Health Information and Quality Authority
Regulation Directorate

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

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Catholic Institute for Deaf People
Centre ID:	ORG-0008269
Centre county:	Co. Dublin
Email address:	geraldinegallagher@cidp.ie
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Catholic Institute for Deaf People
Provider Nominee:	Liam O'Dwyer
Person in charge:	Geraldine Gallagher
Lead inspector:	Sheila Doyle
Support inspector(s):	Maeve O'Sullivan;
Type of inspection	Announced
Number of residents on the date of inspection:	34
Number of vacancies on the date of inspection:	4

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
20 February 2014 10:30	20 February 2014 17:30

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 first monitoring inspection in this centre. Inspectors met with residents, the person in charge (PIC), and other staff members. Inspectors observed practices and reviewed documentation such as care plans, medical records, accident logs, policies and procedures and staff files.

Overall, inspectors found that residents received a good person centred quality service. Staff supported residents to maximise their independence and encouraged them to make decisions and choices about their lives. Residents' communications needs were promoted and residents' health needs were regularly reviewed and met. The inspector found that the residents were comfortable and person centred care was provided by a committed team of staff.

Health needs of residents were met and there was evidence of safe medication management practices. While evidence of good practice was found significant areas of non compliance with the Regulations were identified. Lack of evidence of fire training required immediate action and was addressed by the person in charge. Lack of training in relation to safeguarding residents, and the prevention, detection and response to abuse was also an issue. Several policies were at draft stage and not implemented. The risk management policy and recruitment procedures for both staff and volunteers did not comply with the requirements of the Health Act 2007 (Care and Support of Residents in Designated Centres For Persons (Children and Adults) With Disabilities) Regulations 2013 (as amended) and the National Standards for Residential Services for Children and Adults with Disabilities. These areas are discussed further in the report and included in the action plan at the end.

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 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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors were not satisfied that the care and support provided to residents sufficiently reflected their assessed needs and wishes.

Nurses were responsible for assessing and reviewing resident's needs and care plans. Inspectors reviewed a sample of residents' care plans which contained information on their assessed needs. There was evidence of a range of assessment tools being used and residents' needs were reviewed and care plans revised on an ongoing basis. This however tended to focus on health care needs with minimal evidence of social care needs assessments or plans to meet those needs. Detailed information on areas such as friendships, belonging and inclusion in the community was lacking. The person in charge discussed plans to roll out 'My Information Book'. There was a policy at draft stage to guide practice in this area.

There were systems in place to assess the needs of resident's and ensure that the necessary supports and services were put in place to address those needs. However, further work was required to demonstrate residents' involvement in the development and review of their care plans. Inspectors could find limited evidence of this.

There was some evidence that residents were supported in transition between services but again this tended to focus on health care needs. Documentation reviewed described the resident's medical and health status, medical history and medication records.

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

Theme:
Effective Services

Judgement:
Non Compliant - Major

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
While there were arrangements in place to manage risk, non compliances were identified in the risk management arrangements, emergency planning and fire precautions.

Inspectors read the Health and Safety Statement which had been reviewed by the provider on January 2014. There was a risk management policy but this was not fully implemented and did not meet the requirements of the Regulations. In addition there was no emergency plan in place to guide staff in the event of such emergencies as power outages or flooding.

Inspectors could not evidence if all staff had attended fire training and the person in charge was asked to address this immediately. An email was received by the Authority following inspection confirming that additional training had been provided and all available staff had attended. Those not available due to sick leave or annual leave were to attend prior to their next rostered shift.

The inspector found that other fire precautions had been put in place. There were regular fire drills and both staff and residents participated. The inspector viewed evidence that fire equipment was serviced regularly, as were fire alarms and emergency lighting. Fire evacuation plans were posted clearly around the centre. Because of the specific communication requirements of the residents additional equipment was in place such as a vibrating apparatus that alerted residents to the sounding of the fire alarm. Daily recorded checks were undertaken of fire exits, lights and extinguishers.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors found that there was insufficient systems in place to promote the safeguarding of residents and protect them from the risk of abuse.

There had been no formal training on the protection of adults from abuse as required in the Regulations. This could result in staff not being aware of their roles and responsibilities in relation to the identification and reporting of abuse or suspected abuse. In addition there was no policy on the prevention, detection and response to abuse available to the inspectors. The person in charge told inspectors that this was currently being developed. Despite this staff spoken with and the person in charge outlined the procedures they would follow should there be an allegation of abuse.

Inspectors were not satisfied with the management of restraint. Several residents were using bedrails. However the documented care in place did not sufficiently protect the residents. For example there was no evidence that safety checks were completed whilst the bed rails were in use. The person in charge and nurse on duty told the inspectors that they were in the process of finalising a policy on the use of restraints. The draft version however was not available during the inspection.

All staff involved in moving or handling had received training and inspectors saw them using appropriate techniques. In addition infection control procedures seemed adequate although no policy was available to guide practice.

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

Theme:
Health and Development

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors found that residents were supported to access health care relevant to their documented needs. Residents' health needs were well documented.

Resident's health needs were regularly reviewed with appropriate input from multidisciplinary practitioners where required, with reports evidenced in files. Inspectors reviewed some care plans and medical notes and found that they had access to a general practitioner (GP), to an out of hours GP service and to a range of allied health professionals such as physiotherapists, chiropodists, opticians and dental services. Residents' files contained records of reviews by medical specialists. For example, inspectors saw where a resident had been referred to an occupational therapist for specialist chair advice. Inspectors reviewed a sample of care plans and found that resident's health needs were kept under formal review as required by the resident's changing needs or circumstances. As discussed under outcome 5, there was no documented evidence of resident or relative involvement in this.

Inspectors were satisfied that residents received a nutritious and varied diet. Menu choices were available and inspectors saw staff asking residents what they would like. Choices were on display in the dining room and also discussed individually with residents prior to serving. There was a large central dining room and most residents chose to have their meal there. Staff joined residents for the meal with residents and staff sitting together. Inspectors observed staff in the centre interacting with residents in a respectful, warm and caring manner. All staff were skilled in sign language. Inspectors also noted that there were some smaller kitchenettes around the centre which residents could use if they chose to prepare their own food. In addition, inspectors noted that there was fresh fruit salad and juices available throughout the day in the dining room.

Validated nutrition assessment tools were used to identify residents at potential risk of malnutrition or dehydration on admission and were regularly reviewed thereafter. Weight records were examined which showed that residents' weights were checked monthly or more regularly if required. Nutrition assessment tools were used to identify residents at risk of malnutrition and were repeated on a monthly basis. Inspectors reviewed residents' records and saw where residents were reassessed if they had lost weight. Records showed that some residents had been referred for dietetic review. The treatment plan for the residents was recorded in the residents' files. Medication records showed that supplements were prescribed by a doctor and administered appropriately.

Inspectors saw that a range of activities was available both within the centre and in the community. Some residents were going out shopping on the morning of inspection. Transport was available within the service if required. Records were maintained of residents' participation in the various activities. Staff spoken with were enthusiastic about the social events available. As yet however there was no documented evidence that residents were asked which activities they would like. As discussed under outcome 5 plans were in place to introduce more specific assessment documentation.

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

Theme:
Health and Development

Judgement:
Compliant

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors found evidence of safe medication management practices. All medication other than medication that required strict controls was administered by a medicator, a member of the healthcare assistant staff who had attended additional in house training and was deemed competent. Inspectors spoke to one medicator during the inspection and he displayed an understanding of appropriate medication management and adherence to professional guidelines and regulatory requirements.

Some residents were self medicating and the inspector saw that appropriate checks were in place to monitor ongoing compliance. All residents' medication administration records reviewed had photographic identification in place. There was a centre-specific medication policy that detailed the procedures for safe ordering, prescribing, storing and administration of medicines and handling and disposal of unused or out-of-date medicines. The policy was being updated at the time of inspection.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors were concerned about the lack of evidence regarding an effective management system. An external company had been engaged to assist with registration preparation. A detailed plan was in place. However inspectors noted that the final dates documented for completion of various aspects had passed and tasks had not been completed. This was particularly evident around the development and dissemination of policies to guide practice. Inspectors were also aware that individual staff members including the person in charge did not sufficiently demonstrate an awareness of the

Regulations and Standards and their responsibilities.

Inspectors spoke with the person in charge and found that she had a very good overview of the health and support needs and care plans of all the residents. The person in charge was clear about her role and responsibilities and about the management and the reporting structure in place in the organisation. She told inspectors that she received regular support from her line manager who she met informally on a weekly basis and formally on a monthly basis.

There was no formal appraisal or performance management system in the centre. In addition although plans were in place there was no formal system in place to ensure that the quality of care and experience of residents are monitored on a on going basis.

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

Judgement:
Non Compliant - Moderate

Outstanding requirement(s) from previous inspection:
No actions were required from the previous inspection.

Findings:
Inspectors were concerned that recruitment was not in line with best practice and did not meet the requirements of the Regulations. Inspectors reviewed a sample of staff files and noted that they did not contain the required documents as outlined in Schedule 2 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

The inspector reviewed a sample of staff rosters and noted that on the day of inspection the roster reflected the number of staff on duty. The person in charge and the nurse on duty told inspectors that the staffing levels were based on the assessed needs of the residents. Staff spoken with confirmed there was adequate staff on duty. A training plan was in place but it was unclear to inspectors which staff had attended the various training programmes that were held. Staff spoken with confirmed that there was no formal staff supervision system in place. In addition there was no policy on the provision of supervision.

The provider had failed to maintain a record of current registration details of nursing staff. This was discussed with the person in charge during the inspection. Written confirmation was received by the Authority the next day.

Volunteers attended the centre and provided various activities and services. However there were no files available for inspectors to review. There was no evidence that they had their roles and responsibilities set out in a written agreement or that they had provided a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings, which highlighted both good practice and where improvements were required.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of the residents, relatives, and staff during the inspection.

Report Compiled by:

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Regulation Directorate
Health Information and Quality Authority

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Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Catholic Institute for Deaf People
Centre ID:	ORG-0008269
Date of Inspection:	20 February 2014
Date of response:	21/03/2014

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 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was minimal evidence of social care needs assessments being carried out or plans in place to meet those needs.

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:
Person Centred Plan (PCP) (My Information Book) was signed off and ready for implementation on 6th March 2014.

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

The GP has been asked to complete the relevant section by the end of April.

Staff training on PCP is taking place on Thursday 20th and Friday 21st March.

Meetings with each individual resident and family member/friend will start from Monday 24th March.

A further discussion group with staff will take place on 1st April to identify any issues that may have arisen up to that point.

The proposed completion date for all books is 16th May 2014.

Proposed Timescale: 16/05/2014

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was no evidence of residents' involvement in the development and review of their care plans

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

Please state the actions you have taken or are planning to take:
Following on from Person Centred Plan sign off on the 6th March, the residents have been consulted at the monthly Resident meeting on 10th March, where it was explained what an PCP is, the need for such a document, who would have access to it and what will be documented.

It was also explained that a meeting would take place with each individual resident, their key worker and one senior member staff to discuss their care, needs and future in the centre, an ISL interpreter will also attend each meeting.

It was further explained that their consent would be sought to contact a named family member, friend or other to support them, if they wished, in the meeting when their PCP is being completed.

This exercise started immediately after the residents meeting with some residents choosing not to have support from anyone apart from their key worker or another member of staff.

For those who chose family/ friend a letter was sent off requesting them to attend a meeting, we are currently receiving replies and scheduling dates for each meeting, interpreter dates are being scheduled.

The proposed completion date for all books is 16th May 2014.

Proposed Timescale: 16/05/2014

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
The risk management policy did not meet the requirements of the Regulations.

Action Required:
Under Regulation 26 (1) (a) you are required to: Ensure that the risk management policy includes hazard identification and assessment of risks throughout the designated centre.

Please state the actions you have taken or are planning to take:
Risk management policies and incident reporting policies were signed off on 25th February 2014.

Training was provided on 3rd March on Risk management policy and incident reporting as stated in the implementation plan.

Immediately after the training the new reporting system and forms became live.

Staff from all disciplines attended the training and signed off on their attendance, Incident reports are completed daily as required, risk assessment is carried out where necessary and corrective action is taken immediately where possible, where this is not possible the reports are kept live until all corrective actions have been completed.

This system is now fully operational with the Care Manager monitoring daily.
Risk management policy includes hazard identification and assessment of risks throughout the centre.

Our risk register is currently being drawn up.

Proposed completion date of smoke room is 18th April 2014.

Proposed Timescale: 18/04/2014

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no emergency plan.

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 emergency plan is being drafted at present. On completion it will be made available to all residents, families and staff members.

We have agreed emergency accommodation with St Mary's Centre 185-201 Merrion Road Dublin 4 for high and maximum dependency residents, while all medium and low dependency residents will be accommodated in Bewley's Hotel Leopardstown.

Proposed Timescale: 28/03/2014

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no evidence that safety checks were completed whilst the bed rails were in use. The policy was not available at inspection.

