and Risk Management

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

Theme:

Effective Services

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

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

The risk management system was not effective and did not lead to all risks being reduced or eliminated. The centre had an organisational health and safety statement with supporting documentation on local hazards and risks. The inspectors observed a number of safety measures which had been put in place such as installation of window restrictors, chemicals being locked away. However, this assessment had not identified a number of other hazards and risks that inspectors identified on the day of inspection including very hot water in the taps and the potential for injury as a result of behaviour that challenged. The temperature in the taps was recorded as 50 degrees. This was higher than accepted norms and posed a risk of burning or scalding the young people. An immediate action plan was issued following the inspection and the provider responded with an appropriate action plan within the agreed timeframe.

There was a number of risk management policies 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 provide sufficient guidance on hazard identification and assessment of risk throughout the designated centre, and how to put measures in place

to control identified risks. The policy referenced relevant policies that related to risk such as safeguarding, admissions and untoward events. The risk management policy did not adequately describe the measures and arrangements in place to control accidental injury to residents, visitors or staff; aggression and violence and self-harm. The policy did not adequately describe the centre's procedure for the arrangements in the event of an unexplained absence of a child.

The centre had a risk register which outlined key risks such as fire, infection, food hygiene, interruption of services such as water, heat and power, slips and trips and aggressive behaviour. The assistant director told inspectors that s/he reviewed the risk register regularly. Team leaders and the manager completed some weekly health and safety checks in relation to the pager, panic alarm and cleaning to ensure that these systems were operating appropriately. While staff had completed risk assessments for individual young people which were not comprehensive they had not received specific training in how to undertake a risk assessment so therefore staff had not received appropriate guidance to complete risk assessments. Inspectors found that not all identified risks were assessed. For example, the risk of a young person assaulting staff in a vehicle was not described in risk assessments yet such an incident had occurred. The responses to some risks were vague, for example, 'maybe two staff' was recommended to accompany a young person when travelling in a vehicle or to appointments. Clear definite guidance is required in order for staff to safely carry out their roles.

Procedures in relation to safe practices in areas such as food safety, manual handling, infection control, cleaning schedules, first aid and disability awareness were provided to staff. Inspectors examined a selection of staff training records and these reflected that staff had undertaken mandatory first aid, food safety, infection control training and manual handling. Additional training had been provided for staff in the control of substances hazardous to health, and there was guidance in the centre in relation to products such as detergents which could be hazardous to young people and staff.

There were adequate precautions in place against the risk of infection. A colour coded cleaning system was used to clean different areas of the house with daily cleaning rotas. Pedal operated bins were located throughout the centre. Signage in regard to hand hygiene practices were displayed at sinks. Hand gels were available within the centre. Personal protective equipment such as gloves were available to staff. There were procedures in place in relation to clinical waste, but no clinical waste was created. There were daily checks in place in relation to temperatures in the fridges and freezers in order to ensure that food was stored and all temperatures recorded were within appropriate limits. There had been no reported incidents of outbreaks of infection.

There were measures in place to prevent or respond to fire. The centre had a serviced alarm (which was sounded during the inspection) and fire equipment and emergency lighting had been serviced in November 2014. A certificate of fire compliance from a suitability qualified professional, dated August 2014 was provided to the Authority as part of the registration process. Regular fire drills had taken place though all had taken place during day time hours. All staff had received fire safety training in the last 12 months. Weekly and monthly fire checks were undertaken in line with good practice but there was no record of a daily check. There were adequate means of escape and fire

exits were unobstructed. Prominently displayed procedures, including child friendly pictures were in place for the safe evacuation of residents and staff in the event of a fire. Each young person had their own comprehensive emergency evacuation plan, along with an 'emergency grab sheet' which outlined key information such as medication details and contact details for next of kin. The manager told inspectors that in the event of an evacuation that staff and young people would evacuate to a local hotel, and this was outlined in the emergency plan.

Judgment:

Non Compliant - Moderate

Outcome 08: Safeguarding and Safety

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

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There were some measures in place to safeguard young people but they were inadequate at times. All staff had been trained in safeguarding and in Children First (2011). However, inspectors found that staff struggled at times to manage the young people's behaviour and keep the young people safe. Restrictive practices were used in the centre.

The safeguarding measures within the centre were insufficient. Some safeguarding measures such as risk assessments on individual children and absence management plans were in place but inspectors found that one young person was not always safe within the centre. A young person told inspectors that they did not feel safe in the centre, and staff also raised similar concerns to inspectors. In addition there were incidences of physical and verbal threats by both young people to each other and staff. Incident reports reviewed by inspectors recorded that staff took some measures to physically protect the young person on these occasions by bringing them to their bedroom and locking themselves and the young person into the room. While this kept the young person safe at the time it impinged on their right to free movement as they were detained in the room for up to five hours on one occasion. No formal safety plan was in place to safeguard the physical and emotional wellbeing of the young person.

Appropriate measures were in place in relation to assisting a young person with their

personal care. The centre had a policy in relation to the provision of intimate care. One young person required some assistance with personal care. The process of prompting a young person when showering was clearly described in the young person's intimate care plan to support staff in relation to guiding the resident's personal care in a safe way.

Staff had been trained in safeguarding and child protection. Inspectors found from speaking to staff that they were aware of the different types of abuse and were clear of the process that they had to follow if they observed or were informed of abuse by a young person. The centre had a policy in place which reflected the Children First: National Guidance for the Protection and Welfare of Children (2011). The manager was the designated liaison person and staff was aware of this. However, the manager had not received any additional training in regard to their role as a designated liaison person but told inspectors of their responsibilities under Children First (2011). No child protection concerns were referred to the Child and Family Agency, but social workers were provided with reports on concerning behavioural incidences and the impact of these on both young people were appropriately reported to the social work teams that were responsible for the young people.

Staff struggled at times to manage the young people. There had been a number of serious behavioural incidences in the centre and staff were challenged to manage some of the incidences. Both young people had exhibited challenging behaviour such as property damage, assaults on staff, verbal and physical threats and threats of self harm. Staff utilised a positive behaviour support model. However, this did not effectively manage the challenging behaviour of the young people. The centre had a policy in relation to positive behaviour support which adequately described the model of behaviour management, the roles and responsibilities of staff and managers. The interventions that should be used to respond to young people and support them safely were outlined. All staff in the centre had received training in the management of violence and aggression which was in line with the policy. There were behaviour support plans in place for both young people at the time of these incidents. However, inspectors found that the young people's behaviour, at times, escalated to an unsafe level in the absence of staff following the plan.

The manager told inspectors that they had recently received training in behaviour support plans and had subsequently revised the plans based on the training. Inspectors reviewed the behaviour supports and found them to be of a good quality but a some aspects could not be realised due to the staffing levels. Individual crisis management plans were also in place, and had been updated by staff recently following specific behavioural incidences.

