Health Information and Quality Authority
Regulation Directorate

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

Centre name:	A designated centre for people with disabilities operated by Stepping Stones Residential Care Limited
Centre ID:	OSV-0003257
Centre county:	Dublin 3
Type of centre:	Health Act 2004 Section 38 Arrangement
Registered provider:	Stepping Stones Residential Care Limited
Provider Nominee:	Darren Wright
Lead inspector:	Caroline Browne
Support inspector(s):	Eva Boyle
Type of inspection	Unannounced
Number of residents on the date of inspection:	3
Number of vacancies on the date of inspection:	0

About monitoring of compliance

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

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

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

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

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

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

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

The inspection took place over the following dates and times

From:	To:
21 April 2016 09:00	21 April 2016 17:00
22 April 2016 09:00	22 April 2016 15:00

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

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This was the centre's fourth inspection and was an unannounced monitoring inspection. As part of the inspection process, inspectors spoke with two of the three children living in the centre, reviewed care files, reports, staff files and policies and procedures. Inspectors also interviewed staff and managers and spoke with two parents. Inspectors found that while some deficits from previous inspections had been addressed, some had not been addressed in a timely way and other deficits were identified.

The centre was located in Dublin and provided residential services to three children aged between 10 to 18 years old with intellectual disabilities and autistic disorders. Children had access to many amenities such as public transport, parks, shops and was close to the city centre. Children had a good quality of life with opportunities to participate in activities similar to their peers such as swimming, social clubs and walks in the parks. At the time of the last inspection, children were not receiving formal education. On this inspection, two of the children were receiving education from a tutor employed by the service. Children appeared happy and relaxed and interacted well with staff. There was improved consultation with children to include their wishes and views.

Children were safe. There were some good safeguarding practices in place and staff

responded appropriately to child protection and welfare concerns. Children were provided with emotional, behavioural and therapeutic supports which promoted a positive approach to behaviours that challenged.

Children's needs were not comprehensively assessed, therefore there was a lack of guidance for staff in relation to their needs. Personal plans were not always updated to reflect changes in children's needs. There were regular multi-disciplinary meetings, but it was not clear that the child's progress against their personal plan was consistently reviewed at these meetings.

Some management systems had improved but the centre manager had changed three times in a 12 month period. Risk management, managerial oversight of care practices and quality management systems required improvement. There had been significant staff turnover since the last inspection. There remained gaps in mandatory training, staff files and vetting.

Further deficits identified are outlined in the body of this report.

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

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Findings:
At the time of the last inspection, multidisciplinary meetings did not consistently review the progress of the previous plans and children did not engage in personal plan reviews. Not all children's needs were reassessed on an annual basis. Parents had not received copies of personal plans and there were no child friendly versions of these plans available. Inspectors found that some of these deficits were addressed. However, some actions were not sufficiently addressed and the identified timeframe had passed. In addition deficits were identified in the quality of assessment and personal plans.

Children's assessment of need were not always comprehensive. Children's needs were assessed on admission to the centre. These assessments included children's physical and mental health, family, education and behavioural needs. However, inspectors found that some assessments did not provide sufficient detail to inform the personal plan. Assessments were carried out annually or as the children's needs changed.

The quality of personal plans required improvement. Children had personal plans outlining their individual needs, choices, goals and supports they required but they were not informed by a comprehensive assessment. Since the last inspection, inspectors found that children were consulted through keyworking sessions where they were supported to make choices regarding their care but these sessions did not take place regularly. There were child friendly versions of the personal plans which were accessible to the children. However, inspectors found that personal plans were not updated to reflect on-going changes in children's needs. Goals were developed through the personal planning process. Inspectors found that children's goals were not fully developed in order to guide staff in their practical implementation. For example, one goal for a child was to identify what the child needs to work on for independent living skills. It was not clear how personal plan goals were monitored to ensure improved outcomes for children.

Deficits in relation to person plan reviews had not been addressed. There were multidisciplinary review meetings held in order to re-assess children's needs, but not all up-to-date minutes were on children's records. Parents attended some reviews. However, inspectors found that review meetings did not consistently review the progress of the child against the previous personal plan. Review meeting minutes on file did reflect clear actions and agreed persons responsible.

Children were supported to transition between services. Inspectors reviewed a good transition plan for a child who was recently introduced to the service. This plan considered the child's strengths, interests, communication, social skills and any support issues. This plan identified resources and planned supports required for the transition. It also identified the staff responsible and agreed timelines.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Findings:
At the time of the last inspection the risk management policy was not in line with the regulations and not all staff were trained in fire safety.

While the risk management policy had been reviewed it remained non compliant with the regulations. The policy did not adequately outline the arrangements for the learning from serious incident nor the arrangements in place to ensure risk control measures were proportional to the risk identified.

There was an updated risk register in place. The majority of risks on the risk register were rated as low risks. However, some potential risks in the centre were not identified on the risk register. For example, all of the perimeter doors of the house were locked at all times which posed a risk in the event of fire, but this risk had not been assessed. Inspectors also found that some control measures identified to manage risks were not implemented. For example, one measure was to ensure all staff received training in the administration of medication to treat epilepsy but not all staff had received this training. The centre manager was not trained in risk management.

An incident reporting system was in place and staff completed the relevant reports following an incident. However, while the manager reviewed the completed reports there was no learning being shared with the staff team to prevent other incidents occurring

Some infection prevention and control measures required improvement. There were some systems in place to promote infection control, but these systems were not always implemented. A colour coded cleaning system and cleaning rota had been introduced but staff were not using this system on the day of inspection. Inspectors also observed cloth towels rather than paper towels in bathrooms.

There had been some improvements in fire safety measures but further improvements were required. All staff had received fire safety training. There was suitable fire equipment provided and adequate means of escape. There was a procedure in place for the safe evacuation of children and staff in the event of a fire which was displayed in the centre. On review of records inspectors found that fire fighting equipment was serviced on a annual basis. There were four fire drills since the last inspection, one of which had been a night time drill. However, on review of records inspectors found that not all staff had participated in a fire drill. Fire records were kept which included details of fire drills, fire alarm testing and fire fighting equipment. However, these checks were not monitored effectively as inspectors found some gaps in records for example daily and weekly fire checks.

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

Findings:
At the time of the last inspection, not all staff were trained in the management of behaviour and there was no clear mechanism for review and approval of restrictive practices. Individual intimate care plans were not in place for children.

There were a number of safeguarding measures used within the centre in order to protect children. Safeguarding measures included updated policies, appropriate staffing ratios, social work contact, intimate care plans, behaviour management plans and a visitor's log. The policy on the prevention detection and response to abuse had been updated and was in line with Children First (2011). Staff were aware of the relevant policies.

However, inspectors found that a collective pre-admission risk assessment had not been completed prior to a recent admission in order to determine a child's suitability and the impact of their admission on other children already living in the centre. There had been some incidents of peer to peer abuse following this admission.

Intimate care plans had been reviewed and were more individualised. The plans provided adequate guidance to staff in completing the task but did not direct staff to tell children what was happening. However, staff told inspectors that they spoke to the child in advance of completing any intimate care task.

Child protection concerns were appropriately responded to. The majority of staff were trained in child protection. The centre manager was the designated liaison person (DLP) for child protection but had not received specific training for this role and staff were aware of her role. A child protection concern had been notified appropriately to the relevant authorities and one concern from the last inspection was awaiting formal conclusion by the Child and Family Agency. The centre manager was vigilant around monitoring child welfare and protection concerns and liaised with relevant social workers as required.

Children's behaviour was well managed. There was a policy in place for the provision of behavioural support. Since the last inspection, staff were trained in behavioural management strategies which included de-escalation and intervention techniques. Children were supported with emotional, behavioural and therapeutic support that promoted a positive approach to behaviours that challenge. The centre manager was in the process of providing additional training to staff in relation to behaviour management techniques. Good quality behaviour support plans were in place which identified the behaviour, triggers, contributing factors and support measures required. These plans provided clear guidance to staff in relation to actions to take when a child was displaying behaviour that challenged. Plans were regularly reviewed by the centre manager in order to reflect any changes. Therapeutic interventions were implemented in consultation with a child's family. Interventions were regularly reviewed by the centre manager and multidisciplinary team as part of the personal planning process. Efforts were made to identify the underlying causes of behaviour. For example, one child had a programme in place to establish a better sleep pattern.

Some restrictive practices remained unidentified as was the situation at the last inspection. There was a policy in place in relation to the use of restrictive practices but staff did not always implement it. This policy promoted the use of restrictive practice as a last resort. Risk assessments had been undertaken for some restrictive practice but inspectors found that others, for example locked doors and windows and blocking techniques were not recognised as restrictive practices and had not been risk assessed.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Findings:
At the time of the last inspection, information in relation to immunisation records were not held on children's files. This deficit was addressed.

Children's health needs were assessed on admission to the centre. Inspectors reviewed health assessments which were comprehensive. The majority of children's healthcare needs were met through timely access to healthcare services and appropriate treatment and therapies. For example, children had access to a general practitioner (GP) and relevant professionals such as psychology, occupational therapy, speech and language and a dietician. Inspectors found that there were some delays in accessing psychiatric services. However, it was evident that the centre manager was endeavouring to access the appropriate psychiatric services. Children's files contained their medical histories, various medical reports and immunisation records.

Children's dietary intake had improved since the last inspection. Children's dietary needs were assessed and regularly reviewed by a dietician as required and their advice was implemented by the staff team. Children were encouraged and enabled to make healthy living choices. Children went for walks in the area and had recently started swimming lessons. There was sufficient, nutritious and appetising food available to children at times suitable to them. Inspectors observed children requesting snacks which staff provided. Inspectors observed a mealtime, which was sociable and staff provided assistance to the children in a sensitive manner. Children were supported to prepare their own meals when possible.

Judgment:
Compliant

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Findings:
At the time of the last inspection, administration sheets did not reflect good practice, there were gaps in recording of medication and controlled drugs were not stored safely. Drug errors were not always identified or recorded.

Medication practices were not safe. Not all children had an up to date prescription available in the centre. Staff had not always administered medication as per the prescription and administration log. Inspectors found that some staff had not signed the administration sheet and there were also a number of administration sheets which were not co signed by a witnessing staff member in line with the policy. There were signature sheet on children's files for staff members. However, inspectors found that not all new staff had signed the signature sheets. The centre manager told inspectors she had also identified gaps in recording and some measures were taken to address deficits. However, not all gaps had been identified by the centre manager.

There was a revised medication policy outlining procedures for ordering, prescribing, storing and administration of medicines to children. All medications, including controlled drugs, were securely locked away. The majority of staff had received training in safe administration of medication. All medication held in the centre were appropriately labelled and were in date. Inspectors saw information available to staff in relation to medications stored. Children had as required (PRN) medication which was appropriately labelled. However, the controlled drugs register was not up-to-date.

Medication errors were not formally reported and oversight of errors was ineffective. The centre manager reviewed medication practices, but not all errors were identified by the manager. A medication audit was carried out in November 2015 by an external manager but this did not identify any significant issues.

Judgment:
Non Compliant - Moderate

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

Theme:
Leadership, Governance and Management

Findings:
At the time of the last inspection, management systems required improvement. The annual and six monthly review of the quality and safety of care and support was not robust. Not all staff were aware of protected disclosure. Inspectors found that while some deficits were addressed on this inspection others were not.

There was a clearly defined management structure that identified clear lines of authority, responsibility and accountability for the service. Staff were aware of their responsibilities and the relevant management structures. The centre was managed by a full time person who was suitably qualified and experienced manager who had taken up the position in January 2016. This was the third person to fill this post in the last 12 months. Inspectors found that there were some gaps in her knowledge of the relevant legislation, standards and her responsibility under the legislation. Inspectors found that staff were not always aware of who was the shift leader and rosters did not consistently record the person acting as shift leader. However, oversight of care practices by the centre and external managers was not effective in ensuring safe, quality care to the children.

There were some improvements in management systems but others required further development. Policies and procedures had recently been updated which provided staff with detailed guidance. Communication systems had improved. Staff meetings were utilised better and addressed issues occurring within the centre, for example behavioural issues with children, new guidance that had been developed. There was also a communication book which allowed for effective communication between the staff team. However, the person in charge did not attend senior management meetings where agenda items included staff training, new referrals to the service and children currently attending the services. The person-in charge prepared a report for this meeting in relation to the centre and got written feedback on the report forwarded to the meeting.

Risk management systems were not robust. A risk register was in place but not all risks were identified. A risk sub-committee met every second month to review the risk register but the centre manager did not attend this meeting and did not have access to the minutes.

There were some improvements in the quality management system but there had not been sufficient time to bed down improvements. An external manager undertook audits of, for example health and safety (weekly), medication management and recording but these audits had not identified the issues found by inspectors. There was no plan to prioritise the implementation of findings from audits. In addition, actions identified following the last inspection had not been progressed in a timely way or in line with the action plan provided to HIQA and nobody was overseeing its implementation.

An annual review of some aspects of the quality and safety of care had been undertaken in April 2016 and the report was available in the centre. Inspectors found that there was a good level of consultation with young people and parents in relation to the quality and care to inform the review. While the quality of the review had improved it did not identify all of the issues raised in this report. A meeting was scheduled to agree an action plan.

An unannounced six monthly visit was completed in November 2015 by an external manager. A report and action plan was available but some of the actions had not been implemented in a timely way. The provider's oversight of the required actions was not robust.

Effective arrangements were not in place to support, develop and performance manage staff to ensure they exercised their professional responsibility for the quality and safety of service being delivered. There was no performance management system in place. There was a whistle blowing policy. However, not all staff were aware of how to make a protected disclosure.

Judgment:
Non Compliant - Moderate

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

Theme:
Responsive Workforce

Findings:
At the time of the last inspection, not all staff files contained all the documents required under Schedule 2 of the regulations. Staff members were newly qualified and were not experienced. The frequency and quality of supervision varied. Not all staff received mandatory training. There were improvements in supervision and mandatory training but staff files had dis-improved.

There was a high staff turnover which had an impact on the levels of key working available to children. While there were staff vacancies, the current staff team and manager filled the gaps in the roster. There was a recruitment drive underway and new staff were due to join the team in the coming weeks. The staff were all qualified and those spoken with had a good knowledge of the children, their needs and their plans. However, inspectors found gaps in keyworking due to staff vacancies. While the actual rota was maintained, the centre manager did not keep a record of the planned rota. The roster reflected that there were 16 staff members with a two to one child staff ratio. The centre manager identified that a shift leader was identified on the roster when she was not on duty. However, inspectors found that this was not consistently recorded on the roster and staff were not aware of this role or what their responsibilities were. There was guidance available in relation to on call arrangement should staff need to contact a manager out of hours. However, inspectors found that this was not a formalised system.

The quality of supervision had improved. Staff were supervised regularly by the centre manager. Supervision records reflected that she provided appropriate guidance in relation to care practice to staff at supervision. Supervision sessions recorded actions to be completed with an agreed timeframe and this was followed through at the next session. An external manager supervised the centre manager who had received two supervision sessions since her appointment. Records reflected that discussions were

relevant to her role in the centre.

The majority of staff had received mandatory training. However, there were some gaps in child protection, manual handling, safe administration of medication and the administration of a drug to treat epilepsy. There had been no comprehensive training needs analysis undertaken but the centre manger had completed a training audit. While there was no formal training programme in place, the centre manager had identified some behavioural management training requirements that she would deliver.

The quality of information in staff files was poor. Staff files did not contain all documents in line with Schedule 2 of the regulations. Inspectors found that some staff files contained incorrect contracts of employment and some contracts were not signed. Some staff files did not contain their employment history. A small number of staff files did not have appropriate vetting disclosure.

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:

Caroline Browne
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority **Regulation Directorate** **Action Plan**

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Stepping Stones Residential Care Limited
Centre ID:	OSV-0003257
Date of Inspection:	21 April 2016
Date of response:	10 June 2016

Requirements

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

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

Outcome 05: Social Care Needs
Theme: Effective Services **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Not all assessments were comprehensive.

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

1. Action Required:
Under Regulation 05 (1) (a) 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 prior to admission to the designated centre.

Please state the actions you have taken or are planning to take:
• The Person in Charge will update the existing needs assessments for all young people by 26th August 2016 which will include their health, personal and social needs.
• The Person in Charge will seek further information from relevant professionals where necessary to update the assessments.
• Every young person will have a needs assessment carried out prior to admission involving input from all disciplines currently involved with the young person to ensure all needs assessment is comprehensive.

Proposed Timescale: 26/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plan reviews did not assess the effectiveness of the previous personal plan.

2. 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:
• Personal plan reviews will follow a standard format to ensure the effectiveness of previous plans are assessed.
• Personal Action Plan review measures have been developed and will be implemented to allow regular collation of information regarding the progress of the action plan.

Proposed Timescale: 26/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
The personal plan was not amended in accordance with any changes recommended following a review.

3. Action Required:
Under Regulation 05 (8) you are required to: Ensure that each personal plan is amended in accordance with any changes recommended following a review.

Please state the actions you have taken or are planning to take:
• All current personal plans will be updated following the updates of the young peoples current needs assessments.
• The minutes of each review will indicate the person with responsibility for completing the update of the personal plan.

Proposed Timescale: 26/08/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all review meeting minutes were available in the centre.

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

Please state the actions you have taken or are planning to take:
• Minutes of all review meetings are now in the centre.

Proposed Timescale: 26/04/2016

Theme: Effective Services

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

5. 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:
include all assessed needs following updates to the Assessments of Needs of all young people as detailed in action 1.

Proposed Timescale: 26/08/2016

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 adequately describe arrangements in place for the identification, recording and investigation of and learning from, serious incidents or adverse events involving residents.

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

Please state the actions you have taken or are planning to take:
• The Director of Service will review and update the Risk Management Policy to ensure that it is in line with the requirements of the regulations.

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not adequately describe the arrangements in place to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the residents quality of life have been considered.

7. 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 Director of Services will review and update the Risk Management Policy to ensure that it is in line with the requirements of the regulations.

Proposed Timescale: 30/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk register was not up-to-date as it did not reflect all risks.

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

Please state the actions you have taken or are planning to take:
• The Director of Services will review all risks in the centre. The risk register will then be updated to include all risks.
• The PPIM will undertake risk assessment training provided by the Health and Safety Authority to assist with the appropriate identification of risks.

Proposed Timescale: 29/07/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The colour coded cleaning system available to staff was not being used.

Paper hand towels were not available in bathrooms.

9. 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:
• Staff to receive on-going instruction in operating colour coded cleaning system at team meetings and using the communications log.
• Paper Towels and paper towel storage have been ordered.
• The Person in Charge and Director of Services will carry out spot checks on the implementation of these systems.

Proposed Timescale: 10/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were gaps in daily and weekly fire checks.

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

Please state the actions you have taken or are planning to take:
• A single sheet for all fire checks has been compiled by the person in charge to provide clear direction for staff on the recording of fire safety checks.
• This will be implemented with staff through use of the communications log, team meeting and staff training day.
• The PPIM will undertake weekly checks for compliance in this area.

Proposed Timescale: 20/06/2016

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff had participated in a fire drill.

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

Please state the actions you have taken or are planning to take:
• The Person in Charge will identify which staff members have not yet taken part in fire drills and will schedule fire drills when these staff members are on shift.
• The Person in Charge will ensure that at least one staff member who has completed a fire drill is on shift at all times
• All staff must complete a fire walk outlining the fire drill process prior to commencing their first shift.

Proposed Timescale: 30/06/2016

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 applied in line with policy.

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

Please state the actions you have taken or are planning to take:
• The Director of Services and Person in Charge will undertake training with the staff team in the identification and appropriate use of Restrictive Practices.
• The Person in Charge will update Behaviour Support Plans to identify any restrictive

procedures to be used and how they should be implemented.
• The person in charge will ensure that the restrictive practice in place is the least restrictive option and used for the least amount of time possible
• All restrictive procedures in use will be reviewed regularly at staff team meetings.

Proposed Timescale: 21/06/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Intimate care plans did not provide sufficient guidance for staff re prompting children to what was going to happen during the provision of intimate care.

13. Action Required:
Under Regulation 08 (6) you are required to: Put safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.

Please state the actions you have taken or are planning to take:
• The Person in Charge has updated Intimate care plans to provide further guidance regarding prompting children as to what will happen during the provision of intimate care.
• Copy of the Intimate care plans will be available on the daily clipboard and so easily accessible to staff
• This information has been shared with staff using the communications log and will be shared at team training day 20th June.

Proposed Timescale: 20/06/2016

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all residents were protected from peer to peer abuse.

14. Action Required:
Under Regulation 08 (2) you are required to: Protect residents from all forms of abuse.

Please state the actions you have taken or are planning to take:
• The Person in Charge will monitor and provide feedback to staff using the comments section of behaviour and incident report forms. The Person in Charge will ensure accurate records are kept of incidents of peer-to-peer abuse using information contained in daily observations.
• The person in charge will update behaviour support plans to provide guidance on how to protect service users from peer to peer abuse

• The Person in Charge will provide staff with training in the area of identification, recording, prevention strategies and notification of peer to peer abuse.

Proposed Timescale: 21/06/2016

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 prescriptions were available in the centre.

15. Action Required:
Under Regulation 29 (3) you are required to: Where a pharmacist provides a record of a medication-related intervention in respect of a resident, keep such a record in a safe and accessible place in the designated centre.

Please state the actions you have taken or are planning to take:
• All prescriptions are now available in the centre. The person in charge will ensure that all prescriptions are stored in the centre at all times.

Proposed Timescale: 25/04/2016

Theme: Health and Development

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Medicines were not administered as prescribed.

Monitoring and review of safe medication administration management practices were not effective.

The controlled drugs register was not up-to-date.

16. Action Required:
Under Regulation 29 (4) (b) you are required to: Put in place appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine that is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.

Please state the actions you have taken or are planning to take:
• The Controlled Dugs Register, monitoring of safe administration of medication and medication error forms will be monitored 5 days a week by the PPIM.
• PPIM who is suitably trained in SAMS will provide the staff team with further training in the area of medication management and administration, and medication error forms
• Medication has been discussed at the staff team meeting and individual supervision sessions.

Proposed Timescale: 21/06/2016

Outcome 14: Governance and Management

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The person in charge did not have sufficient knowledge of her responsibilities under the regulations.

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

Please state the actions you have taken or are planning to take:
• The Person in Charge has been provided with information and guidance on their role and the regulations
• The person in charge will review this information and use Supervision to further her knowledge and practical applications of the Regulations.

Proposed Timescale: 02/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were no systems in place to support develop and performance manage all members of the work force to exercise their personal and professional responsibility for the quality and safety of the services delivered.

18. Action Required:
Under Regulation 23 (3) (a) you are required to: Put in place effective arrangements to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.

Please state the actions you have taken or are planning to take:
• The Person in Charge and Director of Services will implement an ongoing staff appraisal system.
• A staff appraisal form has been designed to capture areas of staff performance which require development.
• The Person in Charge will use ongoing observations to assess the performance of staff in areas where training has already been provided.
• The information gathered during these appraisals will be used by the Registered Provider to enhance the existing staff training and development plan.

Proposed Timescale: 02/09/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all staff were aware of the whistle blowing policy.

19. Action Required:
Under Regulation 23 (3) (b) you are required to: Facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Please state the actions you have taken or are planning to take:
• The Person in Charge will discuss the whistleblowing policy at Team meeting every 2nd month and at individual supervision sessions.

Proposed Timescale: 29/07/2016

Theme: Leadership, Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all management systems were effective.

The provider had not ensured that identified actions were implemented in a timely way.

There was no plan to prioritise the implementation of findings from audits.

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

Please state the actions you have taken or are planning to take:
• The Person in Charge and Director of Service will review all existing audits and action plans to ensure they are completed by due date.
• If actions can’t be completed by due date, the Person in Charge and Director of Service will advise the Services Monitor (PPIM) together with an update on why the action is not complete and when the action will be completed.
• The Person in Charge will attend a meeting every two months with the Director of Service, PPIM and Directors to ensure the effective monitoring of management systems.

Proposed Timescale: 15/07/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Staff vacancies had impacted on key work sessions with children.

21. 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:
• Staff recruitment is underway. Two staff members have been recruited since and another member of the team will return from leave on 06/06/2016.
• A weekly checklist will be developed to ensure that keyworking sessions are recorded and if not the PIC will be able to address the deficit immediately.

Proposed Timescale: 16/06/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Planned staff rota's were not maintained.

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

Please state the actions you have taken or are planning to take:
• The Person in Charge will maintain a copy of the planned rota as required by the regulations.

Proposed Timescale: 06/05/2016

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff files contained documents in line with Schedule 2 of the regulations.

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

Please state the actions you have taken or are planning to take:
• All files will be updated to ensure that they are in line with the requirements of the regulations.
• Administrative procedure to be designed to ensure that the requirements are met in each case and staff files to be sampled each month by the PPIM to check for compliance.

Proposed Timescale: 01/07/2016

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 mandatory training.

24. 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:
• The Person in Charge has scheduled MAPA Training, Manual Handling Training and Training in the Administration of Buccal Midazolam for three dates in June 2016.
• All staff who have not yet received this training will do so on these dates.
• A training audit is in place to identify when refresher training are required.

Proposed Timescale: 01/07/2016