

**Health Information and Quality Authority  
Regulation Directorate**

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



<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0003361
<b>Centre county:</b>	Kerry
<b>Type of centre:</b>	The Health Service Executive
<b>Registered provider:</b>	Health Service Executive
<b>Provider Nominee:</b>	Ann Sheehan
<b>Lead inspector:</b>	Breeda Desmond
<b>Support inspector(s):</b>	Aoife Fleming;
<b>Type of inspection</b>	Unannounced
<b>Number of residents on the date of inspection:</b>	29
<b>Number of vacancies on the date of inspection:</b>	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 ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

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

From: 29 April 2015 09:30 To: 29 April 2015 17:00

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

Outcome 01: Residents Rights, Dignity and Consultation
Outcome 05: Social Care Needs
Outcome 06: Safe and suitable premises
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 14: Governance and Management
Outcome 17: Workforce
Outcome 18: Records and documentation

**Summary of findings from this inspection**

This was a follow-up inspection to the triggered inspection on 19 March 2015 and it was the fourth inspection of the centre. The purpose of this inspection was to establish if improvements and appropriate action had been undertaken within the timeframes specified by the provider in their 'Improvement Notice' to ensure the safety and welfare of residents. [Due process from the inspection on 19 March 2015 was awaited so the 'outstanding actions from the previous inspection' section in this report were not completed.] Overall, inspectors noted significant improvements on this inspection regarding the safety and welfare of residents.

The issue which remained outstanding from the 'Schedule of Improvement' notice was:

- 1) The appointment of a full-time person in charge with the appropriate qualifications, skills and experience necessary to manage the centre with responsibility and accountability for the service; to ensure the service is safe, appropriate to residents' needs, consistent and effectively monitored.

As part of the inspection process, inspectors met with residents, part-time person in charge, clinical nurse managers (CNM2) and members of staff. Inspectors observed practices and reviewed documentation such as care plans, medical records, staff

training records, and policies and procedures.

Areas for improvements to ensure compliance with Regulations included:

- 1) staff levels and skill mix
- 2) clinical risk management.

The action plan at the end of the report identifies actions 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 2013.

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

**Outcome 01: Residents Rights, Dignity and Consultation**

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

**Theme:**

Individualised Supports and Care

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

**Findings:**

A residents' advocate had been appointed and she visited the centre on a number of days each week; she also facilitated activities for residents. A formal mechanism to enable the advocate to raise issues was put in place to ensure issues were dealt with in a timely manner. Residents also had access to an external advocate who was the designated office for overseeing allegations of abuse. Information regarding advocacy services was displayed in an accessible format in the visitors' rooms.

The complaints process was on display and was in an accessible format for residents living in the centre. The person in charge was responsible for overseeing complaints and all complaints were submitted to the complaints officer for review and analysis. Nonetheless, comments/complaints/compliments forms were evidenced with many issues recorded as comments even though they were either incidents or complaints. While there was often dual recording in the comments log and again in the incident book, occasionally because problems were recorded as comments and not complaints, issues were missed. The policy on completing the comments/complaints/compliments form only referenced the complaints section. This was discussed at length and the person in charge agreed that this form was confusing and required attention.

**Judgment:**

Substantially Compliant

**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):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

The findings of the inspection 26 February 2015 and 19 March 2015 suggested that care continued to be provided to residents based on the medical model and the transition programme developed by the external service provider was not integrated into daily life in the centre. On this inspection, inspectors found that staff had begun the process of amalgamating personal support plans into the daily lives of residents in the centre to support them to develop, integrate life skills and promote independence, for example, cooking, personal hygiene, shopping and socialisation. The individual daily activity transition record demonstrated a continuation of the narrative from day services to home services. The records demonstrated the activities undertaken, the degree of resident involvement, new skills planned and auctioned.

A new clinical risk assessment was introduced as a pilot to obtain feedback to establish if it was fit-for-purpose for the centre and the resident profile; this included assessments related to risk of suicide, neglect, aggression/violence, self harm and abuse. In addition an evidenced-based falls risk assessment and nutritional risk assessment were introduced with the national consistency descriptors for modified diets incorporated. However, other evidence-based risk assessments (such as skin integrity) were not evidenced to inform best practice regarding both clinical and non-clinical interventions. A sample of personal care plans were reviewed and some contained excellent person-centred information, however, some did not have appropriate plans, for example, one resident had swallowing difficulties evidenced by a report following assessment by the speech and language therapist but there was no care plan to support the recommendations. Nevertheless, these reports were now shared between services to inform care of residents. All residents were assessed by the dietician with reports evidenced and actions implemented following this assessment. Residents were reviewed by the dentist in-house and treatment was completed where necessary.

A policy to ensure care and welfare of respite residents' was put in place to direct staff on the appropriate actions to be taken upon such an admission.

A multi-disciplinary team was set up since the last inspection with weekly meetings to

support the transition programme; members included the person in charge, consultant psychiatrist, CNMs 2, psychologist, risk manager and representatives from the external service provider. Terms of reference were available and two meetings were held to date with minutes evidenced. While this was a new venture, positive feedback was given to inspectors regarding this. Staff stated that they could highlight and discuss residents care and progress at this forum.