While reviews of specific behavioural incidents had occurred the full multi-disciplinary team had not been involved. The manager, and assistant director reviewed all specific incidences internally and the young person's social work team had also been met. However, no additional strategies, insight or approaches that may have assisted in the safe management of behaviour in the centre were identified. In the absence of any substantial actions to respond to these incidents and safeguard the young people inspectors were concerned about the significant risk to the young people and issued an immediate action plan following the inspection. The provider responded with the steps that they were taking to safeguard both young people and this included increasing

staffing levels at high risk times.

Restrictive practices were employed in the centre but it was not evident that the least restrictive practice was employed on all occasions. There was a policy on restrictive practices and there were risk assessments in place in relation to the use of restrictive practices for both young people. However, the risk was not always accurately identified as outlined in outcome 07. A log of restrictive practices was in place. Restrictive practices were sanctioned at the young people's care review meeting by the social work team and dates were scheduled for the review of each restrictive practice. The restrictive practices in use were mainly environmental including sharp knives being locked away and physical interventions including being locked in their room. The system for oversight and review of the restrictive practices to ensure it was in line with good practice was absent.

Judgment:

Non Compliant - Moderate

Outcome 09: Notification of Incidents

A record of all incidents occurring in the designated centre is maintained and, where required, notified to the Chief Inspector.

Theme:

Safe Services

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Notifications were made to the Authority as required by the regulations. This included three day notifications. While these had been reviewed by the Authority on receipt inspectors found during the inspection that the person in charge had not provided sufficient information in relation to some of these notifications and the impact of the events on the young people in the centre.

Judgment:

Non Compliant - Moderate

Outcome 10. General Welfare and Development

Resident's opportunities for new experiences, social participation, education, training and employment are facilitated and supported. Continuity of education, training and employment is maintained for residents in transition.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Residents had opportunities for some new experiences, but the level of social participation with peers varied between young people. Staff were proactive in identifying appropriate training programmes for the young people.

Educational achievements were valued in the centre and staff were proactive in supporting young people to attend suitable training programmes. Assessments of young people's educational abilities were available in the young people's files that described the supports they required in a learning environment. This information was used when identifying a suitable training programme for the young people. One young person had recently completed their junior certificate and was enrolled in further educational training where work experience formed part of the programme. The young person told inspectors that they enjoyed their work experience. Staff had identified two potential training programmes for the second young person and had supported the young person in engaging in an interview process for the courses. The young person had commenced a month's trial period where the young person was to attend the programme on a number of occasions. This process was put in place to establish if the programme was a good fit for the young person. However, inspectors observed the young person telling staff that he/she did not want to attend any training programme and staff were encouraging to the young person.

Staff communicated and engaged regularly with the young person's course facilitators and teachers. Staff met with teachers from the educational programmes and participated in meetings which reviewed the young person's educational achievements and discussed suitable onward training programmes. Inspectors observed staff speaking on the telephone with staff from the young people's training programmes in relation to their progress.

Judgment:

Compliant

Outcome 11. Healthcare Needs

Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:

Health and Development

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

Young people were supported on an individual basis to achieve and enjoy good physical health, but this was in the absence of healthcare assessments or plans in place and there were gaps in healthcare information.

Full medical histories of young people and an overall health care assessment were not available for young people. Some medical background information was available but full information in relation to immunisations was not recorded. This gap in information could place the young people at risk if a parent was not contactable. Copies of the young person's medical examinations when they were received into care or a record of a medical examination when they had been admitted was not contained in young people's records. Therefore, staff members did not have the full medical history of both young people which is key information in order to ensure that all of the young person's medical needs were identified and met.

Young people had timely access to their own GPs and hospital services. Both young people had medical cards and these were held on file. The contact details of an out of hours GP service and local hospitals were available to staff. Staff had accessed these services for the young people in order to ensure that their presenting medical needs were assessed and treated. One of the young people was reluctant to attend appointments at a child and adolescent mental health service as the young person did not want to take medication. Staff had rescheduled appointments and continued to encourage him/her to attend. The manager and staff had identified that a referral to a psychologist was required for a young person and that the staff team would benefit from the specialist advise of a psychologist in regard to the management of behaviour in the centre, but this had not been followed up. Therefore not all services had been put in place to meet the needs of one young person in the centre. None of the young people in the centre required nursing care. However, the manager told inspectors that if future admissions had specific medical needs a nurse would be employed.

Healthy living was promoted by the staff team. Young people were encouraged to engage in exercise and healthy eating. A balanced and varied diet was available to young people. Minutes of monthly young person meetings recorded requests for changes to the menu. The menu for the day was displayed prominently on the notice board, and photographs of the meal options were displayed. Inspectors observed fresh and healthy foods in the centre including fruit and vegetables. Young people told inspectors that the food was good and they liked it. The foods that were consumed by young people at each meal and as snacks were recorded on the individual daily logs of young people. The weight of young people was monitored by the staff team to ensure they remained at a healthy weight. However, the young people's weight had not been identified as a concern by staff or their GP so it was unclear why this practice was in place.

Young people were involved in preparing some of their own meals. Inspectors saw one young person baking buns and observed another young person preparing some food for themselves on their return from their work experience. Specific goals in relation to cooking were outlined in the young people's personal plans.

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:

Young people were protected by the policies and procedures in place which supported staff to manage medication effectively. However, management of controlled medication, medication errors and the returns of unused medications were not in line with the policy and this meant that systems were not fully robust. All staff had up to date training in the safe administration of medication.

The centre had a clear organisational policy for the management, prescription and administration of medication which was in line with the requirements of the Regulations. There was a procedure in place for the safekeeping and disposal of medication.

Inspectors found that all medication including controlled medication was stored securely in line with good practice. A medication fridge was available but it did have a lockable facility. There was no medication stored in the fridge and inspectors did not find any medication that should have been.

Prescription sheets were not all completed in line with the centre's policy. All prescription sheets contained the young person's photo, their date of birth, general practitioner (GP's) name, name of medication, dose, route of and time of administration. A GP's signature was in place for each medication including discontinued drugs. However, as required medications (PRN) did not outline the maximum dosage. There was a potential risk as staff had not all the required information in relation to the safe administration of as required medications.

Staff were not consistently following the policy in relation to the administration of medication. Administration sheets outlined the medications which were on the prescription sheet. There was a signature sheet in place but it was not signed by all staff members, so it may not have been possible to ascertain who administered certain medications. A space was available for staff to record if a young person refused a medication or it was withheld for any reason. On occasions, the administration time of one person's medication did not correspond with the prescription sheet, but there was a note on the file regarding an agreement with the young person's GP about timing of the administration of medication but this was not signed off by the GP.

