<table>
<thead>
<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Catherine's Association Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003409</td>
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<td>Centre county:</td>
<td>Wicklow</td>
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<tr>
<td>Type of centre:</td>
<td>Health Act 2004 Section 39 Assistance</td>
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<tr>
<td>Registered provider:</td>
<td>St Catherine's Association Limited</td>
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<tr>
<td>Provider Nominee:</td>
<td>Kate Killeen</td>
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<tr>
<td>Lead inspector:</td>
<td>Eva Boyle</td>
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<tr>
<td>Support inspector(s):</td>
<td>Bronagh Gibson;</td>
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<tr>
<td>Type of inspection</td>
<td>Announced</td>
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<tr>
<td>Number of residents on the date of inspection:</td>
<td>2</td>
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<td>Number of vacancies on the date of inspection:</td>
<td>2</td>
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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

<table>
<thead>
<tr>
<th>From:</th>
<th>To:</th>
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<tr>
<td>19 August 2015 09:00</td>
<td>19 August 2015 17:15</td>
</tr>
<tr>
<td>20 August 2015 09:00</td>
<td>20 August 2015 17:45</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Outcome 01: Residents Rights, Dignity and Consultation</th>
<th>Outcome 02: Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 03: Family and personal relationships and links with the community</td>
<td>Outcome 04: Admissions and Contract for the Provision of Services</td>
</tr>
<tr>
<td>Outcome 05: Social Care Needs</td>
<td>Outcome 06: Safe and suitable premises</td>
</tr>
<tr>
<td>Outcome 07: Health and Safety and Risk Management</td>
<td>Outcome 08: Safeguarding and Safety</td>
</tr>
<tr>
<td>Outcome 09: Notification of Incidents</td>
<td>Outcome 10. General Welfare and Development</td>
</tr>
<tr>
<td>Outcome 13: Statement of Purpose</td>
<td>Outcome 14: Governance and Management</td>
</tr>
<tr>
<td>Outcome 15: Absence of the person in charge</td>
<td>Outcome 16: Use of Resources</td>
</tr>
<tr>
<td>Outcome 17: Workforce</td>
<td>Outcome 18: Records and documentation</td>
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Summary of findings from this inspection

The centre was located in the countryside in Co. Wicklow. The centre provided care to two children with a diagnosis of autism and learning disability. The purpose of the inspection was to inform the registration process. This was the fourth inspection of the centre. As part of the inspection process the children were observed by inspectors and one child completed a questionnaire. Inspectors also met with two parents, a social worker, four staff, the children's services manager (person in charge), the senior children services manager, acting chief executive and other members of the senior management team.

The service was provided by St. Catherines Association who had applied to register
the centre. There were three previous inspections in April, August and December 2014. In September 2014, a notice of proposal was issued to cancel and refuse registration based on the fitness of the provider. Subsequently, there was a change of Board and a new management structure was implemented. Improvements were found at a follow up inspection in 2014. However, there remained 38 regulatory breaches. This inspection was a registration inspection and inspected the service against all the Regulations. There were 39 regulatory breaches.

Children generally had a good quality of life. Children participated in some activities in the local community and were observed drawing, riding their bike and using the trampoline in the centre. Both children attended a local school. The staff team endeavoured to be person centred in their approach. The children had individual goals that were reviewed and amended regularly. Programmes in relation to the management of children's behaviours were individually tailored to include the preferences of children, such as relaxation options that the children preferred.

The staff team were challenged to manage the behaviour of one child and this impacted on the other child's access to the centre. There was an increase in the use of restrictive practices since the last inspection. Single separation was extensively used by the staff team in the management of a child's behaviour. The child was separated in a relaxation room and they were not permitted to leave this room until s/he calmed. The staff team were endeavouring to identify the causes for this behaviour but had limited success to date.

There were further improvements required in management systems in order for them to be robust. There was an appropriate organisational structure in place, but there had been recent changes in key positions such as the children service manager (person in charge) and the senior children services manager. Reviews of the safety and quality of care and support were completed on a six monthly and annual basis, but they were not effective mechanisms to bring about timely improvement in the service.

Sufficient resources were approved for the centre, but there was not always sufficient staff available to provide the service. There were occasions when four staff members were required to work with two children in order for children's personal plans to be adhered to, but this level of staffing was not always available. This meant that children's personal plans were not always implemented and on occasions children could not participate in activities outside of the centre.
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):
No actions were required from the previous inspection.

Findings:
Children were not aware of all of their rights. Information on children's rights was available to children in a child friendly format. Children were aware of their right to choice, but not all children had the right to freedom of movement in the centre. The privacy of each resident was respected. Inspectors observed staff being respectful and gentle in their interactions with children. It was clear from records that there was some consultation with children by the staff team in regard to their personal plans, but it was not clear that they were consulted on the running of the centre. Some children had access to independent advocacy. A guardian ad litem was involved with one child, but the second child did not have access. Therefore, there was inequity for children's access to independent advocacy which needed to be addressed.

There were measures in place to protect children's belongings. All children's belongings were documented. The centre had a policy in relation to children's money, but it was incomplete as parts of the policy were outlined to be under review. Children's bedrooms had sufficient storage space for items of clothing or other personal possessions to be stored. Neither of the children in the centre had any money in their possession and were not in receipt of pocket money.

Complaints received were managed effectively and were dealt with in a timely manner. There were six complaints recorded on the complaints register from July 2014 to the date of inspection. However, the complaints log did not outline whether the complainant was satisfied at the outcome of the complaint process as required by Regulation 34(2) (f).

The complaints process was unclear and was not in line with the regulations. The policy
identified two different people to manage complaints and there was no identified person to oversee that complaints had been managed in line with the regulations. Information on the complaints procedure was prominently displayed in the centre but the information was out of date as it did not correctly identify the name of the recently appointed children's services manager. Staff and parents were not clear on who managed complaints as some identified the children's services manager and others identified the acting CEO. All of the complaints received had been managed by the children's services manager. A child friendly poster on making a complaint was available in each child's bedroom. However, no children's complaints were recorded.

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):
No actions were required from the previous inspection.

Findings:
Children's communication needs were known to the staff team but personal plans did not provide sufficient detail to guide staff, particularly if staff did not know the child. Inspectors observed children and staff communicating effectively through a range of means including simple language, body language, but other tools such as visual aids were not used in line with their plans.

Children's communication needs were assessed by staff, but the information was dispersed throughout their file. This meant that staff who did not know the children had to search the file to identify the key information. Children had input from speech and language therapists and inspectors found that the subsequent plans had been achieved and the child's communication ability had progressed.

Staff had not received any training on relevant communication techniques. Three members of staff had received training in a specific method of communication, (lámh), but this was not an identified method for the two children currently attending the service.

The centre had a policy in relation to communication and information, but it required improvement. The policy outlined that children's communication needs would be assessed at the time of referral to the centre. Following on from this assessment an 'action plan' would be completed that outlined the supports/ training required both by the child and the staff team. However, it did not provide staff with sufficient guidance in
assessing children's communication needs.

Children had access to radio, television, books and music systems. One child had a hand held computer, but staff told inspectors that the child did not use it extensively.

**Judgment:**
Non Compliant - Moderate

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**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):**

**Findings:**
Children were supported to maintain relationships with family members but had limited opportunities to develop and maintain personal peer relationships or to have links with the wider community.

The centre had a visitor's policy and family members were welcome. The facilities for visits within the centre were appropriate and visits between parents and their children also occurred outside of the centre. Staff had regular contact with family members and kept them up to date. Parents told inspectors that there had been improvements in communication since the last inspection.

Staff told inspectors that one child visited their friends in another residential centre. Children had goals in relation to increased community contact, which included involvement in clubs in the local area, but none of these had been commenced. Implementation of these goals would benefit the development of the children's social skills

Children had access to a range of activities. They participated in going for walks in the woods, to the beach, swimming, and going out for dinner. Inspectors also observed a child riding their bicycle and playing on the trampoline.