**Judgment:**

Substantially Compliant

**Outcome 06: Safe and suitable premises**

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

**Theme:**

Effective Services

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

**Findings:**

Screening was now in place in bedrooms with twin occupancy to afford residents privacy in their bedrooms. Incontinence wear, disposable gloves and aprons were removed from bathrooms and were no longer on display in residents' bedrooms. Previously, one visitors' room was inaccessible to residents and appeared to function as an office with filing cabinets and an office table and chairs, this was now open to residents and was in the process of redecoration; filing cabinets were removed and appropriate furniture and television was being procured.

**Judgment:**

Compliant

**Outcome 07: Health and Safety and Risk Management**

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

**Theme:**

Effective Services

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

**Findings:**

There was a current safety statement and risk management policy and emergency plan. Inspectors reviewed incidents and accidents logs; while some were comprehensive, others were not, consequently there could be little learned from incidents to mitigate

recurrences. A finding of previous inspections was the absence of a process of feedback to staff following accidents and incidents to minimise their reoccurrence however, this remained unchanged. It was reported to inspectors that incidents and accidents were analysed to inform improvement and learning, however, there was little evidence of this. For example, there was an incident relating to a resident receiving a burn from a radiator. While appropriate interventions and treatment were reported for this burn, there was no risk assessment, follow-up or action taken regarding the radiator to mitigate the risk of recurrence.

**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):**

The action(s) required from the previous inspection were satisfactorily implemented.

**Findings:**

Many staff had completed training (21 April 2015 and another training session was scheduled for 21 May 2015) in adult protection since the last inspection. Those staff interviewed articulated appropriate responses regarding actions to be taken following reporting of an allegation of abuse. The HSE policy 2014 'Safeguarding Vulnerable Persons at Risk of Abuse' was introduced and staff interviewed were aware of this policy and its contents. The flow-chart displayed in the centre for response and reporting suspicions of neglect and abuse was updated since the last inspection whereby the reference to the HIQA complaints procedure was removed; it referenced the notification if the allegation was against a staff member (NF07).

Some staff had completed training in positive behavioural supports (31 March 2015) and others were scheduled to attend further sessions.

Debit and credit transactions were co-signed in line with best practice and receipts were now signed by staff to safeguard both the resident and staff member involved in the financial transactions.

**Judgment:**

Compliant



**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:**

The person in charge was not full-time in post as required by the Regulations. The person in post was part-time with other management commitments within the mental health services in the Kerry area. The provider nominee stated in the schedule for improvement notice returned on 24 April 2015 that this post was advertised and would be filled by 11 May 2015 whereby a full-time person would be person in charge with accountability and responsibility for the centre in conjunction with the transition programme for residents in the centre.

The position of person in charge was not full time, consequently, management systems to ensure the service was safe and effectively monitored was not assured; incidents and accidents were not effectively monitored; recording of comments/complaints was not effectively monitored to enable learning and mitigate risks.

An unannounced visit to the designated centre as described in the Regulations had occurred. The provider nominee had conducted this inspection and had compiled a report with actions, responsibilities and timelines assigned. A meeting with some staff had occurred to discuss the findings and other staff had just returned from annual leave and a meeting was scheduled on the evening of the inspection to relay the findings to those staff. An annual review of the quality and safety of care and support as described in the Regulations had commenced. Notifications were submitted in accordance with regulatory requirements.

A detailed programme of works was submitted to the Authority as part of the schedule of improvement notice relating to the transition of residents to de-congregated settings. The Health Services Executive (HSE) was in consultation with the external service provider regarding the transition programme and appropriate accommodation was being sourced to facilitate this transition. It was envisaged that the transition of 22 residents would be completed by October 2015.

**Judgment:**

Non Compliant - Major

**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):****Findings:**

It was identified in the previous inspection reports that there were insufficient numbers of staff at all times and the skill mix appropriate to the provision of care based on a social model rather than a medical model and this remained unchanged. It was reported to inspectors that the external service provider was in the process of recruitment of appropriate personnel to staff the new de-congregated centres to enable a social model of care for residents.

**Judgment:**

Non Compliant - Moderate

**Outcome 18: Records and documentation**

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

**Theme:**

Use of Information

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

Findings were reported under Outcome 7 Health and Safety and Management.

**Judgment:**

Substantially Compliant

## 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:***

Breeda Desmond  
Inspector of Social Services  
Regulation Directorate  
Health Information and Quality Authority

## Health Information and Quality Authority Regulation Directorate

### Action Plan



### Provider's response to inspection report<sup>1</sup>

<b>Centre name:</b>	A designated centre for people with disabilities operated by Health Service Executive
<b>Centre ID:</b>	OSV-0003361
<b>Date of Inspection:</b>	29 April 2015
<b>Date of response:</b>	16 June 2015

### Requirements

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

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

### Outcome 01: Residents Rights, Dignity and Consultation

**Theme:** Individualised Supports and Care

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

Evidence-based risk assessments (such as skin integrity) were not evidenced to inform best practice regarding both clinical and non-clinical interventions.