The systems that were in place for the management of controlled drugs were not

sufficient. A controlled drugs register was not correctly maintained in line with good practice. Drugs were counted at the time of administration, but were not counted at the end of each work shift period in line with good practice. Two members of staff did not consistently sign when controlled drugs were used, so staff were not adhering consistently to the procedures of the centre. Inspectors found that there was a discrepancy in the numbers of controlled drugs that were held in the centre, and there was one additional tablet than what was recorded in the register.

Staff were trained in medication administration. All staff had received training in 2013 and 2014 in the safe administration of medication. The policy required that staff were trained every three years and had competency assessments on a yearly basis. Inspectors reviewed a sample of competency assessments, which were completed by the manager and concluded that staff members were competent in the safe administration of medication. There were staff members who had very recently commenced work on the team, and were not administering medication as their competency assessments had not been completed. Inspectors discussed medication management with new staff members who had recently completed the training and found that they had good knowledge of safe administration practices.

Monitoring of medication practices were not robust. Inspectors reviewed monthly medication audits that a team leader had completed between September and November 2014 but these audits had not identified the deficits identified above by inspectors. Neither the centre manager or team leaders had completed any additional training in relation to competency assessments or medication audit.

The management of out of date or unused medication was not in line with the policy. The manager told inspectors that unused or out of date medication was brought by staff to the pharmacy but they did not record these events.

Judgment:

Non Compliant - Moderate

Outcome 13: Statement of Purpose

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

The centre had a statement of purpose. However, the admissions criteria was very broad and was not matched by a skilled and competent staff team with the ability

care for such a range of both developmental and care needs of the children that the admission criteria identified.

The statement of purpose described the care planning process, activities and hobbies that young people could participate in along with local amenities. It also described the arrangements for attendance at religious services, visits with relatives and friends, the ways in which young people could contribute to the day to day running of the service and information on transitioning from the service or termination of the placement.

However, the statement of purpose did not meet the requirements of regulation three 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 provided to meet those needs.

Other omissions included:

- the total staffing compliment
- the organisational structure
- the criteria for emergency admissions
- details of specific therapeutic techniques or their supervision
- the arrangements made for respecting the privacy and dignity of residents

In addition other aspects were not fully described including the arrangements for a child to meet their social worker, the arrangements for dealing with complaints and emergency procedures in the designated centre.

There was no evidence that the statement had been circulated to the young people or their parents/guardians.

Judgment:

Non Compliant - Moderate

Outcome 14: Governance and Management

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

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There was a clearly defined management structure and some systems in place to ensure the centre operated safely but these were not always effective. This included risk

management and quality assurance mechanisms which had not identified the significant risks that this inspection found. Governance arrangements were also unclear as there was minimal reporting to the Board in relation to the quality and support provided to children.

There was a management structure in place with clear lines of authority. However, the accountability arrangements to the Board were less clear. Staff spoken with were clear about their reporting relationship and what they were accountable for. All staff reported to the manager of the centre. The manager reported to the assistant director of care. The manager had been appointed in September 2014 and was establishing her/himself in the position. The assistant director of care reported to the director of care who reported to the CEO. The director of care was responsible for providing oversight and monitoring of all residential services within the Praxis organisation for the Republic of Ireland. Inspectors found that while each of these positions had clear lines of authority the accountability for the service was with the director of care and senior management team. Inspectors viewed minutes of board meetings and found that there was no formal reporting to the Board in relation to the performance of this centre or the quality of care and support provided to the residents. Inspectors met with a member of the senior management team as part of the inspection and found that he/she did not have a good understanding of the issues that had been occurring in the centre over the last number of months nor had they a good understanding of the regulations and the requirements of the provider.

The manager, who was the nominated person in charge (PIC), was suitability qualified but was new to their current role and required further support in developing into the role of centre manager. S/he had a good knowledge of the regulations and statutory responsibilities, but required ongoing support and guidance in order to implement all of the requirements of the Regulations. The manager had good knowledge of the young people living in the centre and had identified that there were areas that required further improvements in areas such as admissions and staffing levels. An internal leadership programme was being completed by the manager in order to further develop their management skills. The centre manager was supervised by an assistant director of services. The centre manager told inspectors that s/he met with the assistant director of services on a regular basis, at least monthly to review the running of the centre.

Inspectors reviewed the notes from three of these supervision meetings, and found that there was discussion the running of the centre and also in relation to specific incidents with young people, there was actions set for both manager and assistant director to follow up on.

There were appropriate deputising arrangements in place for the manager. Team leaders deputised for the manager in his/her absence. Care staff reported to the manager and were clear about the reporting relationships. An on call system was available for team leaders and staff for out of hours cover. Centre managers from the local area operated the on call system on a rota basis. The inspector reviewed the planned on call rota for this. The minutes of 'zone' management meetings recorded that the on call system was reviewed in terms of the number and type of phone calls received.

There were some management systems in place, but these required further

development in order to ensure that the service provided was consistent and effectively managed and monitored. There was good communication between the manager and staff. The manager effectively communicated with centre staff through team meetings, day to day interactions and guidance and follow-up by email. There were monthly team meeting with a standing agenda which included the young people, policy issues, disability standards and regulations, the Authority and staff updates. The centre manager also attended a managers meeting which was held with the assistant director of the service and other centre managers. Standing issues such as staffing, HIQA reports, manager on call rota and finance matters were discussed at this forum. Both meetings were minuted and staff had to follow up on specific actions.

Other management systems in place included policies and procedures which were available to staff through the intranet. These were in place to guide staff but there was no system in place to monitor their implementation. Risk management systems were not robust as they had not identified a number of significant risks within the centre. Inspectors could not identify any financial planning arrangements during the inspection. The centre manager and assistant director of care told inspectors that some preliminary discussion had taken place with the organisations accountant re 2015 budgets but none were in place for 2014. There was no service or operational plan in place for the centre.

While there was some monitoring of the quality and safety of the service this monitoring did not identify all of the deficits in the service. The assistant director of care undertook a monthly visit to the centre to review care files and other documentation including minutes of resident's and team meetings. They also spoke with the residents. The manger received a report subsequent to the visit and was required to implement improvements where deficits were found. While this monitoring had identified issues in relation to the challenging behaviour no significant changes had been identified or implemented and the risks to the young people persisted. Team leaders completed medication audits but as identified in outcome 12 again these did not identify all deficits. There was some oversight of incidents by the manager and assistant director and some actions resulted. However, no annual review of quality and safety of care and support in the centre had been completed in line with Regulation 23 (1)(d) or six monthly unannounced visit had been completed.

There were arrangements in place for staff to exercise their professional accountability if they had concerns about the service. There was a protected disclosure policy in place for staff to raise concerns in relation to the running of the service and staff were aware of this policy.

There was an up to date service level agreement in place for one of the residents with the Health Service Executive (HSE). The resources provided to the service were outlined in the agreement. However, it was only signed by one party.

Judgment:

Non Compliant - Moderate

Outcome 15: Absence of the person in charge

The Chief Inspector is notified of the proposed absence of the person in charge from the designated centre and the arrangements in place for the management of the designated centre during his/her absence.

Theme:

Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were suitable arrangements in place for the management of the designated centre in the absence of the manager who was the person in charge. The manager had not been absent for a period of 28 days.

In the event that the manager was absent, one of two team leaders were responsible for managing the centre and taking on the role of the person in charge. Inspectors spoke with the team leaders and they were aware of their regulatory responsibilities. The manager told inspectors that the team leader would be supported by the manager on call and by the assistant director. The manager was aware of the requirement to inform the Authority if they was going to be absent for 28 days or more.

Judgment:

Compliant

Outcome 16: Use of Resources

The centre is resourced to ensure the effective delivery of care and support in accordance with the Statement of Purpose.

Theme:

Use of Resources

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

The management of existing resources was adequate. While the centre did not have a designated budget there were sufficient financial resources in place to deliver care and support in line with the statement of purpose. However, there were times when workforce planning was poor and the number of staff rostered did not meet the needs of young people. Additional staff members had recently joined the staff team and there were further staff interviews scheduled for December 2014.

The centre did not have a designated annual budget for the running of the centre. Sufficient petty cash was provided over a month period to run the centre and items such

as grocery shopping, motor tax and other incidental expenses were met through petty cash. The manager reviewed and reconciled the accounts at the end of each month and provided a monthly report on expenditure.

The assistant director outlined to inspectors that a meeting had been held with the person in charge, assistant director and an accountant in relation to putting a budget in place for the running of the centre in 2015. An operational plan was in place for the centre

Judgment:

Non Compliant - Moderate

Outcome 17: Workforce

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

Theme:

Responsive Workforce

Outstanding requirement(s) from previous inspection(s):

This was the centre's first inspection by the Authority.

Findings:

There were insufficient staff with the right skills to meet the assessed needs of residents. The staff team consisted of new and relief staff, and the team required time to stabilise and develop their skills as a team. All new staff had completed a comprehensive induction programme and the majority of staff had completed an extensive training programme. Staff received regular good quality supervision.

While the staff team held appropriate qualifications, there were times when there were insufficient numbers of staff with the skills and competencies to meet the needs of the young people. Inspectors found that there were occasions in the recent past where there were insufficient staff rostered to be able to implement all aspects of a young person's behavioural management support plan. Two staff members were rostered to sleepover in the centre each night. The number of staff rostered to work during the day varied, and this was dependent on whether a young person attended their training programme. Additional staff were rostered in on the day as were required. Staff rostered to work during the day varied from 2-3 staff. While the person in charge maintained a planned and actual roster for previous weeks the current roster for the week of the inspection was not up to date with revised staffing arrangements.

A consistent staff team had not been in place for a substantial period of time. New staff had commenced working in the centre in the weeks prior to the inspection and interviews for further staff were scheduled for December 2014. However, 50 per cent of

the staff identified in the statement of purpose were temporary staff including the team leader who had responsibility for covering for the person in charge. These staff had worked in the centre for a number of months but remained on a temporary contract. Additional relief staff from another praxis residential centre were also rostered to work in the centre. This meant that the residents' right to continuity of care and support could not be guaranteed.

Staff files were not complete. There was a recruitment policy in place which was in line with good practice and provided some safeguards for children. Inspectors reviewed a sample of staff files and found that the majority of staff files were in line with Schedule 2 of the regulations. All staff had been vetted by An Garda Síochána and appropriate references were in place. However, inspectors found gaps in two files including the date that an employee commenced employment and a full employment history.

There was a comprehensive system of induction in place for new staff members. New staff members had recently completed an induction programme which included the majority of their mandatory training. Three staff members had only commenced working in the centre in the weeks preceding the inspection. Inspectors spoke with two new members of staff and they outlined that they had been assigned time to read records on the children, shadow colleagues and to familiarise themselves with the centre's procedures. A staff member told staff that the induction was comprehensive and there was a lot of information to take on board. There was a probation process in place which the new staff would be part of.

There was a comprehensive education and training programme available to staff but staff required time to develop their skills in implementing the training. In addition the programme had been developed without a training needs analysis. This meant that the programme did not reflect the training and development needs of the centre as it was not informed by the needs of the young people attending the service. All staff had received mandatory training in the areas of fire safety, child protection and safeguarding, emergency first aid, behavioural support and manual handling. Training was also provided to staff in other areas such as confidentiality, medication management, infection control and food hygiene. Six members of the staff team had also received training in epilepsy which was an identified medical need of one of the young people, but five members of staff required refresher training in this.

All staff received regular good quality supervision which was provided by the manager and team leader. The majority of permanent and relief staff had received training in supervision for supervisees. Supervisors were trained in supervision. Supervision contracts were agreed between supervisors and staff. A standard supervision template was used for recording issues that were discussed. The following issues were discussed at supervision; agreed goals from the previous month, staff issues, health and safety, children/young person, quality issues and centre policies. Therefore staff received formal support from their supervisor, and benefited feedback and discussion in regard to good practice and areas which required improvement.

Judgment:

Non Compliant - Moderate

Outcome 18: Records and documentation

The records listed in Part 6 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 are maintained in a manner so as to ensure completeness, accuracy and ease of retrieval. The designated centre is adequately insured against accidents or injury to residents, staff and visitors. The designated centre has all of the written operational policies as required by Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

Theme:

Use of Information

Outstanding requirement(s) from previous inspection(s):

No actions were required from the previous inspection.

Findings:

There were good procedures in place for the secure storage of records. The majority of records required by schedule 4 were in place but improvements were required in the quality of the recording. The policies of the centre did not meet all the requirements of Schedule 5, as there was no policy in place for incidents where a resident goes missing.

The majority of records required by schedule three and four of the regulations were in place. However, there was no record of the charges to residents or complaints as outlined in previous outcomes. The quality of recording required improvement in some instances. A register of residents was maintained and up to date and it complied with the regulations. The register was up to date. The child's name, date of admission, next of kin, date of admission and discharge was recorded.

Paper records were well ordered and indexed and stored securely to prevent data protection breaches and preserve the young people's information in a confidential manner. Young people's files were up to date and contained all of the information as required by the regulations including a photograph, some medical details, next of kin details, name of the organisation that arranged the admission to the centre and correspondence relating to each young person. In addition records of medical appointments and interventions were maintained and other reports and correspondence from schools, training programmes and other health and social care services were in place. However, inspectors found not all records were dated and signed off by the manager or relevant staff member. Young people were aware that records were maintained on them and had accessed their personal plans.