**Judgment:**
Substantially Compliant

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**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):**
No actions were required from the previous inspection.

**Findings:**
There had been no new admissions to the centre since the last inspection. There was a policy on referrals, admissions and discharge policy but it required further development to ensure that the admission and discharge process was clear to staff. The admissions and discharge policy and guidelines were not robust or centre specific. The policy did not outline how referrals were reviewed to ensure that they were appropriate and met the criteria of the statement of purpose of the centre. An admissions process outlined the completion of pre-admission risk assessments for children who were going to be admitted into a specific centre. The purpose of these assessments was to establish any possible risks that the new admission would have on existing children and this was in line with the requirements of Regulation 24 (b). However, the policy did not outline what process occurred if the risk assessment highlighted that a child needs was not compatible with those of the other children in the service. The policy outlined the process that would be followed in the event of a child being discharged in a planned or unplanned way to another service.

No contracts of care were in place that outlined the terms on which a child shall reside in the centre. Therefore, the parents/guardians of children may not be clear about the services provided to their children, charges or the expectations that the service had on parents.

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

Findings:
Children's needs had been reassessed since the last inspection. A revised assessment template was used to record the children's needs. However, this revised template was not completed for one child. Inspectors found that the new comprehensive assessment template had been developed that incorporated children's medical, psychological, communication, educational, cultural, social and religious needs.

A new system was in place in relation to new admissions. New admission procedures outlined that a risk assessment would be completed for all new admissions and a personal plan completed within 28 days of admission in line with regulations. No new children were admitted to the centre since the last inspection.

The quality of children's personal plans was mixed. Inspectors found that while one personal plan was completed, another was in a draft format and a personal planning meeting was scheduled. Personal plans did not contain sufficient information, for example, the personal plan did not outline plan in place to meet a child's mental health needs and another did not identify the care status of a child. Therefore, the staff team may not be aware of this key information. Children's views, wishes and preferences were outlined in their personal plan. Parent's views were outlined on some specific issues such as arrangements for visits, the child's activities and cultural needs.

Both children had achievable goals which were reviewed regularly. The progress that children made in regard to their goals was recorded and it was evident that goals were changed appropriately where there was a change in circumstances. The lives and opportunities provided to children had improved as a result of implementation of key goals, such as key contact with family.

There was multidisciplinary involvement in personal plan reviews including behaviour support therapist, and social workers. Parents told inspectors that they had attended personal planning meetings to discuss their child's progress. However, inspectors found that it was not always clear that the effectiveness of children's personal plans were reviewed at personal planning meetings.

Children did not have copies of their plans. A social worker told inspectors that they had received a copy of a child's personal plan.

Children received some preparation work for adulthood. Children used public transport and were involved in the development of skills such as baking, learning to tie their shoe laces and making their beds. Neither child was at the stage of planning onward transitions to adult services.

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):**

**Findings:**
The centre was a bungalow that had a large front garden. It was homely, clean, appropriately decorated and well maintained with comfortable furnishings. The design and layout of the centre was as per its statement of purpose. It had appropriate cooking and dining facilities. There was suitable heating, lighting and ventilation. There were three bedrooms, one for staff members and two bedrooms for the children, one of which was en-suite bedroom. There were adequate toilets, bathrooms and showers for children. There was also a sitting room, conservatory and a relaxation room.

There was sufficient space at the back and front of the premises for children to play. There was secure fencing surrounding the site of the centre and an electronic gate at the entrance to the centre. The large front garden had a trampoline with safety netting, goal posts and footballs.

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

**Findings:**
On the last inspection, further improvements were required in the areas of infection control, risk management and fire safety.

The centre had a centre specific safety statement with supporting documentation on
local hazards and risks. Individual risk assessments for the children were completed as well as environmental risk assessments. Inspectors observed a number of safety measures which had been put in place such as chemicals and sharp knives being locked away. In addition, hot water temperatures were regulated.

The majority of staff had received training in relation to manual handling. A record of maintenance requests for the house was kept but it was not up to date, as some tasks were completed but the date of completion was not recorded. Therefore, it was unclear how management reviewed the timeliness of maintenance requests.

There were risk management systems in place but they continued to require improvement. Inspectors found that there were risks recorded on the risk register that were not current risks and other active risks such as the inability to consistently have the right number of staff to meet the needs of the children were not recorded.

A risk management policy was in place but it was not in line with Regulation 26. The risk management policy had been revised and set out the risk management framework including the roles and responsibilities of the managers and staff and how to identify and assess a risk. However, the policy did not set out the arrangements for the identification, recording and investigation of and learning from serious incidents and adverse events. Nor did it include the arrangements in place to ensure that the risk control measures were proportionate to the risks identified and had considered the impact on the children's quality of life.

There was a process for reporting incidents and accident, but it was not clear how incidents other than behavioural incidents were reviewed. Staff were aware of the process. The majority of accidents and injuries had occurred to staff members, during incidents of challenging behaviour. It was not always clear how these incidents were reviewed and if recommendations were made. However, the impact of incidents on staff was documented and the acting chief executive officer had met with the staff team about the impact of working in the house. The person in charge told inspectors that external debriefing supports were being put in place to support the staff team.

There were some good infection prevention and control measures in place, but there were improvements required in relation to the storage of food. The centre was observed to be clean. Schedules were in place in relation to cleaning and the children's services manager provided oversight. New appropriate storage facilities for the colour coded cleaning system had been put in place since the last inspection. Staff had access to preventative, protective equipment (PPE) such as gloves and aprons and staff were observed using them. Signage in regard to hand hygiene practices were displayed at sinks and hand gels were observed to be placed strategically and available to staff. There was a system in place for the ongoing monitoring of the temperature of the fridge and freezer. While there had been no reported incidents of outbreaks of infection, inspectors found that staff did not consistently label food in the fridge and freezer when it was purchased or opened.

Procedures in relation to fire safety had improved but further improvement was required. All staff had received training in fire safety. All fire equipment was found to be maintained and tested on a regular basis. The centre had a fire alarm. A fire assembly
point was located at the front of the house, adjacent to the exit to the house. There were daily checks of fire exits, equipments, and weekly checks of escape routes. All staff and children had participated in fire drills, some of which took place at night. There were seven fire drills between March and the date of inspection. All children had an individualised evacuation plan and a contingency plan was included in the event of evacuation. However, there was a gap in records of fire alarms testing since the end of June 2015 and furnishings and bedding in the centre remained non fire-retardant.

Judgment:
Non Compliant - Moderate

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

Theme:
Safe Services

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

Findings:
On the last inspection, inspectors found that reports of alleged abuse were not reported in a timely way and restrictive practices were not all appropriately recorded.

There were some safeguarding practices in place, but some required further development in order to be effective. Staff members treated children with respect and warmth and were observed by inspectors as being attentive to children's needs. Risk assessments on individual children were completed and clear procedures were in place in the event of a child leaving the centre without permission. However, there were gaps in information contained in the 'if I go missing document' on children's records, as parents/guardians contact details were not included. This meant that staff may not be able to contact parents/guardians if children went missing from the service. Formal absence management plans were not in place for the children. Therefore, staff may not be clear on the steps to take should a child go missing from the centre.

Good quality intimate care plans were in place that provided staff with clear guidance in relation to the support or assistance that children required. The plans outlined if children required assistance in a range of intimate care areas such as bathing, showering, washing their hair, toileting and washing. Staff told inspectors how they tried to assist the children in becoming more independent in relation to their intimate care and that
much of the assistance that both children received was through prompting. This was in line with the contents of the plans. However, the policy on intimate care was not comprehensive as it did not provide sufficient guidance for staff as it focused on showering and bathing children and did not include other intimate care tasks.

The centre had a policy on child protection that was in line with Children First (2011). All staff interviewed by inspectors were aware of who the designated liaison person was and were aware of the steps to take if they had a concern in relation to the welfare of a child. The contact details of the designated liaison person were displayed in the centre, so staff, children and families could access the information easily. Concerns were appropriately referred to the designated liaison person.