**Action Required:**

Under Regulation 13 (1) you are required to: Provide each resident with appropriate

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

care and support in accordance with evidence-based practice, having regard to the nature and extent of the resident's disability and assessed needs and his or her wishes.

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

Baseline Risk Assessment has been carried out on all residents in the centre which included looking at skin integrity. A FALLS Risk Assessment and a Dietary Assessment has also been completed for each individual.

Process is continuing in completing a comprehensive Risk Assessment for each individual within the designated centre. However, any immediate risks have been addressed as they presented.

**Proposed Timescale:** 14/08/2015

**Theme:** Individualised Supports and Care

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

The complaints policy included little detail on completing the comments/complaints/compliments form and only referenced the complaints section.

**Action Required:**

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

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

- A new template has been developed which includes complaints only.
- The complaints procedure has been printed off in "Easy Read" format and is situated in the visitor's room for residents to avail of.
- A separate template in respect of the centre is included on the Complaints shared folder for Mental Health Services.
- Any complaints received by the Complaints Officer are forwarded to the PIC/CNMII and will be investigated under HSE Complaints Process "Your Service, Your Say". Actions taken will be reported back to the Complaints Officer.
- These will be recorded in the template on the shared folder.
- Any complaints at unit level will be managed by the CNMII in conjunction with PIC and the completed form will be sent to the Complaints Officer for logging.
- The Complaints Officer will update the Management Governance Group on a quarterly basis.

**Proposed Timescale:** 16/06/2015

**Theme:** Individualised Supports and Care

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

While there was often dual recording in the comments log and again in the incident book, occasionally because problems were recorded as comments and not complaints, issues were missed.

**Action Required:**

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

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

- A new template has been developed which includes complaints only.
- The complaints procedure has been printed off in "Easy Read" format and is situated in the visitor's room for residents to avail of.
- A separate template in respect of the centre is included on the Complaints shared folder for Mental Health Services.
- Any complaints received by the Complaints Officer are forwarded to the PIC/CNMII and will be investigated under HSE Complaints Process "Your Service, Your Say". Actions taken will be reported back to the Complaints Officer.
- These will be recorded in the template on the shared folder.
- Any complaints at unit level will be managed by the CNMII in conjunction with PIC and the completed form will be sent to the Complaints Officer for logging.
- The Complaints Officer will update the Management Governance Group on a quarterly basis.

**Proposed Timescale:** 16/06/2015

**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:**

A sample of personal care plans were reviewed and some contained excellent person-centred information, however, some did not have appropriate plans, for example, one resident had swallowing difficulties evidenced by a report following assessment by the speech and language therapist but there was no care plan to support the recommendations.

**Action Required:**

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

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

- Individual Support Plans are now being updated with recommendations from Multidisciplinary reports.
- The reports are being filed in Individuals files with a notation in the nursing notes referencing the availability of the report.
- All staff are being reminded to familiarise themselves with the reports and the updated Support Plan.

**Proposed Timescale:** 16/06/2015

**Outcome 07: Health and Safety and Risk Management**

**Theme:** Effective Services

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

There remained an absence of feedback to staff following accidents and incidents to minimise their reoccurrence.

**Action Required:**

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

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

- A robust system of monitoring all incidents and adverse events has been put in place which includes monthly reporting of such events to the Management Governance Group and the Multi-Disciplinary Transition team.
- All serious incidents and adverse events will be reviewed and the learning and recommendations shared with all staff.
- An action plan will be developed to ensure recommendations are implemented.
- The PPPG on risk management has been revised to include this process and the new risk assessment process for individuals.

**Proposed Timescale:** 16/06/2015

**Outcome 14: Governance and Management**

**Theme:** Leadership, Governance and Management

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

The person in charge was not full-time in post as required by the Regulations.

**Action Required:**

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

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

A full time Person In Charge is now in place with the appropriate qualifications, skills and expertise to manage the centre.

**Proposed Timescale:** 16/06/2015

**Theme:** Leadership, Governance and Management

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

The position of person in charge was not full time consequently management systems to ensure the service was safe and effectively monitored was not assured; incidents and

accidents were not effectively monitored; recording of comments/complaints was not effectively monitored to enable learning and mitigate risks.

**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 Terms of Reference and Membership of the Management Governance Group and the Multi-Disciplinary group were reviewed and revised to ensure good governance and clear responsibilities.
- Weekly meetings have been held of both groups to ensure all the immediate risks were resolved since the beginning of April 2015. These have now reduced to fortnightly meetings.
- Meetings will continue every 2 weeks to ensure strong governance and leadership remains in place until all the residents have successfully transitioned out into the community.
- A full time Person in Charge is now in place and working on site in the centre.

**Proposed Timescale:** 16/06/2015

**Outcome 17: Workforce**

**Theme:** Responsive Workforce

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

There were insufficient numbers of staff at all times and the skill mix appropriate to the provision of care based on a social model rather than a medical model and this remained unchanged. [Staff numbers and skill mix was based on a medical model of care.]

**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:**

- