### Centre name:
A designated centre for people with disabilities operated by St Catherine's Association Limited

### Centre ID:
OSV-0003409

### Centre county:
Wicklow

### Type of centre:
Health Act 2004 Section 39 Assistance

### Registered provider:
St Catherine's Association Limited

### Provider Nominee:
Ian Grey

### Lead inspector:
Orla Murphy

### Support inspector(s):
Bronagh Gibson;

### 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 1 day(s).

**The inspection took place over the following dates and times**

From: 03 April 2014 09:30  
To: 03 April 2014 17:00

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

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**Summary of findings from this inspection**

The first inspection of this three-bedded residential centre was announced and was carried out by two inspectors over one day. As part of the inspection, the inspectors met with the director of services (person in charge), staff members, an administrative officer and one young adult. A range of documentation and policies were reviewed such as care files, behaviour support plans, administration records, daily care records, a personal plan, fire safety records, policies and procedures and staff files.

The centre was notified to the Authority under section 69 of the Health Act as a children's centre. However, on arrival at the centre inspectors found there were three young adults and no children resident there. One young adult was resident in the centre full time and two others were spending two weeks in the centre each month, followed by two weeks at home. The young adult resident in the centre full time was in the centre on the day of the inspection. All the resident's assessed needs required high staffing levels which were in place in the service and there were no vacant places in the centre. Inspectors found that the young adults had been under 18 years on admission to the centre, but no onward placement had been identified for them and as a result they remained living in a children's centre. Two of these young adults had been in this unsuitable placement for a considerable amount of time and there was no evidence of suitable placements being sourced. As a result, the centre was operating outside of its purpose and function. In day to day care practices the impact of this was that the policies, ethos and staff training were all oriented toward
caring for children, not adults, and this meant the young adults were at risk of not fulfilling their potential and not being adequately prepared for moving on to age-appropriate placements.

The centre had been in operation for three years prior to the inspection. In practice the inspector found that the staff team were caring for the residents effectively in relation to supporting them to undertake tasks of daily living. Each young adult had a comprehensive behaviour support plan which was implemented by staff with good outcomes for residents. As a result of these support plans, residents were able to access a wider network of community facilities and activities. Staff spoke positively about the residents, and had several supports in place to ensure that families were informed of support that worked well in the centre, so it could be replicated at home. Staff were committed to the residents' wellbeing and valued family relationships and ties.

However, there had been deficiencies in some systems, policies and records in the centre which were in the process of being addressed by way of the introduction of new recording systems, policies and procedures. Historical staff recruitment was not robust and there were some deficits in checks for several staff. However, the organisation was in the process of taking steps to address the deficiencies. Some staff had little relevant experience and/or no relevant qualifications, and this posed a risk when working with children or adults with complex needs. A range of training was provided to staff. However, there were deficiencies in identifying training needs and in the supervision of staff. There was no formal oversight of the quality and safety of care practices provided within the centre.

Recording systems were adequate in many respects but improvements were needed in some areas. Risk management procedures had been recently introduced but these were not embedded into practice, and as a result risks had not been formally identified and assessed at the point up to this inspection.
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

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

Findings:
The assessment of residents’ needs was incorporated within several separate assessments of activities of daily living and a behaviour support assessment and plan. Person-centred plans had been recently introduced for residents. However, the plans reviewed by inspectors were not yet fully completed and the voice of the resident was not adequately reflected. Comprehensive behaviour support plans were in place and these provided clear strategies for staff and families to support residents in many aspects of daily life. Communication systems and tools were also used effectively to support residents in their lives. Outcomes had improved for residents in many respects since their move to the centre. However, the centre and its ethos was child-oriented and this, and a lack of agreed future plans, meant that residents placements were not appropriate.

Inspectors examined a range of documents within residents' care files. Behaviour support plans comprehensively identified the resident’s needs and preferences in relation to communication, routines and wellbeing. These also incorporated responses and strategies to manage behaviour that challenged the staff team or the community. Person-centred plans had recently been developed by the centre. These identified needs and goals in areas such as education, health, social skills, community participation and relationships. However, the content of these plans was brief and required much further development. The plans did not adequately recognise the residents' status as adults. For example, plans viewed did not acknowledge that residents had no onward placement to move to as adults. Plans also did not address autonomous issues for residents such as independent advocacy or managing finances. This meant there was a lack of appropriate planning for these young adults, and there was a risk they would not receive an age-appropriate service within the centre. There was consultation with professionals involved
with the resident and with their family in the assessment process, but this was not reflected in the personal plan. In addition, the resident’s voice was not adequately represented in the plan.