A residents guide was in place, but did not meet the requirements of the regulations and was not written in a child friendly manner. It outlined the process for personal plans, challenging behaviour sanctions and reviews for children in care.

There was appropriate storage facilities in place for records. All records in relation to the

young people were stored in locked fire proof filing cabinets which were stored in a locked filing room. Keys for the cabinets were held in a locked key storage cupboard, and the manager or team leader held the key. This was in place to protect against data protection breaches and to maintain young people's confidential information in a safe way. The person in charge told inspectors that there was sufficient space for files to be archived within the centre at this point in time.

The service did not meet with all the requirements of schedule 5. No policy was in place in relation to children going missing from the centre. The manager told inspectors that the protocol used between the Child and Family Agency and An Garda Síochána was operational in the centre. All policy documents had been reviewed between 2013 and 2014, and the dates for the next review was present on all policies. Review dates varied between 6 months and 2 years. Staff had easy access to policy documents through the organisation's intranet.

The centre was adequately insured against accidents or injury to residents, staff and visitors. The insurance certificate was reviewed by inspectors and the renewal date was March 2015.

Judgment:

Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

Health Information and Quality Authority Regulation Directorate

Action Plan

Provider's response to inspection report¹

| | |
|----------------------------|--|
| Centre name: | A designated centre for people with disabilities operated by Praxis Care |
| Centre ID: | OSV-0001913 |
| Date of Inspection: | 01 December 2014 |
| Date of response: | 06 May 2015 |

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

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

Outcome 01: Residents Rights, Dignity and Consultation

Theme: Individualised Supports and Care

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

Young people had no access to independent advocates in the centre and information on young people's rights was not user friendly.

Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access

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

to advocacy services and information about his or her rights.

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

A. The Person In Charge has engaged EPIC services to provide external advocacy to the service and provide information to staff and young people on their services. Date: 14/02/15

B. The Person In charge has insured that the Young People have access to independent advocates and information on this is available. This will be discussed regularly in key working sessions. Date: 28/02/15.

C. Leaflets on the service provided by EPIC have been made available in a form appropriate to the age and understanding of each young person in the centre: Date: 28/02/15

D. Young people will be advised of the advocate programme on an ongoing basis during keyworking sessions. Date: 28/02/15

Proposed Timescale: 28/02/2015

Theme: Individualised Supports and Care

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

Personal information was inappropriately discussed at residents meetings and led to conflict on occasions between residents.

Action Required:

Under Regulation 09 (3) you are required to: Ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships, intimate and personal care, professional consultations and personal information.

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

The Registered Provider and Person In Charge will ensure that the personal information of the Young People will not be discussed at residents meetings. Monthly house meetings now discuss items in a structured format and house rules are reiterated at each meeting. Personal information relevant to the young people is restricted to discussion in keyworking sessions.

Proposed Timescale: 28/02/2015

Theme: Individualised Supports and Care

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

The complaints process was not robust. No complaints were recorded in the log and

young people and staff did not know who the complaints manager was.

Action Required:

Under Regulation 34 (1) you are required to: Provide an effective complaints procedure for residents which is in an accessible and age-appropriate format and includes an appeals procedure.

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

- A. The Registered Provider will ensure that all complaints are managed in line with the organisation's Complaints Policy. Date: 01/03/15
- B. All complaints will be recorded appropriately in a Complaints Log. Date: 20/01/15
- C. The Complaints Policy will be reviewed with all staff to ensure full compliance in the management of complaints. It will be reviewed with all Young People in an accessible and age appropriate format which will include details on the Complaints Manager at local level and Complaints Officer at organisational level. Date: 31/03/15

Proposed Timescale: 31/03/2015

Theme: Individualised Supports and Care

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

The complaints procedure did not adequately identify how the nominated person, other than the person nominated in Regulation 34(2)(a), ensured that the procedure was followed and the record of all complaints were maintained.

Action Required:

Under Regulation 34 (3) you are required to: Nominate a person, other than the person nominated in Regulation 34(2)(a), to be available to residents to ensure that all complaints are appropriately responded to and a record of all complaints are maintained.

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

- A. The Assistant Director has been identified as the nominated person separate from the Complaints Officer to have oversight of the complaints process, in line with the requirements of regulation 34 (3). Date: 01/04/15
- B. The Complaints Policy and the information leaflet for residents have been amended to incorporate this change. Date: 10/04/15

Proposed Timescale: 10/04/2015

Outcome 03: Family and personal relationships and links with the community

Theme: Individualised Supports and Care

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

Friends of the young people did not visit the centre.

Action Required:

Under Regulation 11 (2) (a) you are required to: Ensure that as far as reasonably practicable, residents are free to receive visitors without restriction unless in the opinion of the person in charge, a visit would pose a risk to the resident concerned or to another resident.

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

The Person In charge will encourage Young People to bring their friends to visit the Designated Centre during key working sessions and during any other available opportunities. Friends of the Young People are most welcome to visit the Designated Centre and this will be fully facilitated and supported at any time.

Proposed Timescale: 31/03/2015

Outcome 04: Admissions and Contract for the Provision of Services

Theme: Effective Services

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

The contract did not document any charges or additional charges for residents.

Action Required:

Under Regulation 24 (4) (a) you are required to: Ensure the agreement for the provision of services includes the support, care and welfare of the resident and details of the services to be provided for that resident and where appropriate, the fees to be charged.

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

A. The contract/agreement for the provision of services has been amended to include Supplementary charges and Contributions, in accordance with the requirements of regulation 24 (4) (a). Date: 31/03/15

B. The young people will be issued with revised contracts. Date: 30/04/15

Proposed Timescale: 30/05/2015

Theme: Effective Services

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

Both admissions to the centre were emergency but the statement of purpose does not

set out the admissions criteria for an emergency admission.

Action Required:

Under Regulation 24 (1) (a) you are required to: Ensure each application for admission to the designated centre is determined on the basis of transparent criteria in accordance with the statement of purpose.

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

The Registered Provider, in line with best practice, will no longer accept emergency admissions to the Designated Centre and this is reflected in the Statement of Purpose. The Admission Procedure will be adhered to for all admissions.

Proposed Timescale: 31/05/2015

Theme: Effective Services

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

The mix of resident's in the centre was unsafe at times as their needs could not always be met.

Action Required:

Under Regulation 24 (1)(b) you are required to: Ensure that admission policies and practices take account of the need to protect residents from abuse by their peers.

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

A. The admissions policy has been amended to take account of the need to protect the young people from abuse. Date: 10/12/14

B. A comprehensive risk assessment has been completed for existing residents and will be further reviewed.

C. A behavioural review of young people currently in the centre will be completed. Date: 14/04/15

D. Safety plans have been put in place for each young person in the designated centre with regard to peer to peer abuse. Date: 10/12/14

E. Full assessments will be conducted on any future potential admissions to the designated centre, and these will include risks assessments with regard to peer to peer abuse. Date: 10/12/14

Proposed Timescale: 14/04/2015

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

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

The risk management policy did not include the measures and actions in place to control the risk of 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:

The organisation has revised its risk management policy and now has a single comprehensive document which includes the measures and actions in place to control accidental injury to residents, visitors or staff as in regulation 26 (1) (c) (ii)

Proposed Timescale: 10/04/2015

Theme: Effective Services

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

The risk management policy did not include the measures and actions in place to control the risk of self harm.

Action Required:

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

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

A policy on the management of self harm has been written, which includes measures and actions in place to control the risk of self harm, and this forms part of Praxis Care's Risk Management Policy

Proposed Timescale: 10/04/2015

Theme: Effective Services

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

The risk management policy did not include 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 risk management policy has now been amended to include an "Escalation Policy" to ensure compliance with Regulation 26 (1) (d).

Proposed Timescale: 31/03/2015

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 of water in the taps was recorded as 50 degrees.

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:

A. An engineer completed work at the designated centre on the 8th and 9th December 2014. Thermostatic mixing valves were installed under all sinks and the maximum set temperature at each valve is set 43degrees Celsius. All shower valves were serviced and reassembled to operate within the same action as each other. All shower valves were set to a maximum flow temperature of 43 degrees Celsius. All water temperature tests were carried out with an ETI Thermatite Digital Thermometer; instrument serial number; D12440922-completed on the 09/12/2014.

B. The risk management systems will be reviewed with regard to the assessment, management and ongoing review of risk, including a system for responding to emergencies, to ensure that they are comprehensive and they comply with all the requirements of Regulation 26 (2).

Proposed Timescale: 30/04/2015

Theme: Effective Services

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

The risk management policy did not include the arrangements to ensure that risk control measures were proportional to the risk identified, and that any adverse impact

such measures might have on the young persons quality of life had been considered.

Action Required:

Under Regulation 26 (1) (e) you are required to: Ensure that the risk management policy includes arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.

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

The organisation has reviewed the risk management policy to ensure compliance with Regulation 26 (1) (e). This includes the admission procedures which allow for the assessments of risks to all residents through accepting a new resident into a designated centre and to identify steps to be taken to mitigate that risk.

Proposed Timescale: 10/04/2015

Theme: Effective Services

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

The risk management policy did not include the measures and actions in place to control the risk of violence and aggression within the centre.

Action Required:

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

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

The risk management policy now includes the measures and actions in place to control the risk of violence and aggression in the Designated Centre.

Proposed Timescale: 01/04/2015

Theme: Effective Services

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

The risk management policy did not include the measures and actions in place to control the unexpected 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:

A. The organisation has reviewed its policy to provide more detailed procedures to

follow in the event of the unexplained absence of a young person and to ensure compliance with regulation 26 (1)(c)(i). Date 10/04/15.

B. A visible absence management plan will be a standing item on every staff meeting and reviewed by the team. Date 31/03/15

C. Within each resident's file, there is an absence management plan and this is updated as circumstances in the life of the resident changes. Date 31/03/15

Proposed Timescale: 10/04/2015

Theme: Effective Services

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

The risk management policy did not identify hazards and did not include an assessment of risks hazard identification and 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:

The risk management policy now includes hazard identification and assessment of risks throughout the designated centre in accordance with regulation 26 (1) (a).

Proposed Timescale: 10/04/2015

Theme: Effective Services

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

The risk management policy did not adequately detail measures and actions in place to control identified risks.

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 Risk Management Policy now includes the measures and actions required to be in place to control the risk identified and perform a schedules are in place with timelines to control identified risk.

Proposed Timescale: 10/04/2015

Theme: Effective Services

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

No daily fire checks were taking place.

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:

- A. At the Designated Centre weekly and monthly fire checks are completed according to policy. There is a daily fire register completed to list the residents and staff who sleep in the building overnight. Date: 01/12/14
- B. Fire Exits are checked daily. Date: 10/04/15

Proposed Timescale: 10/04/2015

Outcome 08: Safeguarding and Safety

Theme: Safe Services

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

Not all steps had been taken to alleviate the behaviour of one young person.

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:

- A. A comprehensive behavioural management review has been arranged for all young people in the designated centre. Date: 14/04/15
- B. A psychological assessment will be carried out on all young people in the designated centre. Date: 30/05/15

Proposed Timescale: 30/05/2015

Theme: Safe Services

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

Environmental restrictive practices were in place but there was no monitoring to ensure the practice was least restrictive for the least amount of time.

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:

- A. A log of all restrictive practices is now being maintained within the designated centre. This will be reviewed at every team meeting to ensure all practices are least restrictive for the least amount of time. Date: 30/04/15
- B. The Registered Provider will ensure all restrictive practices are recorded and monitored to ensure compliance with the regulations and the national guidelines. Date: 30/04/15
- C. The Assistant Director on a monthly basis will audit all restrictive practices. Any issues of concern will be escalated appropriately. Date: 30/04/15
- D. The Escalation Policy ensures monitoring of all restrictive practices at the appropriate management level.

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 had insufficient skills to respond to behaviour that challenged.

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 Person In Charge and staff will engage in a comprehensive behaviour management review of all young people. The organisation has completed a Training Needs Analysis which identifies further training requirements. Any training identified will be promptly facilitated for the team.

- A. The organisation has completed a Training Needs Analysis to identify any training requirements to assist staff in acquiring skills to respond to behaviours which challenge. Date: 31/03/15

- B. Bespoke training in behaviour management input has been arranged by the Staff Development Department to respond to the specific identified needs of the young

people. The need for bespoke training will be identified on an ongoing basis at the admission panel process. Date: 01/04/15

C. Inexperienced staff members will be mentored by other experienced staff until they feel confident in their new role. Date: 01/04/15

Proposed Timescale: 01/04/2015

Theme: Safe Services

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

Serious behavioural incidents had occurred in the centre and residents were not adequately safeguarded at all times.

An appropriate safety plan was not in place should further serious incidents occur.

There was no input from the full multi-disciplinary team on the management of the child's behaviour.

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:

A. A further staff review has occurred within the Designated Centre. The organisation will ensure additional supervisory staff are on duty to oversee the management of the unit. The staffing arrangement remains 2 sleepover staff and one additional day staff in place for all shifts. New staff have commenced in post with vacancies currently being recruited.

B. Plans are in place for each young person in the event of a serious incident.

C. Safety plans are in place for each young person.

D. All significant events are notified to the Chief Inspector in line with the regulations.

E. All risks and significant events are now escalated within the organisation to the appropriate management level as per the Escalation Policy.

F. A comprehensive behaviour management review of all young people has been arranged. Restrictive practices will be revised during this process.

G. Multi-disciplinary Team reviews are held at least 6 monthly or as required. A serious Untoward Event will warrant the Person in Charge to organise an emergency review within 72 hours.

H. House meetings will be held on a fortnightly basis to reinforce house rules.

- I. All young people are aware of the complaints procedure.
- J. Additional bespoke training has been identified and arranged.
- K. Multi-disciplinary Team input has increased in the centre.
- L. All young people have been referred for day services.

Proposed Timescale: 31/03/2015

Outcome 09: Notification of Incidents

Theme: Safe Services

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

There was insufficient information provided on two notifications.

Action Required:

Under Regulation 31 (1) (f) you are required to: Give notice to the Chief Inspector within 3 working days of the occurrence in the designated centre of any allegation, suspected or confirmed, abuse of any resident.

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

The Person In Charge will submit notifications in line with the Regulations to the Chief Inspector within 3 working days in the occurrence of any allegation, suspected or confirmed abuse of any resident. The Person In charge will ensure sufficient supporting information is included in all notifications, in line with the requirements of the Authority. Any additional information will be forwarded to the Chief Inspector by the Person In Charge in line with requirements of the Authority.

Proposed Timescale: 31/03/2015

Outcome 11. Healthcare Needs

Theme: Health and Development

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

The manager had not followed up on accessing the services of a psychologist for one young person.

Action Required:

Under Regulation 06 (2) (d) you are required to: When a resident requires services provided by allied health professionals, provide access to such services or by arrangement with the Executive.

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

A. The Person In charge arranged for the young person concerned to access a psychologist. Date: 02/04/15

B. Where a young person requires services from allied health professionals in the future, this will be arranged by the Person In Charge. Date: 31/03/15

Proposed Timescale: 30/04/2015

Theme: Health and Development

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

No comprehensive healthcare assessment had been undertaken and there were gaps in the young people's health information.

Action Required:

Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan.

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

A. A comprehensive health care assessment has been completed for all young people in the designated centre. Date: 08/04/15

B. For all future referrals this will be completed prior to admission. Date: 08/04/15

Proposed Timescale: 08/04/2015

Outcome 12. Medication Management

Theme: Health and Development

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

The management of controlled medication was not effective.

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:

A. Two staff count and sign the controlled drug register at time of administration and at the end of shift. Date: 16/02/15

B. The disposal of unused and out of date medication is recorded on a relevant template and signed off by two staff and also by the relevant chemist. An additional book that records the disposal of unused and out of date medication is now in place in the Designated Centre. Date: 20/02/15.

C. The Person In Charge is responsible for the management of controlled medication to ensure its effectiveness and meets the requirements of regulation 29 (4)(d) and the misuse of The Drugs Act 1988.

Proposed Timescale: 20/02/2015

Theme: Health and Development

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

The administration time of a young person's medication did not always match the prescription time.

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:

The organisation has 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.

The General Practitioner has written a letter to the Person In Charge outlining permissible time variations for administration of medication for the young person. This information is now available within the designated centre and is referenced in the young person's personal plan.

Proposed Timescale: 31/03/2015

Theme: Health and Development

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

The system in place in relation to returning out of date and unused medication was not in line with the centre's policy.

Action Required:

Under Regulation 29 (4) (c) 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 out of date or returned medicines are stored in a secure manner that is segregated from other medical products, and are disposed of and not further used as medical products in accordance with any relevant national legislation or guidance.

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

The disposal of unused and out of date medication is recorded on a relevant template and signed off by two staff members and also by the relevant chemist. This is a new practice in place. No out of date and unused medication will be stored in the designated centre in line with the policy. An additional book that records the disposal of unused and out of date medication is now in place in the Designated Centre. To ensure adherence to the designated centre's policy, the Assistant Director will monitor the procedure on a monthly basis and the organisation will review its procedures through its internal audits system. All unused medication has been managed in line with policy.

Proposed Timescale: 28/02/2015

Outcome 13: Statement of Purpose

Theme: Leadership, Governance and Management

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

The statement of purpose had not been made available to the residents and or their families/guardians.

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 has been reviewed to ensure it contains all the information as set out in the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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:

The statement of purpose had not been made available to the residents and or their families/guardians.

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:

The Registered provider will ensure that all residents and their representatives are provided with a copy of the Statement of Purpose.

Proposed Timescale: 10/04/2015

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

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

The manager was not receiving sufficient support in developing into the role.

Action Required:

Under Regulation 14 (2) you are required to: Ensure that the post of person in charge of the designated centre is full time and that the person in charge has the qualifications, skills and experience necessary to manage the designated centre, having regard to the size of the designated centre, the statement of purpose, and the number and needs of the residents.

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

A. A mentoring and buddy system has been set up to support all new managers into developing into their role. Date : 01/04/15

B. The Assistant Director has increased the support to the designated centre. Date: 01/04/15

C. The manager will receive twice monthly supervisions for a period of three months initially and this will then be reviewed. Date: 01/04/15

D. The manager will participate in a robust behaviour management review of the young people to support the manager in the role. The manager, through supervision, will be supported to identify any additional training which would be beneficial to the role. Date: 01/04/15

E. Managers attend management zone meetings monthly where they receive peer support.

F. Two Quality Conferences are held per year to enable dissemination of good practice throughout the year.

Proposed Timescale: 01/04/2015

Theme: Leadership, Governance and Management

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

No annual review of the quality and safety of the centre had been completed.

Action Required:

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

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

An annual review Proforma is now in place. An Annual review of the quality of the designated centre will be conducted on the 21/04/15. This annual review will comply with the requirements 23 (1) (d).

Proposed Timescale: 21/04/2015

Theme: Leadership, Governance and Management

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

No annual review had been completed, and therefore young people and their families had not been consulted.

Action Required:

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

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

All young people and their representatives will be notified in advance of the annual review of the service. The annual review will be discussed in the monthly keyworking sessions and invitations will be forwarded to the young people's representatives before the 21/04/15. In situations where families of the young people do not wish to attend annual review, their views will be discussed over the telephone and be added to the annual review.

Proposed Timescale: 21/04/2015

Theme: Leadership, Governance and Management

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

No unannounced audit of the quality and safety of the service had been completed.

Action Required:

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

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

The Registered provider/ or their nominee will conduct unannounced visits to the designated centre, in accordance with the requirements of 23 (2) (a) which commenced in January 2015. A report has been prepared, including a plan to address the concerns identified ,in accordance with the regulation.

Proposed Timescale: 31/01/2015

Theme: Leadership, Governance and Management

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

Management systems were not effective to ensure safe quality care and support was provided to residents.

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. Additional supervisory staff are being recruited to allow appropriate management and administration time for the Person in Charge. This will ensure safe quality care and support is provided to residents.

B. Internal audits will be increased for this designated centre to ensure compliance with existing management systems.

C. The management structures will be further reviewed, and any necessary changes made, to ensure compliance with regulation 23(1)(c).

D. Management oversight has increased since 01/04/15

Proposed Timescale: 01/04/2015

Theme: Leadership, Governance and Management

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

The accountability arrangements to the Board were unclear.

Action Required:

Under Regulation 23 (1) (b) you are required to: Put in place a clearly defined management structure in the designated centre that identifies the lines of authority and accountability, specifies roles, and details responsibilities for all areas of service provision.

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

The organisation has developed an Escalation Policy which will ensure any risk or incident is escalated at the appropriate level through the tiers of management. The policy outlines the type of risks or incidents which need to be escalated to the appropriate levels within the organisation. Sub Committees of the Board will also be informed depending on the risk or incident - the Health and Safety Committee, the Care, Development and Research Committee, the Governance Committee, the Finance Committee, as appropriate. The Registered Provider will continually review accountability arrangements to the Board to ensure compliance with regulation 23 (1)(b).

Proposed Timescale: 01/04/2015

Outcome 16: Use of Resources

Theme: Use of Resources

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

There was poor workforce planning.

No budget was in place for the service.

Action Required:

Under Regulation 23 (1) (a) you are required to: Ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.

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

The Registered Provider has ensured there is a budget in place from the 1st April 2015 to the 31st March 2016. This document is available to the Designated Centre. The Registered Provider will also ensure the Designated Centre is resourced appropriately to ensure effective service delivery.

Proposed Timescale: 01/04/2015

Outcome 17: Workforce

Theme: Responsive Workforce

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

The skill mix of staff varied - there was a mix of new and more experienced staff on staff rotas. Staff expressed concern about the ability of the team to safeguard a young person in the centre.

Action Required:

Under Regulation 15 (1) you are required to: Ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.

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

A. The organisation has completed a comprehensive review of staffing levels. New staff have and will be recruited. The number, qualifications, and skill mix of the staff group is dictated by the number and assessed needs of the young people.

B. The Registered Provider is providing a review of behaviour management and bespoke training within the Designated Centre which will include a review of staff numbers and skill mix within the Designated Centre.

C. The organisation has engaged in this process and will ensure this comprehensive review of staffing levels and skill mix is completed and ongoing. In anticipation of the outcome of this review the Person in Charge is advertising for both team leaders and support workers.

Proposed Timescale: 30/05/2015

Theme: Responsive Workforce

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

A number of staff worked in the centre on a temporary 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:

New staff have been recruited and there is currently a staff team employed for the Designated Centre on a full-time permanent basis. Relief staff consistently cover shifts within the Designated Centre. The service, as a part of the review of staffing levels and skill mix, is currently advertising for new staff. The Registered Provider will ensure that the staff team is consistent and employed on a permanent basis, where possible. All these measures have been put in place to ensure compliance with regulation 15 (3).

Proposed Timescale: 30/04/2015

Theme: Responsive Workforce

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

The staff roster was not up to date on the week of the inspection.

Action Required:

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

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

There are four weeks rota on file at any one time within the Designated Centre. Currently, there is a planned rota file and an actual rota file. The Person In Charge will ensure that staff rosters are maintained up to date.

Proposed Timescale: 03/12/2014

Theme: Responsive Workforce

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

There were gaps in staff files in relation to full employment history and date of commencement of employment.

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:

A. All staff employment history is now recorded in their staff files. Date: 01/04/15

B. Any gaps within the staff employment history will be discussed at interviews and reason recorded: Date: 01/04/15

C. The Person In Charge will place the dates of commencement of employment within the service in each staff file. Date: 01/04/15

Proposed Timescale: 01/04/2015

Theme: Responsive Workforce

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

The continuous professional development training programme was not informed by the needs of the centre.

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. The Person In Charge will ensure core training is up to date for all staff. There should be 100% training compliance within the Designated Centre unless reduced absence/or staff are registered to attend upcoming training. Date: 01/04/15
- B. A Training Needs Assessment has been completed for the Designated Centre. The Staff Development Department has been in liaison with the Designated Centre and is ensuring that staff have access to appropriate training, including refresher training as part of a continuous professional development programme. Date: 01/04/15.
- C. Comprehensive behaviour management training will be provided to all staff including positive behaviour support. Date: 14/04/15
- D. Additional training such as grievance, person centred planning, supervisors training etc. have all been identified and either completed or arranged. Date: 30/05/15

Proposed Timescale: 30/05/2015**Outcome 18: Records and documentation****Theme:** Use of Information**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**

Not all policies as required by schedule 5 were in place.

Action Required:

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 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 organisation has reviewed its policies and are currently updating policies to ensure compliance with schedule 5 of the Healthcare Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with disabilities) Regulations 2013.

Proposed Timescale: 30/05/2015**Theme:** Use of Information

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

The resident's guide did not meet the requirement of the regulations.

Action Required:

Under Regulation 20 (1) you are required to: Prepare a guide in respect of the designated centre and provide a copy to each resident.

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

The revised resident's guide has been developed for the young people to reflect their understanding of the service in a pictorial format. This guide has been given to all the young people and updated. All new admissions will receive an appropriate guide to the service.

Proposed Timescale: 01/04/2015

Theme: Use of Information

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

The quality of record keeping was not consistent and some recordings were undated and unsigned.

Action Required:

Under Regulation 21 (1) (b) you are required to: Maintain, and make available for inspection by the chief inspector, records in relation to each resident as specified in Schedule 3.

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

The Registered Provider has delegated authority to the Person In Charge to ensure that all records relating to each young person are signed and dated by the staff members and Person In Charge as appropriate.

Proposed Timescale: 31/03/2015

Theme: Use of Information

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

Records of charges and complaints were not maintained in the centre.

Action Required:

Under Regulation 21 (1) (c) you are required to: Maintain, and make available for inspection by the chief inspector, the additional records specified in Schedule 4 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:

- A. Complaints are now recorded within the complaints log within the designated centre. Date: 02/01/15
- B. The organisation has a Bills Agreement and Guide to Costs which outlines and records all charges to young people. This document is referred to in the support plan for each young person. The Person in Charge has simplified these costs for the young people identifying the organisation's financial responsibilities for activities and services provided for each young person. Date: 01/05/15
- C. The organisation is currently revising 'Supplementary Charges and Service User Contribution Procedure' to provide clear guidance to staff on how costs should be recorded and communicated to service users. Date: 01/05/15

Proposed Timescale: 01/05/2015