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

Please state the actions you have taken or are planning to take:
A restraint register is now in place and will be updated weekly by the staff nurse.
In all cases where a restrictive procedure is in place at present a full and comprehensive assessment is being carried out by the staff nurse.

At present there are ten residents for whom restraints are in place, of the ten, six assessments and restraint care plans have been completed, the remaining four will be completed by 31st March.

Release and review forms will be made available to all care staff by 31st March who will document when the restraint is released. The restraint release will take place at two hourly intervals for 10 minutes when the resident is awake & while visitors are present, unless documented to the contrary.

Staff will check on residents who are using cot sides every two hours throughout the night and release the cot sides while there is a staff member in the room.

The house GP has signed off on all restraints being used in the house.

Resident consent has been received from the resident where possible.

The proposed date for full implementation is 31st March.

Proposed Timescale: 31/03/2014

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There had been no formal training on the protection of adults from abuse. There was no policy on the prevention, detection and response to abuse available to the inspectors.

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

Please state the actions you have taken or are planning to take:
The policies for safeguarding and Protection from Abuse, Responding to Allegations of Abuse and Management of Whistleblowing were formally approved on 22nd October 2013 and were available on the day from that day.

Training sessions for all staff were carried out on 11th March 2014 on Abuse, Neglect, Safety and Welfare of Vulnerable Adults.

Due to sick leave and annual leave 5 members of staff were not available on the day. Training is being re-arranged for these members of staff.

Proposed timescale for staff not yet trained is 4th April 2014

Proposed Timescale: 04/04/2014

Outcome 14: Governance and Management

Theme: Leadership Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Individual staff members including the person in charge did not sufficiently demonstrate their awareness of the Regulations and Standards and their responsibilities.

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:
A policy and procedure for staff supervision will be implemented on 26th March 2014

Refresher training for management will be completed by 27th March 2014

Training for all supervisors will commence 10th April 2014

A schedule for staff supervision will be drawn up after all training has been completed.

Proposed timescale for completion of all staff and volunteers supervision is 30th May 2014

Proposed Timescale: 30/05/2014

Theme: Leadership Governance and Management

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There was no formal system in place to ensure that the quality of care and experience of residents were monitored on a ongoing basis.

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

Please state the actions you have taken or are planning to take:
An audit schedule is being developed in a thematic approach to ensure that the quality care and experience of all residents are monitored.

For example: Risk Management policy and procedure went live on 3rd March and will be audited on 4th April 2014

Personal Support Plan "My Information Book" will go live on 21st March and will be audited on 21st April 2014.

The Monthly Resident's Meeting might also help with this monitoring.

On a monthly basis starting from 4th April 2014.

Proposed Timescale: 04/04/2014

Outcome 17: Workforce
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** Staff files were incomplete. **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 staff have been requested to submit the required documentation by 28th March 2014. After all checks on the relevant documentation have been completed the staff files will be updated. Proposed completion of staff files is 25th April 2014
Proposed Timescale: 25/04/2014
Theme: Responsive Workforce **The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:** There was no evidence that volunteers had their roles and responsibilities set out in a written agreement. **Action Required:** Under Regulation 30 (a) you are required to: Set out the roles and responsibilities of volunteers working in the designated centre in writing. **Please state the actions you have taken or are planning to take:** We now have a draft volunteer policy and procedure which outlines: The Role of the volunteer, Nature of the work, Description of the service, The Benefit to the organisation, Organisations commitment to the volunteer. This will be signed of and ready implementation on 26th March 2014. New volunteers will only be allowed commence after Garda Vetting approval has been received. Proposed timescale sign off by volunteers is 4th April 2014
Proposed Timescale: 04/04/2014

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Volunteers had not provided a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012.

Action Required:
Under Regulation 30 (c) you are required to: Ensure volunteers working in the designated centre provide a vetting disclosure in accordance with the National Vetting Bureau (Children and Vulnerable Persons) Act 2012 (No. 47 of 2012).

Please state the actions you have taken or are planning to take:
At present there are two volunteers in the centre, Garda Vetting forms were completed and sent to Vetting Unit in 2012. We sent off our two volunteer's Garda vetting forms, one which has been cleared and the other we are still waiting on. A further call has been made today to inquire and it has been agreed to re-apply.

New volunteers will only be allowed commence after Garda Vetting approval has been received.

16th June 2014; Garda Vetting Unit advised of 12 week processing period for all applications.

Proposed Timescale: 16/06/2014