Inspectors found that staff were responding to residents needs on a day-to-day basis and this progress was recorded in behaviour support reports and daily observation records which supported all staff to deliver appropriate care to residents. There were a variety of communication tools used with residents such as picture boards, symbols and technology such as web applications. Staff knew residents well and this was reflected in how the resident’s gestures, behaviour and moods were interpreted and responded to positively by staff. Some residents had complex communication, social and behavioural needs and one resident had progressed significantly since a move to the centre two years ago. The support and programmes offered by the centre to this resident had improved their outcomes in relation to their wellbeing, community participation and communication.

Inspectors found there was no record of progress against the aims of the personal plan which meant that the effectiveness of the plan could not be adequately determined when reviewed. The staff completed detailed daily records regarding the wellbeing and events in residents' lives in a separate record. These records included details of activities, support provided, health issues and their wellbeing. Overall, plans were not sufficiently person-centred and residents' progress against plan goals were not recorded and monitored to ensure their needs and wishes were being met and promoted.

Of the three residents living in the centre, only one remained in education and attended school within the service. There was effective communication between the school and the centre and inspectors found evidence that behaviour support programmes were followed consistently in the centre, at home and in school. For the two remaining adults in the centre there was no education or training placement in place as the service as a whole catered for children, not adults. These young adults had no meaningful occupation during the day which meant they could not experience regular community integration with their peers and develop their skills to maximise their independence. Inspectors found that staff supported these residents to access activities in their community such as shopping, eating out and leisure activities. However, these were staff led and did not provide residents with an appropriate level of peer interaction or range of experiences to maximise their autonomy as adults or promote their right to be integrated into their community.

The three young adults were living in a children’s residential centre and inspectors found that the service was predominantly child-oriented in its ethos, policies and practices. The director of services informed inspectors that there were significant efforts by the organisation to identify, with the Health Service Executive (HSE), onward suitable placements in adult services elsewhere. In the case of two residents these efforts had been ongoing for nearly two years but had not yielded any positive outcomes for them. Inspectors were informed that despite the service level agreement with the HSE to provide childcare services, there was no efforts to support adult residents to transition to more appropriate placements. Inspectors requested copies of correspondence regarding this matter but this was not provided by the service. Inspectors found that although the residents had complex needs and support was needed in many areas of daily living, staff
had maximised their independence within the home in areas such as shopping, laundry and preparing snacks. Inspectors observed this on the day of the inspection and this seemed to provide the resident with a positive experience in their home, promoting autonomy and a sense of achievement. However, inspectors found no acknowledgement in resident’s personal plans or behaviour support plans of their progression into adulthood or the supports needed to realise this outcome. As a result, residents and families would be unsure about their future and would likely be unprepared to transition to another service. This may have significant consequences for their wellbeing should appropriate placements be identified.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Effective Services

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

**Findings:**
There were limited systems in place to promote the health and safety of residents and staff by the centre. Inspectors read two health and safety statements, the most recent dated 2008. Systems were recently introduced to identify and assess risks but these had not been implemented at the time of the inspection. Fire safety had shown some signs of improvement in recent months but there were significant deficits in compliance.

The health and safety policies and procedures were examined and found to be not specific to the centre and were out of date. The director of service told inspectors that there was no updated health and safety statement nor any arrangement for the assessment or identification of hazards or dangers. Policies regarding risk management in relation to the environment and residents safety had recently been updated and introduced. Inspectors found these to be mostly adequate, but as they were recent, many aspects of the procedures had not yet been implemented, and risks were still not routinely identified or assessed. In addition, these procedures did not adequately support the identification of hazards and did not comply with regulations.

Formal risk assessments had not been carried out on the environment or in relation to resident’s safety overall. Behaviour management support plans had detailed actions to mitigate risk in relation to behaviour, but there was no risk register in place in the centre and the formal procedure for identifying, monitoring or escalating risk had not yet been applied. While there had been no serious adverse events since the centre had opened, there had been no procedure in place to respond to these, should they occur. Inspectors found that the service manager and staff, when interviewed, had implemented daily
practices to protect residents in the centre and staff demonstrated an awareness of risk. Staff also had preventative practices in place with regard to anticipation of incidents and determining triggers that escalated certain situations. These practices were reflected in daily records and in behaviour support plans. For example, there were agreed plans in relation to physical aggression, and very comprehensive instructions as to how to respond to signs of potential incidents involving specific residents. Inspectors identified a range of areas in relation to young adults that required much more robust and formalised risk assessment. These included aspects of care practice such as incidents of self-injurious behaviour, protocols for leaving the centre, the locking of the front entrance and safeguarding in personal care/group living. Overall, while no significant harm had occurred by the absence of procedures and assessments, there was not a robust system in place to underpin safe staff practice and ensure the safety of residents and staff by the routine identification of risk and actions to address them.

The inspector found no hazards within the centre, and there was no access for inspectors to health and safety audits or hazard identification records as these were completed by the Health and Safety Manager and the records were not accessible to the person in charge during the inspection. However, there was a practice of locking front and back doors in the centre and there was an electronically controlled locked gate on the exterior of the property. The implications this had for residents liberty versus their safety had not been formally considered and assessed by the service. This meant that residents, as adults, were not free to arrive and leave their home as they may wish and they would be unable to exercise their rights in this regard. This was borne from concerns around resident’s vulnerability and complex needs, but had not been adequately accounted for within a risk assessment, given that the deprivation of liberty infringes on individual rights. In an effort to protect, rights had not been considered by the staff team. The director of services told inspectors that there was a draft emergency plan in the event that the centre became unusable, which was awaiting sign off by the management team. However, this was in draft format and was not made available to inspectors.

Inspectors found that harmful substances such as detergents and cleaning agents were stored securely and there was adequate hand-washing facilities and procedures regarding this in the centre. No clinical waste was produced in the centre. Inspectors found that all staff had undertaken first aid and manual handling training.

There were adequate systems and procedures in place in relation to fire precautions but there was no certificate of compliance in relation to fire regulations and not all staff were up-to-date in their fire training. Records were maintained of tests of equipment, lighting and alarms, which were carried out by an external contractor. Most were up to date and satisfactory, but some fire fighting equipment checks appeared to be out of date. Fire evacuation procedures were on display throughout the centre and exits were appropriately signposted and staff interviewed were aware of evacuation procedures. Visual checks or sample tests were carried out by staff but inspectors noted from an examination of records that these checks had only begun six months prior to the inspection. Records showed that staff had held two fire drills in the year prior to inspection, and any issues arising during these events such as evacuation concerns or equipment malfunction were recorded, evaluated and addressed. Some external doors to the centre were locked when residents were present, as was the external gate which
led onto a minor road and the impact of this on evacuation in the event of a fire had not been considered. The lack of compliance with fire regulations and identified risks meant that while checks were now carried out regularly, the service could not be assured that the centre itself was compliant with fire safety requirements, and there may be significant deficits that would pose a risk to children and staff in the event of a fire.

**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):**

**Findings:**
There were some systems in place in the centre to safeguard children and protect them from the risk of abuse and the centre followed Children First: National Guidelines for the Protection and Welfare of Children (2011). However, aspects of safeguarding such as mitigating risk were not robust. Significantly, there were no procedures in place to safeguard and protect adults as this centre had three adult residents.

Inspectors found that there were policies and procedures in place for the prevention, detection and response to abuse relating to children and these were supported by a policy on intimate care. However, a review of the child protection policy document showed that there was no policy on whistle-blowing, and staff interviewed did not understand the concept of protected disclosure. There was a named designated liaison person and deputy designated liaison person whose roles and responsibilities were clearly outlined in the centre’s policy document. This was in line with Children First (2011). All staff interviewed were aware of the role of the designated person. However, as none of these procedures and systems applied to adults, there was a significant risk that concerns of an adult protection nature would not be addressed effectively for the residents when there were no procedures in place to underpin staff practice.

Staff and the service manager were aware of what constituted abuse and all demonstrated a keen awareness of the specific vulnerabilities of residents with disabilities. Daily records reflected that staff used a range of communication techniques to ascertain resident’s wellbeing and they communicated effectively with residents. All of
the residents living in the centre had very complex needs and throughout the inspection staff demonstrated warmth and a very high regard for residents. The inspector observed staff and one resident interacting positively and they were very responsive to both verbal and non verbal cues given by the resident. There were barriers to self protection for residents living in the centre. A resident's understanding and ability to communicate if they felt unsafe was affected by their individual needs and their ability to express themselves, which varied. Technology and visual aids were used by staff to support residents. Staff interviewed demonstrated a good knowledge of the more subtle indicators of the resident’s wellbeing. It was evident that staff knew the residents well, and could describe indicators such as happiness, distress or pain for each resident to inspectors. The inspectors spent time observing one resident and their interaction with staff and surroundings. This resident expressed themselves freely during the inspection and staff were responsive to them, interpreting their wishes and monitoring their wellbeing.

There was a policy on the management of behaviour and training records showed that all staff were trained in a specific model. The centre had access to a behaviour specialist who was employed by the parent organisation. A positive behaviour approach was in place in the centre and this was evident in the plans read by inspectors. Each resident who required a behavioural support plan had one drawn up in consultation with all professionals involved and the behaviour specialist. Two of the residents in the centre had a behaviour support plan and effective actions were clearly laid out in care files and on communication boards to ensure residents were supported and responded to consistently. However, some measures were taken, such as locking doors to prevent absconding and staff said that there were times when they physically intervened, for example to guide a resident to a particular area or out of harms way. The social care leader told inspectors that locking doors for this purpose was not based on a formal risk assessment and was not informed by a specific guidance or policy that considered the balance between resident’s right to safety and liberty. Physical interventions were not formally recorded although recording mechanisms were developed for these interventions.

Documents examined during the inspection and staff interviews showed that daily practices were in place to safeguard residents, such as the rationale for staffing ratios and monitoring residents in the centre. However, there were insufficient formal systems or guidance in place such as risk assessments for vulnerable adults or procedures regarding adult's finances. Staff identified that they would raise concerns about adults with their line managers, but this was an informal system to address the absence of robust procedures. The director of services informed inspectors there had been no reports or concerns about abuse in the centre in the two years prior to this inspection. However, when staff were interviewed, it was evident they had not considered potential abuses that predominantly affect adults such as financial abuse or welfare concerns about the lack of onward placements for the residents. It was clear that the service had maintained a child oriented centre and had not progressed or adapted to view things from an adult needs perspective. The lack of formal systems and procedures for the protection of vulnerable adults left the service and residents potentially vulnerable to inconsistent practices and not recognising abuse; which could result in residents being unsafe.
There were systems in place for recording and balancing petty cash and small amounts of residents' money. However, staff were not safeguarded as only one staff member signed monies in and out. Residents could access their monies readily.

**Judgment:**
Non Compliant - Moderate

### Outcome 12. Medication Management

*Each resident is protected by the designated centre's policies and procedures for medication management.*

**Theme:**
Health and Development

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

**Findings:**
There were policies and procedures in place that supported staff in the protection of residents in relation to medication management. The centre had written policies and procedures related to the administration, prescribing, storage and transfer of medications. This suite of policies and procedures were clear and accessible to staff. Storage of medication was secure and was accessed safely. Staff interviewed by inspectors were aware of these policies and procedures. The processes in place for handling medication were in line with current guidelines and legislation.

Medication was stored in a secure, locked cabinet. Inspectors observed that medication in this cabinet was in date and clearly identified the person it was prescribed to. Prescription sheets were in place for each resident and there was a system to check received medication to ensure it was assigned to the correct resident. The keys to access the medication cabinet were securely held in a locked area. Administration sheets were in place for each resident and these were found to be up to date and accountable, in line with the centre's procedures. In addition, there was a clear procedure for checking and administering controlled drugs and inspectors found them to be effective and correctly implemented.

Each resident had a set of medication records that included any assistance they may require to take their medication. These records were well maintained and photographs of residents were in medical records for easy identification and prevention of administration errors.

There was a robust system of recording, reporting and reviewing medication errors in place. Staff told inspectors that all errors were reported immediately to the social care leader and then to the director of nursing for the overall organisation. There were no errors in the administration of medication that could not be resolved locally in the year prior to inspection and records reviewed showed that the systems in place were
implemented consistently and in a timely manner. All staff were trained in the administration of medicines, including those for the emergency management of seizures. The administration of medication was reviewed regularly in line with the centre’s procedures.

Judgment:
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):

Findings:
There was a statement of purpose and function for the centre which did not adequately describe the population catered for, as required by the regulations. The centre was operating outside of its statement of purpose and function as, while it was set up to care for children, there were only adults resident in the centre. The statement did not describe the age range of children it catered for, but did reflect that the centre was for children only. The statement also described the ethos of the centre, the model of care, and the facilities and service available in the centre. However, the service was providing three placements for adults and there were no children placed in the centre. The director of services was unsure about how practice could be reconciled with the statement. There was no indication that alternative placements would be found for these residents during the inspection, and, as such all residents were due to remain in the centre. As the maximum capacity for the centre was three residents, there was no opportunity for the centre to fulfil its purpose and function in offering placements for children while the current adult residents were there. These residents were not appropriately placed in the centre as all systems, policies and the ethos of centre were tailored to children, not adults. The statement examined by inspectors described the facilities, the building, services, some care arrangements and relevant policies and procedures of the centre. However, the statement did not describe a number of facilities in line with regulations such as arrangements for education, training, religion, contact and this did not comply with the information described in Schedule 1 of the regulations.

The inspectors found that staff were aware of the purpose of the service and the children it catered for, but were unclear about how this differed when caring for adults. The inspectors could not be assured that the residents, their families, staff and the
organisation had a clear understanding of the specific purpose of the centre from the information contained within the statement.

Judgment:
Non Compliant - Major

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):

Findings:
There were inadequate management systems in place to ensure the service provided was safe, effective and appropriate to the needs of residents, as there was a lack of clarity in relation to manager’s roles, responsibilities and lines of accountability. The person in charge at the time of the inspection was not present in the centre on a regular basis. There was a need to introduce formal systems of quality assurance so that service delivery could be monitored, reviewed and improved.

The director of services was the proposed person in charge of the centre at the time of the inspection. The centre was managed on a day-to-day basis by the social care leader Fiona Doyle, who had oversight of staffing and residents welfare. This social care leader reported to the director of services. The director of services reported in to the board of management. The director of services Dr. Ian Grey, who was the proposed person in charge, did not visit the centre routinely and meet with children and staff. He had visited last in January 2014 but he acknowledged that this was non-routine. Dr. Grey informed inspectors that he met weekly with all social care leaders, including Ms. Doyle. Both Dr. Grey and Ms. Doyle described these meetings as forums to discuss any issues in the centres and examine practices such as behaviour support plans and person-centred plans. However, minutes of these meetings were not available to the inspectors in the centre at the time of the inspection. In addition, there was a manager of staff training and a manager of auxiliary services (health and safety) who managed their respective fields for all centres and staff. The director of services said that along with the school principal, these managers formed the executive team. Inspectors were informed that no member of the Board had visited the centre as part of their role.

The director of services described a fragmented management system that did not have
clear lines of accountability and this was evident in an organogram of the management structure provided in the service level agreement between the service and the Health Service Executive. Different managers had their individual roles and responsibilities but reported individually to the Board. Therefore the director of services had no control over, and could not influence activities associated with the roles of the other managers. For example, the director of services could not ensure that the centre had an up-to-date health and safety statement as this was the responsibility of the auxiliary (health and safety) manager. The director of services said he could only access key records held by these managers, for example on staff training or fire safety or health and safety, by request. Inspectors found that this system did not support the director of services to have sufficient oversight of the centre in his role as the person in charge of the centre.

There was a lack of clarity on the purpose and function of the centre and the service generally and an equal lack of clarity on whose role it was to determine this; the Board, the directors of service or the Health Service Executive. Considering the centre was operating outside of its purpose and function by accommodating adults in a children’s centre, with no clear strategy to rectify this, the potential for this centre to meet the regulations was seriously hampered. Systems were also not in place to deliver an adult-oriented service which meant that resident’s needs may not be adequately identified or met.

The director of services told inspectors that monthly board meetings were held. The director of services said that service priorities, the organisational strategy and any problems identified were discussed at this meeting. Although minutes of these meetings were requested from the director of services, they were not provided to inspectors. The director of services said that although he reported to the board, there were no key performance indicators identified by which performance at a local or organisational level could be measured. There was no formal system in place to monitor the centre’s performance against standards or regulations. As described previously, there were three adults living in this children's centre without any planned placement to move on to. The director of services stated that several efforts had been made by himself and the chair of the board of management to address this issue, but the outcome remained the same and the centre was operating outside of it's statement of purpose and function for some time. Quality assurance of records and care practices was inadequate and there was little evidence within the centre that these areas were examined to assess safety and quality or to improve practices. Inspectors found that board members were not vetted although this process had begun in the weeks prior to this inspection.

Although there was a supervision policy and social care leaders met staff on a day-to-day basis, there was no formal supervision process in place and no records were kept of informal supervision. Staff meetings were held in the centre, and minutes of these showed that relevant information from the monthly managers meetings was fed back to the staff. Minutes showed that feedback was primarily in relation to policy development and implementation, centre practices and routines.

Inspectors were provided with a copy of the organisational service level agreement with the Health Service Executive which referred directly to the delivery of a residential service and outlined key performance indicators. The service level agreement identified services provided to children only, not adults as was the case for this centre. The
director of services said that he reported to the Health Service Executive annually but that there were no ongoing formal monitoring arrangements in place either by managers within the organisation or by the HSE.

**Judgment:**
Non Compliant - Moderate

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

**Theme:**
Responsive Workforce

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

**Findings:**
There was an adequate number of staff available to meet the needs of the children and to deliver a safe service in the centre. There was a formal system in place that assessed and matched the needs of the children based on their dependency levels. The director of services informed inspectors that there were no staff vacancies and the centre had a relief panel of core staff available to cover staff leave. Inspectors examined the staff roster for a four-week period. The roster highlighted there were four core staff and five relief staff in use in the centre, which meant the number of relief staff outnumbered the core staff in place. Relief staff worked 20-36 hours per week. There was up to three staff on duty at times where all residents were in the centre. A staff member was on sleepover in the centre every night, and the roster showed that only relief staff undertook sleepovers.

Historical recruitment processes and procedures were not robust and therefore did not promote the safety of children or adults in receipt of a service. However, inspectors found that steps were being taken to address deficiencies in the vetting of staff. A revised and satisfactory recruitment policy and procedure was in place since March 2014. Inspectors reviewed a sample of staff files and found that updated Garda Síochána vetting was completed and/or in the process of completion. Checks were inadequate under the previous recruitment procedures and there were several deficiencies identified. For example, not all staff files had a copy of a full employment history, relevant qualifications, and satisfactory references. Inspectors found that some staff did not have any relevant qualifications or experience in the field of social or healthcare when they had been employed. This meant there was a risk that staff would be unable to effectively meet the needs of residents with complex needs and behaviour. These staff had not gone on to gain a relevant qualification during their time in the
centre. In addition, this raised safeguarding concerns, as staff without appropriate experience and qualifications may not deliver safe and effective care to vulnerable residents. This issue was not adequately considered or monitored by the director of services.

There was a training programme in place that endeavoured to ensure all staff had standard core training and refresher training. The director of services and social care leader informed inspectors that there was no training needs analysis carried out to identify training needs, but if identified training required was needed for the centre, this would be provided. Training was requested from the training manager and organised through that office. Training records were provided to inspectors and showed there were gaps in core training for some staff. There were other significant deficits for this centre as there was no training relating to caring for adults. For example, there was no training provided in adult protection, sexual/intimate relationships, independence skills, rights and advocacy.

The centre had a supervision policy that was not implemented. Staff were not provided with formal supervision but staff informed inspectors there was an informal process carried out on a day-to-day basis. These informal sessions were not recorded.

Arrangements were in place for students to undertake placements but the director of services said that no volunteers worked in the centre.

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:

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

<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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<tr>
<td>Date of Inspection:</td>
<td>03 April 2014</td>
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<td>Date of response:</td>
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Requirements

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

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

Outcome 05: Social Care Needs

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents needs as adults had not been sufficiently assessed in the centre.

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

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1 The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.
and circumstances, but no less frequently than on an annual basis.

**Please state the actions you have taken or are planning to take:**
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

The following actions are scheduled in respect of the regulation.

1. Health needs of each resident will be assessed by their local GP. All recommendations in respect of health needs will be incorporated into the Personal Plan for each person.

2. Personal and social care needs will be identified by a person centred planning process including the use of widely used assessments to determine needs in these areas.

3. Health, social and personal needs will be reviewed by the team on at least an annual basis.

**Proposed Timescale:** 30/08/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
The ethos, systems and policies of the centre were child orientated and had not been adapted to meet the needs of adult residents.

**Action Required:**
Under Regulation 05 (3) you are required to: Ensure that the designated centre is suitable for the purposes of meeting the assessed needs of each resident.

**Please state the actions you have taken or are planning to take:**
The three adults who were resident in the centre have now left the centre. The residents who now reside in there are under the age of 18.

**Proposed Timescale:** 28/05/2014

**Theme:** Effective Services

**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
Personal plans were in a written format and were not accessible to residents.

**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
Please state the actions you have taken or are planning to take:
We will ensure that personal plans are completed in a format that suits the communicational needs of each individual resident. All personal plans will make extensive use of visual aids to facilitate understanding.

Proposed Timescale: 30/09/2014
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Residents and families views and wishes were not clearly represented within the personal plan.

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

Please state the actions you have taken or are planning to take:
The person in charge will ensure that as part of the personal planning process that personal planning meetings are held with the resident, their family and other member of the resident's circle of support at least annually to ensure that the views and wishes of the resident and their families are clearly represented within the residents personal plan. A record of all personal planning meetings will be kept along with a record of attendance.

Proposed Timescale: 30/09/2014
Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Personal plans did not address the needs of residents to move onto an appropriate adult placement and did not outline the supports required to prepare residents for such a move.

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

Please state the actions you have taken or are planning to take:
As part of the review process of personal plans, the person in charge will ensure that
consideration is now given to the need to identify appropriate placements for residents long before they approach adulthood. The person in charge and the registered provider will liaise with the HSE disability manager in a timely fashion in order to identify future adult placements residents. A record of these communications/meetings will be kept in the residents file.

At annual review meetings for Personal Plans, the needs for individuals in respect of future adult placements (e.g., skills needed across self-care, communication, community access, leisure) will be identified and discussed. Identified needs will be included in Personal Plans.

**Proposed Timescale:** 30/09/2014

### 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 centre’s risk policy and assessments had not yet been implemented.

**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 Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

The provider has reviewed its risk policy and assessments using guidance from ‘Guidance for Designated Centres, Risk Management’ published by Hiqa November 2013. The identification of all risks and recording of same as per the centres policy is now underway by the Person in Charge.

**Proposed Timescale:** 30/05/2014

**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
The centre had no certificate of fire compliance as required by regulations and no fire risk assessment had been undertaken in the centre.

**Action Required:**  
Under Regulation 28 (1) you are required to: Put in place effective fire safety management systems.
Please state the actions you have taken or are planning to take:
The provider is liaising with an engineer in order to address this issue to the satisfaction of the Authority. The provider will furnish the Authority with the relevant certificates once they have been received.

**Proposed Timescale:** 30/09/2014  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
Not all fire equipment had up to date checks by a qualified contractor.

**Action Required:**  
Under Regulation 28 (2) (b)(i) you are required to: Make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.

**Please state the actions you have taken or are planning to take:**  
This has been completed. A contract has been established for future periodic checks of fire equipment to take place on a regular basis.

**Proposed Timescale:** 30/05/2014  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**  
There was no evidence that fire precautions and evacuation plans had been reviewed.

**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:**  
The Health and Safety Officer has reviewed all fire precautions and evacuation plans. The centre has an evacuation plan in place and this plan is available in the centre. All staff are aware of the plan. A record of all reviews will now be kept on record in an assessable manner.

**Proposed Timescale:** 31/05/2014  
**Theme:** Effective Services

**The Registered Provider is failing to comply with a regulatory requirement in**
the following respect:
Not all staff had undertaken fire safety training.

**Action Required:**
Under Regulation 28 (4) (a) you are required to: Make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.

Please state the actions you have taken or are planning to take:
The registered provider has undertaken a complete review of all fire safety training. Deficits have been identified and are currently being addressed. It is planned that all staff in the organisation will have completed fire safety training not later than 1st September 2014. The PIC will ensure that the roster will include at all times a staff member trained in fire safety across all times of day.

**Proposed Timescale:** 01/09/2014

<table>
<thead>
<tr>
<th>Outcome 08: Safeguarding and Safety</th>
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<td><strong>Theme:</strong> Safe Services</td>
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The Registered Provider is failing to comply with a regulatory requirement in the following respect:
There were inadequate policies, procedures and training in place for the protection of vulnerable adults.

**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 residents of the centre are now children. Staff are trained in Children First and the provider has policies in place for the protection of vulnerable children.

The PIC along with the registered provider and training co-ordinator is undertaking a training needs audit of all staff. The training co-ordinator is now involved in weekly strategic management meetings in order to identify, address and manage the training needs of each location in an achievable manner in order to ensure best practice in relation to safeguarding residents and the prevention, detection and response to abuse.

**Proposed Timescale:** 01/09/2014

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<th>Theme: Safe Services</th>
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The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Staff had not received training in the protection of vulnerable adults.
**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 residents of the centre are now children. Staff are trained in Children First and the provider has policies in place for the protection of vulnerable children.

The PIC along with the registered provider and training co-ordinator is undertaking a training needs audit of all staff. The training co-ordinator is now involved in weekly strategic management meetings in order to identify, address and manage the training needs of each location in an achievable manner in order to ensure best practice in relation to safeguarding residents and the prevention, detection and response to abuse.

**Proposed Timescale:** 01/09/2014

**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 and function does not accurately reflect the age, ethos, care practices, arrangements and relevant procedures in place for the group of residents in the centre.

**Action Required:**
Under Regulation 03 (2) you are required to: Review and, where necessary, revise the statement of purpose at intervals of not less than one year.

**Please state the actions you have taken or are planning to take:**
The group of clients now in the centre are all under the age of 18 and the statement of purpose reflects the age, ethos, care practices, arrangements and relevant procedures in place for the group of residents in the centre.

A review of all statements of purpose will be completed at least annually.

**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:**
The statement of purpose and function was not in a format accessible to residents and their families.
### Action Required:
Under Regulation 03 (3) you are required to: Make a copy of the statement of purpose available to residents and their representatives.

**Please state the actions you have taken or are planning to take:**
The registered provider will review the statement of purpose in order to insure that it is in an accessible format for residents and their families.

**Proposed Timescale:** 31/07/2014

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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:**
The director of services is the person in charge for several centres and is not present in the centre sufficiently to discharge the requirements of the role.

**Action Required:**
Under Regulation 14 (4) you are required to: Where a person is appointed as a person in charge of more than one designated centre, satisfy the chief inspector that he or she can ensure the effective governance, operational management and administration of the designated centres concerned.

**Please state the actions you have taken or are planning to take:**
The director of services is no longer the person in charge.
The House Leader for the centre will be the Person in Charge going forward.

**Proposed Timescale:** 31/05/2014

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**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The documents retained for the director of services did not include two written references, evidence of qualifications or photographic ID.

**Action Required:**
Under Regulation 14 (5) you are required to: Obtain the information and documents specified in Schedule 2 in respect of the person in charge.

**Please state the actions you have taken or are planning to take:**
These documents have been obtained and are now contained in the director of services personnel file.
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<th>Proposed Timescale: 31/05/2014</th>
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<td><strong>Theme:</strong> Leadership, Governance and Management</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
The management structure, accountabilities and responsibilities of roles were not clearly defined or identifiable.

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

**Please state the actions you have taken or are planning to take:**
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

The registered provider has prepared a governance document which outlines the management structure within residential services. Job descriptions are in place for care staff and house leaders.

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<th>Proposed Timescale: 30/06/2014</th>
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<td><strong>Theme:</strong> Leadership, Governance and Management</td>
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**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was insufficient managerial oversight and monitoring of the quality and safety of care in the centre.

**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 Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

The service provider will implement the following steps: A governance framework has been established which sets out the management system of residential services. This document also sets out the review systems for ensuring quality and safety.
These include:
1. Weekly residential review meetings are held between the PIC and the provider and as part of this there are a number of standing agenda items for review including:
   - Review of all risks identified in the previous week and recording in the centre risk register.
   - Identification and review of restrictive procedures implemented (if any) in the previous week.
   - Identification of maintenance issues
   - Any child protection concerns in line with Children First.
   - Review of progress of individual children.
   - Discussion and review of staffing arrangements.
   - Identification of training needs for staff.
   - Weekly tracking of HIQA audit for compliance with standards.
2. Monthly reports are sent to the Board of Directors in respect of weekly meetings.
3. Quarterly residential review. This involves the following:
   - Full review of risk register for each residential centre in the previous three months.
   - Audit of restrictive interventions implemented in previous quarter
   - Completion of Quarterly returns for HIQA
   - Completion and review of quarterly progress report for Behaviour Support Plans
   - Review of all Person Centred Plans and monitoring system
   - Identification of organisational issues requiring change to ensure more effective services.
   - Identification of changes required to the Residential Services Policy and Procedures manual
   - Review of complaints, concerns and adverse events

An appraisal system for all staff is now in place. Appraisals take place twice annually or more often if required between staff and the PIC in each location. Records are kept of appraisals by the PIC.

A supervision policy has been developed (31st March 2014). PIC’s will be responsible for the supervision of staff in each unit. Supervision will take place not less frequently than every eight weeks. A suitable supervision training course is being sought by the registered provider for all PIC’s in order to ensure best practice. A record all supervision will be kept in accordance with the supervision policy and national guidelines.

**Proposed Timescale:** 30/09/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no performance development system for staff in place in the centre.

**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:**
An appraisal system has been developed and is now in use. Records of appraisals will be kept as required. As training needs are identified, these will be managed in order to ensure the quality and safety of service delivery.

The PIC along with the registered provider and training co-ordinator is undertaking a training needs audit of all staff. The training co-ordinator is now involved in weekly strategic management meetings in order to identify, address and manage the training needs of each location in an achievable manner in order to ensure best practice in relation to safeguarding residents and the prevention, detection and response to abuse.

**Proposed Timescale:** 30/06/2014

**Theme:** Leadership, Governance and Management

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
There was no whistleblowing procedure in place in the centre and staff were not aware how to make protected disclosures.

**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 registered provider commits to develop a policy as a matter of priority in line with regulation 23 (3) (b) in order to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents. A specific policy around protected disclosure will be developed and be incorporated into the manual of policies and practices in residential care.

**Proposed Timescale:** 31/07/2014

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

**The Registered Provider is failing to comply with a regulatory requirement in the following respect:**
Some staff did not have the necessary or appropriate qualifications and experience to work in the centre.

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

Please state the actions you have taken or are planning to take:
The Authority did not agree this action plan with the provider despite affording the provider two attempts to submit a satisfactory response.

The registered provider will complete a training needs audit of the centre and develop policies to address any training deficits. In addition, an audit of staff qualification for the centre is being conducted and a policy around helping staff meet qualification standards will be developed.

Proposed Timescale: 31/10/2014
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff had the required checks, documents and information in the staff files as required by the regulations.

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

Please state the actions you have taken or are planning to take:
The person in charge is in the process of developing a system that will ensure that all required checks, documents and information in staff files is up to date and in an accessible format as required by the regulations.

Proposed Timescale: 31/07/2014
Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all staff in the centre had attended all relevant core training.

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 acknowledges that not all staff in the centre had attended all relevant core training. The registered provider is committed to addressing the training
needs of all staff. A training needs audit of the centre will take place to assess core training needs deficits and training needs as identified will be put in place.

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<td>Theme: Responsive Workforce</td>
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**The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:**
There was no formal supervision provided to staff in the centre.

**Action Required:**
Under Regulation 16 (1) (b) you are required to: Ensure staff are appropriately supervised.

**Please state the actions you have taken or are planning to take:**
The person in charge acknowledges the importance of supervision in social care. A supervision policy has been developed (31st March 2014). PIC’s will be responsible for the supervision of staff in each unit. Supervision will take place not less frequently than every eight weeks. A suitable supervision training course is being sought by the registered provider for all PIC’s in order to ensure best practice. A record all supervision will be kept in accordance with the supervision policy and national guidelines.

| Proposed Timescale: 31/10/2014 |