The staff team were challenged in managing the complex behaviour of one child and this was impacting negatively on the quality of the other child’s life. Detailed behaviour support plans were in place for both children and a policy regarding positive behavioural support was implemented. All of the staff team had received training in managing behaviour that challenged, nine members of the staff team had received advanced training in the area and some staff had received positive behavioural support training. There was no obvious impact on the child and the management of his behaviour as a result of this advanced training but not all staff had received the training.

The staff team had endeavoured to identify and alleviate the underlying causes of behaviour that was challenging for each child with the assistance of a multi-disciplinary team including a behavioural support specialist, psychology and a child and adolescent psychiatrist. Since the last inspection a behaviour support therapist had been assigned to work in the centre on a daily basis and had regular input with the staff team. Information regarding a child’s behaviours was also passed on to a child and adolescent psychiatrist. The acting chief executive officer told inspectors that she was exploring further inputs from alternative child and adolescent psychiatrists.

The use and type of restrictive practice had changed and increased since the last inspection. The centre had updated its policy on restrictive practices which outlined the process for approval and review of restrictive practices. Inspectors found that these processes were implemented for identified restrictive practices, such as the use of physical and mechanical restraints. However, it did not provide guidance on the use of the ‘relaxation room’ when used for behaviour management. The policy identified that seclusion was not permitted. However, inspectors found that single separation was being used to manage a child’s behaviour. This was brought to the attention of the acting chief executive officer and she identified that the concept of seclusion had been discussed generally at board level, had been prescribed medically but she acknowledged her concerns about its use.

A log of restrictive practices was maintained, but it did not record all restrictive practices used in the centre. Inspectors found that single separation was used in the centre with the door held closed to contain a child in the room and to prevent him leaving. On other occasions, the door was open, but staff would not permit the child to leave the room until he had calmed down. Inspectors found that one child used this room on almost a daily basis. Inspectors found that the child spent from two minutes up to 50 minutes in this room on individual occasions. This practice was single separation, but had not been
identified as such by senior management or staff and was not recorded on the restrictive 
practice log.

Staff told inspectors that the 'relaxation room' was used as a method of last resort and 
there were times where it was used due to the high level of risk to the child and/or staff. 
However, it was not always clear from the records what other methods were used prior 
to this practice being utilised. On some of these occasions, staff took the other child out 
of the centre due to the behaviour of the other child. This practice was not recorded in 
the restrictive practice log, but the child`s freedom of movement was curtailed.

On other occasions one of the children chose to go the relaxation room to calm down 
and engage in a range of relaxation techniques and this was identified as part of the 
child's plan.

Regular reviews of specific incidents which included restrictive practices were held by 
the children's services manager and the behavioural support specialist. In addition, a 
rights committee also reviewed specific incidents and made recommendations in regard 
to practice. However, despite these review mechanisms, the incidences of challenging 
behaviours and the use of restrictive practices had increased significantly since the last 
inspection. In addition, the practice of single separation was not discussed at this forum.

**Judgment:**
Non Compliant - Major

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**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):**
No actions were required from the previous inspection.

**Findings:**
Not all notifications were made appropriately to the Chief Inspector. Not all restrictive 
practices used in the designated centre were returned in quarterly returns. However, a 
notification of change of person in charge was not submitted to the Authority in a timely 
way.

There were systems in place in relation to recording incidents and accidents in the 
designated centre and they were reviewed by the children services manager.

**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):
No actions were required from the previous inspection.

Findings:
The children participated in a range of activities both in and outside of the centre. However, they had limited contact with their peers. There was a good supply of age appropriate books and games in the centre. Inspectors observed children participating in activities such as cycling their bike, playing on the trampoline and drawing. Staff told inspectors that one child visited friends in another residential centre. However, it was not clear that the children had regular contact with their peers.

Educational achievements were valued in the centre and children were facilitated to attend their school. The centre had a comprehensive policy on children's education and referenced the relevant legislation about the education needs of children with disabilities. Inspectors found that the staff team were actively involved in supporting both children in their school placements. Both children experienced difficulties in school. However, it was evident that there were regular meetings between centre staff and the school in regard to the children's educational attainment. The staff team advocated on behalf of the children and inspectors saw evidence of written correspondence between the centre and the school principal.

There was good communication between staff and the schools in regard to both children. Information in relation to the children's school placements, educational resources, their class group was recorded and their current educational plans which outlined their goals up to November 2015 were available in the centre.

None of the children in the centre were at the stage of onward planning in relation to further training or third level education.

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):
No actions were required from the previous inspection.

Findings:
Young people's health care needs were appropriately assessed and the majority of their needs were being met. Children had timely access to medical practitioners and to a range of allied health professionals such as a behavioural support, social workers, psychologists, occupational therapist and speech and language therapists. Contact information for general practitioners (GP) and an out of hours GP service were readily available to staff in the event of an emergency. Staff with the consent of parents/guardians, requested follow up appointments or requested further information in relation to children's medical conditions. However, a mental health assessment was outstanding for one child despite on-going efforts.

Children's medical background information was available. Inspectors found that there were copies and records of information in relation to children's allergies and immunisations. Some children attended specialist services such as a child and adolescent psychiatrist and correspondence was maintained on the child's records. Meetings were facilitated for parents with children's medical specialists when parents had queries about their child's medical care. Records in relation to children's dental appointments were kept.

All children's medical needs were assessed on an annual basis by their doctor, and a comprehensive report was on the children's files. Inspectors found that when children required follow up investigation, they received these services in a timely manner. In addition, one child had an epilepsy emergency plan on file, that gave clear guidance to staff in the event of a seizure, while there were plans in regard to other specific conditions, such as hay fever.

Children's nutritional needs were appropriately assessed by the staff team. The staff team had referred both children to a dietician. Children received a nutritious and varied diet. Inspectors found that there was a good supply of fresh and frozen food in the centre. Fresh fruit and yoghurts were available to children if they required a snack.

Judgment:
Compliant

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):
No actions were required from the previous inspection.

Findings:
The staff team was trained and were aware of good medication management practices. There were written operational policies relating to the ordering, prescribing, storing and administration of medicines to children. The medication management policy gave clear guidance on the administration, prescription and administration of medication. Information and procedures in relation to controlled drugs was also provided. Effective practices were in place in relation to the safe administration of medication.

Medications were stored in line with the directions supplied by the pharmacy. Inspectors found that medications were appropriately stored. Keys to the medication cabinet were carried by the shift leader. There were no controlled drugs in use, but a controlled drugs register and facilities for storage were in place if required. No out of date medication was held in the centre and there were systems in place for the recording of medication that was returned to the pharmacy. There were procedures in place for the recording when emergency medications were taken out or returned by staff and inspectors observed staff completing this process.

There were prescription sheets in place for all medications. A sample of prescription sheets were reviewed and found to be complete, accurate and signed by a medical practitioner for all medications (PRN). The administration of medication was in line with good practice. All prescription sheets had the name of the child, photographic identification, the name of each medication, time of administration, dosage, space for one member of staff to sign off the administration of the medication as per the centre's policy and space for a comment. Not all staff members had signed a signature sheet. Therefore, the administration of medication was not always traceable.

The majority of staff was trained in the safe administration of medication and all staff had received training in the administration of emergency medications. Three staff was due to receive training in the management of epilepsy.

There was a system in place for the recording and review of medication incidents and errors. There had been a number of medication errors, including staff omitting to record the administration of a medicine and a medication administered after it had been discontinued by a doctor. The children's services manager followed this up with relevant staff and team meetings.

Comprehensive audits of medication were completed and there was no trends of errors identified.

Judgment:
Substantially Compliant
**Outcome 13: Statement of Purpose**

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

**Theme:**
Leadership, Governance and Management

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

**Findings:**
The statement of purpose remained non-compliant with Regulation 3. While, it had been reviewed, it was contradictory in regard to the age group that services were provided to. In one area it outlined that services were provided to boys and girls aged less than 17 years, and in another section outlined that it provided care to children between 9-14 years with a diagnosis of learning disability.

The statement did not identify the support needs that the centre intended to meet. The profile of children that the centre provided services to was very broad, as the skills required to manage the needs of a nine year old are different to that of a seventeen year old and the staff team had not been developed to match this broad range.

There was insufficient information in the statement of purpose in relation to the;
- The staffing levels.
- The educational arrangements (as it was focused on current residents arrangements).
- Emergency admissions

A copy of the statement of purpose had not been provided to children and their families.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Leadership, Governance and Management
Outstanding requirement(s) from previous inspection(s):
Some action(s) required from the previous inspection were not satisfactorily implemented.

Findings:
The service was provided by St. Catherine's Association and three previous inspections had taken place in April, August and December 2014. In September 2014, a notice of proposal was issued to cancel and refuse registration based on the fitness of the provider. Subsequently, there was a change of board and a new management structure was implemented. Improvements were found at a follow up inspection in December 2014. However, there remained 38 regulatory breaches against the selected regulations reviewed as part of that inspection.

There was a clear management structure with defined lines of authority and accountability. There had been some recent changes to the management team such as the senior children services manager and the children's services manager who was the person in charge. Staff were clear about the structure, who they reported to and their roles and responsibilities. They acknowledged that they had good leadership from the acting chief executive and the previous children's service manager but that they worked in a stressful environment.

The board met on a regular basis and were kept up to date by the acting chief executive in relation to the centre. Inspectors reviewed minutes of the board and found that key information in relation to the service was discussed. Reports went to the board in relation to the children and their behaviour and as previously identified discussion had taken place in relation to the proposed use of seclusion. However, the minutes did not reflect a decision or direction from the board and inspectors found that it was in use in the centre.

The children's services manager had been appointed in the weeks prior to the inspection and was in the process of induction at the time of the inspection. While she had no previous management experience, she was knowledgeable about her statutory responsibilities and had a good knowledge of the children's needs. In addition, she had developed a plan of key areas that required her attention, including communicating and consulting with children, cultural awareness, stress for her staff team. However, as this was her first appointment in a management role additional supports were required to strengthen her managerial skills. An identified shift leader managed the centre when the children's services manager was not on duty. However, there was nobody identified to act up for the manager in the event of a longer term absence.

There were some improvements in the management systems in the centre. There were policies and procedures in place and staff had recently received training on these. These revised policies were in the process of being implemented but as previously identified some required further work to ensure they provided sufficient guidance to staff. In addition, there was good communication systems in place including team meetings, respite and residential meetings and reports on the service was submitted to the board. Where complex decision making was required, it was discussed at a senior management level. The children's services manager made decisions in relation to the day to day operation of the centre, but not all decisions were clearly recorded. Risk management
and quality assurance remained areas for improvement. The risk management policy had not been fully implemented and quality assurance remained in the early stages of development with some audits having been completed. An example of the audits included medication management and fire safety.

Insufficient progress had been made by the management team in implementing the action plan submitted by the centre following the last inspection. The majority of actions had not been completed within designated timeframes and some deficits were identified as on-going. Inspectors found that some key deficits in previous inspection reports were only now beginning to be addressed by the senior management team such as the continuous professional development of staff. Some progress had been made in relation to the development of the staff team in the management of behaviour, rights and cultural needs of the children but others were outstanding such as in the use of restrictive practices.

While the provider had completed an annual review of the quality and safety of care and support in May 2015, it was not in accordance with the standards as required by the regulations. The review was not comprehensive and the process did not provide for effective consultation with the children and their representatives. The annual report identified some deficits in the centre, such as insufficient staffing at times, but it did not outline how this impacted on the children or how this issue was going to be resolved in a timely way. It was not clear that a copy of the review was made available to the families of the children. There was no clear plan in place to address any of the deficits identified in a timely manner.

An unannounced six monthly visit of the centre was completed on the 6 August 2015. This review was not comprehensive as it did not clearly identify the safety and quality of care and support being provided in the centre. Inspectors found that some deficits highlighted in the annual review, were also identified in the six monthly review and were identified by inspectors during the course of this inspection. For example, written contracts of care were not in place for children and insufficient staffing levels. Despite repeated identification of deficits, they had not been adequately addressed in a timely manner.

Performance management systems were in the process of being developed. The provider was proactively managing performance issues through the human resource department. Staff were aware of the whistle blowing procedures within the centre.

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:**
Appropriate notifications were made to HIQA re absences of the person in charge.

**Judgment:**
Compliant

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**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):**

**Findings:**
The centre was sufficiently resourced for the day to day operations but the provider was challenged in filling staff posts. Additional staff hours had been approved by the provider for the centre since the last inspection but the children's services manager struggled to fill these shifts due to a lack of relief staff. This meant that the needs of the children were not always met due to the available staffing level.

While there was no designated budget assigned to the centre, there was sufficient petty cash for children's activities, clothing and other expenses. The service had an account with a local supermarket which was paid centrally by the organisation and this allowed children to participate in grocery shopping.

The premises were leased but the lease was due to expire in 2016. The acting chief executive told inspectors that the lease had been extended in 2015 and that she believed that an extension of the lease would be possible.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Responsive Workforce

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

**Findings:**
Inspectors found that the centre had improved their recruitment procedures. On previous inspections inspectors found testimonials rather than references were on file. New procedures identified that references and garda vetting would be sourced prior to appointment and that references would be verified. A new member of staff had recently been recruited but had not commenced as garda vetting was awaited.

Good induction programmes were in place for new staff. Inspectors reviewed an induction timetable for the children's services manager that was ongoing at the time of inspection and found that it was comprehensive. In addition, staff told inspectors that they were inducted well into the centre.

There was not sufficient staff with the appropriate skills and competencies to meet the needs of children. Since the last inspection a core team of 12 staff had been established with an additional 4 relief staff covering some of the gaps in the roster. Inspectors found that the majority of this team were qualified or engaged in a relevant professional training programme.

Inspectors found that the roster indicated that there was always a qualified member of staff working on each shift.

Since the last inspection, inspectors found that just over half of the staff team had received training in advanced behaviour management and a behaviour support therapist had been assigned to the centre to work with the staff team. Inspectors found that the team did implement a number of these techniques for the two children. However, given the profile of the two children and their complex needs the staff team continued to require development in a number of areas previously identified on inspections, including, autism, learning disabilities, rights and the use of restrictive practices.

The provider had increased the number of staffing hours in order to meet the needs of the children. However, inspectors found that only half of these hours had been filled through the relief panel. This meant that there were occasions when individual children could not complete activities that were outlined in their personal plans.

The children services manager maintained a planned and actual rota. Inspectors reviewed a sample of rotas and found that three to four staff members were on duty during day time hours. At night, there was one staff member who was awake while a second staff member slept over in the centre. A shift leader was identified for each shift on the rosters examined by inspectors.
Staff supervision had been rolled out since the last inspection but was found to be of a mixed quality. Inspectors reviewed a sample of supervision files and found that supervision was in its infancy. Supervision contracts had been completed with staff and the contract identified that supervision was to occur on a six-eight week basis. Staff had only received one to two supervision sessions but staff members outlined that they found supervision useful. Inspectors found that supervision included staff issues, for example stress, management of the children's behaviours and training but the individual children's needs were not always included in the recorded discussions. Recording of the session, decisions and timeframes for agreed actions required improvement in order to ensure accountability and provide an effective record of the meeting and follow through. The newly appointed children's services manager was scheduled to complete training in supervision in September 2015.

Some staff had received professional development since the last inspection. This included children's rights, restrictive practices, culture and communication. Training gaps were identified in a recent training needs analysis. Training needs for the team, such as report writing, personal planning, autism training were identified and an organisational training programme was in place. However, there was no record that staff had been assigned places for any of these training sessions. There remained some gaps in mandatory training. One member of staff required training in medication management and manual handling. First aid training was outstanding for two members of staff.

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:
The majority of records required by schedule three and four of the regulations were in place. However, the residents guide did not entirely meet the requirements of Regulation 20 (1). It did not give sufficient information in relation to the terms and
conditions relating to residency or the arrangements for children to be involved in the running of the centre, nor the procedures regarding complaints and the arrangements for visits. The directory of residents was incomplete as it did not meet the requirements of Regulation 19. It documented the names of current residents, but information on previous residents was not included. Full contact information in regard to the next of kin of the residents was not included in the directory of residents.

There were some improvements required in the quality of recordings, as inspectors found that some documents were undated and not signed off by staff or the children's services manager. Paper records were well ordered, indexed and stored securely to prevent data protection breaches and preserve the children's information in a confidential manner. Children's files included their photograph, medical details, next of kin names, and all correspondence relating to each child. Correspondence from other professionals were consistently on children's files. There were no records of children having accessed their own records. Arrangements were in place for records to be archived.

The centre had all the required policies under Schedule 5. Inspectors found that some records such as the records management policy and the money management had sections or templates that were under review. Some of the policies required further review to provide sufficient guidance to staff, such as the risk management, children's money, intimate care, admissions and discharges, communications and information policies.

The centre was adequately insured, and inspectors viewed the insurance policy that was valid until May 2017.

Judgment:
Non Compliant - Moderate

Closing the Visit

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

Acknowledgements

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

Report Compiled by:

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

<table>
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<tr>
<th>Centre name:</th>
<th>A designated centre for people with disabilities operated by St Catherine's Association Limited</th>
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<tbody>
<tr>
<td>Centre ID:</td>
<td>OSV-0003409</td>
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<tr>
<td>Date of Inspection:</td>
<td>19 August 2015</td>
</tr>
<tr>
<td>Date of response:</td>
<td>25 November 2015</td>
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Requirements

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

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

Outcome 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:

Not all children had access to independent advocacy.

1. Action Required:

Under Regulation 09 (2) (d) you are required to: Ensure that each resident has access to advocacy services and information about his or her rights.

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
Please state the actions you have taken or are planning to take:
1) The Designated Liaison Person (DLP) made contact with the Child & Family Agency on September 4th 2015 in order to source independent advocacy via social worker for the resident in question. A summary report was forwarded by the DLP on September 7th to the Child & Family Agency. The report is currently with the principal social worker for review. The DLP has made weekly contact with the Child and Family Agency but has been unable to secure a response. St. Catherine’s Association will continue to explore this avenue in order to secure independent advocacy for this resident.

2) Other options will be explored through external national advocacy services.

3) Additionally, St. Catherine’s recognise the need for internal advocacy for children within the association. The keyworker assigned to a resident will also be recognised as the child’s advocate within the association. The keyworker will develop the child’s knowledge of their rights during children’s meetings. The keyworker will also advocate on behalf of the child during multidisciplinary Team Around the Child (TAC) meetings.

4) St. Catherine’s will explore the development of an internal advocacy forum to strengthen internal advocacy for the children.
   1) 07/09/15
   2) 15/11/15
   3) 30/11/15
   4) March 2016

**Proposed Timescale:** 01/03/2016

**Theme:** Individualised Supports and Care

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
It was not clear that children were consulted in the running of the designated centre.

**2. Action Required:**
Under Regulation 09 (2) (e) you are required to: Ensure that each resident is consulted and participates in the organisation of the designated centre.

**Please state the actions you have taken or are planning to take:**
1. Children’s meetings will be held with individual residents going forward and keyworkers will lead this process. Minutes will be recorded and logged in each resident’s Personal Folder.

2. The Speech and Language Therapist has been consulted with respect to both residents in order to develop a total communication approach. This will ensure that the maximum participation of each resident is achieved in the organisation of the designated centre.
   31/10/15
| **Proposed Timescale:** 31/10/2015 |  |
| **Theme:** Individualised Supports and Care |  |
| **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** |  |
| The complaints log did not outline if the complainant was satisfied with the outcome of the investigation of the complaint. |  |

3. **Action Required:**
Under Regulation 34 (2) (f) you are required to: Ensure that the nominated person maintains a record of all complaints including details of any investigation into a complaint, the outcome of a complaint, any action taken on foot of a complaint and whether or not the resident was satisfied.

**Please state the actions you have taken or are planning to take:**
1. The complaints log has been revised to include satisfaction of outcome. The complaints procedure is being implemented and all staff have been notified of changes via email.

2. The importance of logging children’s complaints was highlighted to staff and examples of these complaints were provided.

3. The complaints poster has been revised to include the new CSM as the Local Complaints Officer (LCO) for the designated center.

| **Proposed Timescale:** 23/09/2015 |  |
| **Theme:** Individualised Supports and Care |  |
| **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** |  |
| It was not clear from the policy if there was a separate person in place to oversee the complaints process |  |

4. **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:**
The Organisational Complaints Lead (OCL) has nominated a senior manager (PPIM) to oversee the complaints process in line with Regulation 34 (3).

The complaints policy has been revised to clarify the roles of the nominated persons.
Proposed Timescale: 20/10/2015

Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The policy identified two people to manage complaints.

5. Action Required:
Under Regulation 34 (2) (a) you are required to: Ensure that a person who is not involved in the matters the subject of a complaint is nominated to deal with complaints by or on behalf of residents.

Please state the actions you have taken or are planning to take:
The policy has been amended to clarify the roles of complaints officers as set out below:

●Within St. Catherine’s Association the CSM / Manager of each designated centre / location will be deemed the Local Complaints Officer (LCO) for that centre / location.
●Where complaints cannot or should not be resolved at the first point of contact due to their seriousness or complexity, these complaints must be escalated to the Organisational Complaints Lead (OCL), whereby a complaint Review Officer will be appointed to resolve the matter by informal means or formal investigation. Senior Services Managers (SSM) are deemed to be Review Officers and can be delegated a complaint for review by the Organisational Complaints Lead.
●If a Complaint is made against a Local Complaints Officer or a Review Officer, the complaint is dealt with by the Organisational Complaints Lead. The Organisational Complaints Lead within SCA is the Acting CEO.
●A Senior Services Manager (i.e. PPIM) has been nominated to oversee the complaints process in line with the Regulation 34 (3), Health Act 2007, S.I. No. 367 of 2013. This oversight shall ensure that all complaints are appropriately responded to and that records are maintained by the appropriate complaints officer as specified under Regulation 34 (2) (f).

20/10/15

Proposed Timescale: 20/10/2015

Outcome 02: Communication

Theme: Individualised Supports and Care

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not provide sufficient detail to guide staff to communicate effectively with children.

6. Action Required:
Under Regulation 10 (2) you are required to: Make staff aware of any particular or individual communication supports required by each resident as outlined in his or her
Please state the actions you have taken or are planning to take:
1) Personal plans will be updated to include sufficient detail to guide staff in communicating effectively with both residents.

2) A communication passport has been identified as a need for both residents and will be completed in consultation with the residents, keyworkers, Speech & Language Therapist, CSM and parents. These communication passports will identify individual communication needs for each child in one concise document and so information will not be dispersed throughout the Personal Plan folder.

Proposed Timescale: 07/11/2015
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all assistive technology was used.

7. Action Required:
Under Regulation 10 (3) (b) you are required to: Ensure that where required, residents are facilitated to access assistive technology and aids and appliances to promote their full capabilities.

Please state the actions you have taken or are planning to take:
1) A review of alternative communication methods has been scheduled with the speech and language department and behaviour support for one resident. A request has been made by the speech and language department for a more suitable AAC device for this resident as the current device has been identified as unsuitable without the prerequisite skills.

Proposed Timescale: 07/11/2015

Outcome 03: Family and personal relationships and links with the community
Theme: Individualised Supports and Care

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Children had limited opportunities to have contact with their peers.

8. Action Required:
Under Regulation 13 (2) (c) you are required to: Provide for residents, supports to develop and maintain personal relationships and links with the wider community in accordance with their wishes.
Please state the actions you have taken or are planning to take:
1. The CSM and staff will liaise with other centres in a more structured manner going forward in order to increase both residents’ opportunities to have contact with peers.
2. A log has been created to record contact with peers for both residents going forward.
3. Staff will continue to explore options to join community based clubs with both residents in order to develop relationships and links with the wider community in accordance with their wishes. One resident is currently being supported to join a club.
4. The opportunity for another resident to start swimming sessions with a peer is currently being explored.

Action 1 – 02/10/15
Action 2 – 02/10/15
Action 3 – 31/10/15
Action 4 – 15/11/15

Proposed Timescale: 15/11/2015

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 admissions and discharge policy and guidelines did not outline how referrals were reviewed to ensure that they were appropriate and met the criteria of the statement of purpose. In addition the policy did not outline the process should a risk assessment highlight that a new admission may not be suitable to be placed with other children in the centre.

9. 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 referrals, admission and discharge policy and guidelines will be reviewed to include the process by which a new referral is deemed appropriate and in accordance with the statement of purpose for the designated centre.

The revised policy will also outline the process to be followed in the event that a risk assessment indicates a new admission may not be suitable to be placed with other residents in the designated centre.

Proposed Timescale: 15/11/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in
the following respect:
No contract of care was in place for children.

10. **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:**
1. A contract for the provision of care has been drafted and circulated to the Senior Management Team and Children’s Services Managers for review.
2. Once agreed, the contract for the provision of care will be reviewed with parents/guardians and signed off.
Action 1 – 20/10/15
Action 2 – January 2016

**Proposed Timescale:** 01/01/2016

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**Outcome 05: Social Care Needs**

**Theme:** Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
One child’s comprehensive assessment was incomplete.

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

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

**Process:**
Residents’ comprehensive assessments are completed using information provided by each member of the team around the child. This includes information from multi-disciplinary reports as well as meetings with parents, social workers and the child.

A ‘Team around the Child’ (TAC) meeting takes place at least once per year or as required depending on the needs of the child. Any change in need, circumstances or issues in relation to the child’s care, personal plan and comprehensive assessment are discussed through the TAC process and action dates for completion are confirmed.

**Actions:**
1. St. Catherine’s Association have acknowledged the need for a clinical team dedicated to residential and respite services in order to ensure comprehensive assessments and personal plans are reviewed on an annual basis. The Senior Clinical Services Manager
has identified a team of clinicians for residential services, and children attending respite that have been assessed as having high support needs. This team was formed on 14th October 2015 and will meet on a weekly basis. This team will schedule meetings with the Children’s Services Managers (CSM) in order to agree their caseload.

2. A schedule of annual reviews to be completed in 2016 will be developed by the CSM’s and Clinical Managers for children availing of residential and respite services.

3. With respect to the incomplete comprehensive assessment for one resident, A Team Around the Child meeting took place for this resident on 7th September. The revised comprehensive assessment required the input of some clinicians to complete the annual review for 2015. Follow up was requested during the TAC meeting and will be added to the comprehensive assessment once complete.

Proposed Timescale:
Action 1 – 30/11/15
Action 2 – 15/12/15
Action 3 – 30/11/15

Proposed Timescale: 15/12/2015

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
One child’s personal plan was in draft format.

12. Action Required:
Under Regulation 05 (4) (a) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which reflects the resident’s assessed needs.

Please state the actions you have taken or are planning to take:
1. Residents’ personal plans are developed in line with their comprehensive assessment which includes information provided by each member of the team around the child.
2. A ‘Team around the Child’ (TAC) meeting takes place at least once per year or as required depending on the needs of the child. Any change in need, circumstances or issues in relation to the child’s care, personal plan and comprehensive assessment are discussed through the TAC process and action dates for completion are confirmed.
3. With respect to the Personal Plan for one resident being in draft format. It has been reviewed at a TAC meeting on September 7th. The plan has been updated to include information on the new CSM and Keyworker.
4. The Personal Plan will be updated to include any changes following receipt of outstanding clinical review of comprehensive assessment for 2015.
Action 3 – 07/09/15
Action 4 – 22/11/15
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<thead>
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<th>Proposed Timescale: 22/11/2015</th>
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<tr>
<td><strong>Theme:</strong> Effective Services</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Personal plans were not comprehensive and did not outline some key information.

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

**Please state the actions you have taken or are planning to take:**
Personal Plans will be reviewed to include all key information including the care status and mental health needs of residents. A request has been made to one resident’s psychiatrist in this regard.

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<table>
<thead>
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<th>Proposed Timescale: 22/11/2015</th>
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<td><strong>Theme:</strong> Effective Services</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
It was not clear that personal plan reviews reviewed the effectiveness of the previous plan.

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

**Please state the actions you have taken or are planning to take:**
The effectiveness of personal plans is reviewed through the Team Around the Child (TAC) process.

1. A summary page is now included in the new Personal Plan template in order to document progress on goals, identify changes in circumstances, new developments and further actions required going forward. This process allows for the review of effectiveness of personal plans to be documented in a clearer manner.
2. St. Catherine’s Association have acknowledged the need for a clinical team dedicated to residential and respite services in order to ensure comprehensive assessments and personal plans are reviewed on an annual basis. The Senior Clinical Services Manager has identified a team of clinicians for residential services, and children attending respite that have been assessed as having high support needs. This team was formed on 14th October 2015 and will meet on a weekly basis. This team will schedule meetings with the Children’s Services Managers (CSM) in order to agree their caseload.
3. A schedule of annual reviews to be completed in 2016 will be developed by the CSM’s and Clinical Managers for children availing of residential and respite services.
Proposed Timescale:
Action 1 – 7/10/15
Action 2 – 30/11/15
Action 3 – 15/12/15

Proposed Timescale: 15/12/2015
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Children had not received copies of their personal plans.

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

Please state the actions you have taken or are planning to take:
1. Both children have received copies of their personal plans.
2. Personal plans will be discussed with residents during children’s meetings and minutes will be recorded. Keyworkers will develop social stories as required in order to support resident’s participation and understanding.
Action 1 – 02/10/15
Action 2 – 31/10/15

Proposed Timescale: 31/10/2015

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 outline the arrangements for the identification, recording and investigation of, and learning from, serious incidents or adverse events involving residents.

16. 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:
An adverse events policy has been drafted and is in effect since 8th September 2015. This policy outlines the processes to be followed when an adverse event occurs.
The Risk Management policy will be reviewed in line with Regulation 26 (1) (d) and will reflect the arrangements in place for the identification, recording and investigation of, and learning from, serious incidents or adverse events.

**Proposed Timescale:** 24/11/2015

**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 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.

**17. 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 Risk Management policy will be reviewed in line with Regulation 26 (1) (e). Guidance will be included to ensure that the 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.

**Proposed Timescale:** 24/11/2015

**Theme:** Effective Services

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

Staff did not consistently label food in the fridge and freezer with the date of opening.

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

Please state the actions you have taken or are planning to take:
A food hygiene and safety representative has been assigned in the designated centre to ensure that residents are not at risk of infection associated with poor food handling processes. All food in the fridge and freezer is now consistently labelled with the date of opening and a first in first out (FIFO) system is in operation.
Proposed Timescale: 01/09/2015
Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Furnishings and bedding in the centre were not fire retardant.

19. Action Required:
Under Regulation 28 (2) (a) you are required to: Take adequate precautions against the risk of fire, and provide suitable fire fighting equipment, building services, bedding and furnishings.

Please state the actions you have taken or are planning to take:
The Health & Safety Officer conducted a comprehensive fire risk assessment in the designated centre on September 11th 2015 and has classified the centre as a low fire risk. All furniture, furnishings and other material are purchased from reputable suppliers/retailers and we have genuine reason to believe that they have undergone rigorous testing, have already been impregnated with fire retardant material at production/manufacturing stage to ensure that they fully comply with European Union fire safety and/or consumer safety requirements and have been awarded a CE mark (i.e. pre-requisite consumer safety requirement). The full assessment is available in the designated centre.

Proposed Timescale: 11/09/2015

Outcome 08: Safeguarding and Safety
Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all restrictive practices were identified and recorded. Single separation was used to manage a child's behaviour. The use of physical interventions were extensively used.

20. 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:
Action 6: 23/10/15Staff are trained in Management of Challenging Behaviour philosophy and techniques, which training is based on evidence based practice. The training and support plans guide staff in the use of least restrictive practices for the shortest duration possible in order to safely and effectively manage all incidents of physically challenging behaviour. This is in line with national policy and framework.
Additionally, any restriction used for a child has been identified by the appropriate discipline as the least restrictive option at that time. Examples include psychiatry for any chemical restraint, positive behaviour support for any physical or environmental restraints and physio and OT for any mechanical restraints necessary. Supports and goals are immediately identified in order to work towards reducing this restriction.

The recording of restrictive practices within the centre has been reviewed and communicated to staff via email, in person and at team meetings:

1. The duration of time spent in the relaxation room with staff supervising in the doorway and exit blocked due to challenging behaviour is now being recorded on the restrictive practice log under ‘Single Separation’ and will be included on future returns to the regulator.
2. Additionally, there will be an addition to the ‘Positive Behaviour Support’ policy which addresses the use of ‘Single Separation’ and a detailed procedure on the implementation of single separation in place to guide staff. This will form part of the reactive strategy in the behaviour support plan and will be scripted by the behaviour analyst.
3. Any incident where one resident’s movement is redirected or restricted in his home due to risk of challenging behaviour from the other resident is also recorded under ‘Freedom of Movement’. The duration, location and rationale for restriction is noted on the restrictive practice log and recorded on the Incident Report Form.
4. A second people carrier is used on occasion in order to ensure both residents have access to preferred activities within the community. The second people carrier includes a Perspex screen behind the driver. Any use of this people carrier is recorded as ‘Travelling on a bus with Perspex’ in the restrictive practice log.
5. Identified restraints are sent to the ‘Rights Review Committee’ for assessment.
6. Three members of the team are scheduled to attend restrictive practice training on 23rd October 2015.

Action 1: 1/09/15
Action 2: 1/12/15
Action 3: 1/09/15
Action 4: 1/09/15
Action 5: 1/09/15

Proposed Timescale: 01/12/2015

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
It was not consistently evident that other measures were taken prior to the implementation of a restrictive practice such as single separation.

21. **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 comprehensive behaviour support plan including bullet pointed proactive and reactive strategies is in place for the resident and all staff are trained in Management of Challenging behaviour philosophy and techniques.
- All staff are required to follow the behaviour support plan, with support and guidance from the positive behaviour support specialist.
- The training and support plans guide staff in the use of least restrictive practice for the shortest duration possible in order to safely and effectively manage all incidents of physically challenging behaviour.
- All steps of the reactive strategy are clearly set out for staff.
- Staff working with the resident attempt to verbally deescalate the situation at all times and encourage the resident to follow relaxation strategies prior to the implementation of restrictive practices which are only used as a last resort.
- The use of proactive and relaxation strategies are highlighted in the incident recording sheets and opportunity to calm is provided to the resident when engaging in challenging behaviour.

Proposed Timescale: 01/09/2015

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:
Not all restrictive practices were notified to the Authority.

22. Action Required:
Under Regulation 31 (3) (a) you are required to: Provide a written report to the Chief Inspector at the end of each quarter of any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.

Please state the actions you have taken or are planning to take:
1. The recording of restrictive practices within the centre has been reviewed since the inspection and communicated to staff via email, in person and at team meetings.

2. There is now a system in place whereby all restrictive practices are identified as being the least restrictive practice available at that time by the relevant discipline. The use of restrictive practices undergo examination from the rights review committee and plans are put in place to reduce any such restriction where possible.

3. All restrictive practices within the designated centre will be notified to the regulator going forward.
4. Staff have received training on restrictive practices in general to ensure that all restrictive practices are identified.

Action 1 – 01/09/15
Action 2 – 01/09/15
Action 3 – 01/09/15
Action 4 – 23/10/15

**Proposed Timescale:** 23/10/2015

**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:
Not all staff had signed the signature sheet.

23. **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:
1) All staff have signed the signature sheet since the inspection.
2) With respect of new staff, medication management forms part of the induction process. New staff sign the medication management sheet following completion of in-house medication management training. New staff are only responsible for medication management following successful completion of this training and clinical assessment on site. New staff are booked on this course for the 20th and 21st October, 2015.

1) 01-09-15
2) 21-10-15

**Proposed Timescale:** 21/10/2015

**Outcome 13: Statement of Purpose**

**Theme:** Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The statement of purpose did not provide sufficient information on all aspects of Schedule 1.

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

**Please state the actions you have taken or are planning to take:**
The Statement of Purpose will be reviewed to provide sufficient information as required under Schedule 1 to include more specific admission criteria such as age profile and level of need supported. Further information will be included with respect to staffing levels, emergency admissions, and arrangements in place to support residents to attend educational services.

**Proposed Timescale:** 16/10/2015

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
It was unclear that copies of the statement of purpose were made available to parents.

**25. 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 revised Statement of Purpose will be made available to parents.

A printout will be given to parents to take home and this will be recorded in the family access report books.

**Proposed Timescale:** 31/10/2015

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**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:**
Quality assurance and risk management systems required development.

**26. 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:**
1. Staff will receive supervision through their line manager in order to ensure that safe, quality care is consistently provided to children attending the designated centre.
2. The Children’s Services Manager will complete Performance Management training.
3. The Children’s Services Manager will implement the performance management process in the designated centre with support from the Human Resources Department as required.

4. The Senior Children’s Service Manager will engage in performance management with the Children Services Manager to ensure that agreed actions and targets are met. Both the PIC and the Person Performing in the Management of the Centre will be held to account if agreed actions are not met in a timely manner.

5. The organisation will develop a more comprehensive and robust internal audit structure, which will consider the effectiveness of management structures and systems in ensuring the quality and safety of care in the centre.

6. The Risk Register in the centre will be reviewed to include identified gaps in order to ensure risk can be effectively controlled in the centre.

7. The Quality Compliance and Training (QCT) team will develop a quality assurance system in 2016. In the interim, a schedule of audits has been developed to include six monthly provider visits, annual review of the quality and safety of care, medication management audits and a comprehensive six monthly schedule of Health and Safety Audits.

8. Further training on risk management training has been secured and offered to staff.

9. The risk sub-committee reports back to the Senior Management Team on identified risks and any agreed action plans to mitigate as against identified risk.

Action 1 – 1/09/15
Action 2 – 31/12/15
Action 3 – 31/03/16
Action 4 – 31/03/16
Action 5 – 31/03/16
Action 6 – 30/11/2015
Action 7 – 30/03/2016
Action 8 – 31/01/2015
Action 9 – 30/12/2015

**Proposed Timescale:** 31/03/2016

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The report of the six monthly visit was not comprehensive as it did not clearly identify the safety and quality of care and support being provided in the centre.

27. **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 Quality, Compliance and Training Team are developing a more comprehensive...
unannounced audit template for use within the designated centre.

• A more comprehensive unannounced visit will be completed in the centre and a comprehensive report developed 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.

• The Quality, Compliance and Training Team will analyse the report and put in place an action plan to address any concerns regarding the standard of care and support.

Action 1: 30/12/2015
Action 2: 30 January 2016
Action 3: 28 February 2016

Proposed Timescale: 28/02/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The review was not comprehensive and the process did not provide for effective consultation with the children and their representatives

28. 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:
1. The 'Annual Review of Quality and Safety' will be completed by the person in charge (PIC) of Woodbeg Residential Centre. This review provides for effective consultation with residents and their representatives. The family liaison co-ordinator will assist the PIC with this aspect of the annual review.
2. It is acknowledged that the annual review in its current format requires development in order to meet the regulatory requirements. The Quality, Compliance and Training Team (QCT) team is in the process of developing a more comprehensive and robust audit structure. Under this structure, the annual review will provide more comprehensive information and will clearly identify the safety and quality of care and support being provided in the centre. Consultation with the children and their representatives will take place as part of this process and the Family Liaison Coordinator will support where necessary.
3. In developing the more robust audit structure, it has been agreed to appoint a staff member into an auditory role (1 Whole Time Equivalent) to support the provider and the Person in Charge with the regulatory requirements pertaining to audits and to ensure effective governance and oversight of action plans arising from the annual review.

Action 1: 30/11/2015
Action 2: 31/01/2016
Action 3: 28/02/2016
Proposed Timescale: 28/02/2016  
**Theme:** Leadership, Governance and Management  

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The annual review of quality and safety of care and support was not effective.

### 29. 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:**
1. The 'Annual Review of Quality and Safety’ will be completed by the PIC of Woodbeg Residential Centre. This review will be an effective review of quality and safety of care and support for the residents and will include consultation with parents and family members. The family liaison co-ordinator will support the PIC with this process.
2. The Quality, Compliance and Training Team will analyse the annual review and put in place an action plan to address any concerns regarding the standard of care and support.
3. It is acknowledged that the annual review requires further development to be fully compliant with the regulations. St. Catherine’s Association intend to develop an independent internal audit structure which will ensure that the annual review of quality and safety of care is effective going forward. In developing the more robust audit structure, it has been agreed to appoint a staff member into an auditory role (1 Whole Time Equivalent) to support the provider and the Person in Charge with the regulatory requirements pertaining to audits and to ensure effective governance and oversight of action plans arising from the annual review. The Senior Management Team will oversee the implementation of any agreed action plan to ensure effective learning from the audit process.
4. A baseline of data and statistics will be developed to monitor progression with action plans and to ensure effective learning. This system will be paper based initially pending effective implementation of an electronic database. Negotiations are presently underway to develop and build a custom database with an external IT provider.

<table>
<thead>
<tr>
<th>Action 1: 30/11/2015</th>
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<tr>
<td>Action 2: 30/12/2015</td>
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<td>Action 3: 28/02/2016</td>
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<tr>
<td>Action 4: 30/11/2016</td>
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</tbody>
</table>

Proposed Timescale: 30/11/2016

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**Outcome 16: Use of Resources**  
**Theme:** Use of Resources  

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
The premises were leased until 2016. Additional staff hours had been approved by the provider for the centre since the last inspection but the children's services manager struggled to fill these shifts due to a lack of relief staff. In addition, there was no designated budget for the centre.

30. **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:**
1. The facilities manager is negotiating with the landlord of the property to secure a lease for a period of 3 years and nine months, which period will cover the term of registration.
2. A recruitment process is currently in progress in order to ensure that a functional relief panel is established for the centre to fill additionally sanctioned hours.
3. A budget is currently being drafted for the designated centre. The PIC will receive training in budget management prior to the budget being allocated to the designated centre.

Action 1 – 30/11/2015  
Action 2 – December 2015  
Action 3 – March 2016

**Proposed Timescale:** 01/03/2016

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**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was not sufficient staff with the appropriate skills and competencies to meet the needs of children.

31. **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:**
1. A recruitment process is currently in progress in order to ensure that the centre had suitable staff with the appropriate qualifications, competencies and skill mix in order to meet the needs of the children.
2. A training needs analysis has been completed for the location based on the staff team and assessed needs of the residents. A training calendar is in place and staff will be booked to attend courses as they arise in areas such as positive behaviour support, challenging behaviour, introduction to autism, culture, communication, mental health...
awareness and dual diagnosis.

**Proposed Timescale:** 31/12/2015  
**Theme:** Responsive Workforce

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**  
There were some gaps in staff's mandatory training, and also in the provision of continuous professional development for staff.

**32. 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:**  
1. Remaining staff completed an Advanced Management of Challenging behaviour course on the 31st August 2015. A new member of staff has been scheduled for the full Basic Management of Challenging Behaviour course on October 10th/11th.
2. One outstanding member of staff has received training in medication management since the inspection.
3. Remaining gaps in mandatory training such as manual handling and occupational first aid will be addressed through the next available course on the training calendar. In the meantime, it is ensured that there is always staff rostered on duty that have completed all mandatory training.
4. A training calendar is in place and staff will be booked to attend courses as they arise in areas such as positive behaviour support, challenging behaviour, introduction to autism, learning disabilities culture, communication, mental health awareness and dual diagnosis, children’s rights and restrictive practices. Information gathered at these courses will be discussed at monthly team meetings in order to promote the sharing of knowledge. This will be recorded in the minutes.

Action 1 & 2 – 21-10-15  
Action 3 – December 2015  
Action 4 – February 2016

**Proposed Timescale:** 28/02/2016

**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 were complete and some policies required review in order to provide sufficient guidance to staff.
33. **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:**
Policies will be reviewed in order to provide sufficient guidance to staff including:
- The Quality, Safety and Risk Management Policy
- Children’s Money
- Referrals, Admissions, Transfers and Discharges Policy & Guidelines

**Proposed Timescale:** 30/11/2015
**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not record all residents who had resided in the centre.

34. **Action Required:**
Under Regulation 19 (1) you are required to: Establish and maintain a directory of residents in the designated centre.

**Please state the actions you have taken or are planning to take:**
The directory of residents will be revised to include all residents who have resided in the centre.

**Proposed Timescale:** 30/11/2015
**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The directory of residents did not contain all information as required in paragraph (3) of Schedule 3.

35. **Action Required:**
Under Regulation 19 (3) you are required to: Ensure the directory of residents includes the information specified in paragraph (3) of Schedule 3 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 directory of residents will be revised to include all information as required in paragraph 3 of Schedule 3 such as full contact information in regard to the next of kin.
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<tr>
<th>Proposed Timescale: 31/10/2015</th>
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<tr>
<td><strong>Theme:</strong> Use of Information</td>
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<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>The terms and conditions of residency in the centre were not adequately outlined in the residents guide.</td>
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</tbody>
</table>

**36. Action Required:**
Under Regulation 20 (2) (b) you are required to: Ensure that the guide prepared in respect of the designated centre includes the terms and conditions relating to residency.

Please state the actions you have taken or are planning to take:
The residents guide will be reviewed to include clear terms and conditions of residency in the centre.

<table>
<thead>
<tr>
<th>Proposed Timescale: 15/11/2015</th>
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<tr>
<td><strong>Theme:</strong> Use of Information</td>
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<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>The residents guide did not include arrangements for resident involvement in the running of the centre.</td>
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</tbody>
</table>

**37. Action Required:**
Under Regulation 20 (2) (c) you are required to: Ensure that the guide prepared in respect of the designated centre includes arrangements for resident involvement in the running of the centre.

Please state the actions you have taken or are planning to take:
The residents guide will be reviewed to include arrangements for resident involvement in the running of the centre.

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<th>Proposed Timescale: 15/11/2015</th>
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<tr>
<td><strong>Theme:</strong> Use of Information</td>
</tr>
<tr>
<td>The Registered Provider is failing to comply with a regulatory requirement in the following respect:</td>
</tr>
<tr>
<td>The residents guide did not provide information on how residents could access inspection reports.</td>
</tr>
</tbody>
</table>

**38. Action Required:**
Under Regulation 20 (2) (d) you are required to: Ensure that the guide prepared in respect of the designated centre includes how to access any inspection reports on the centre.

**Please state the actions you have taken or are planning to take:**
The residents guide will be reviewed to include sufficient information on the complaints procedure.

**Proposed Timescale:** 15/11/2015

**Theme:** Use of Information

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The residents guide did not provide sufficient information on the complaints procedure.

39. **Action Required:**
Under Regulation 20 (2) (e) you are required to: Ensure that the guide prepared in respect of the designated centre includes the complaints procedure.

**Please state the actions you have taken or are planning to take:**
The residents guide will be reviewed to include sufficient information on the complaints procedure.

**Proposed Timescale:** 15/11/2015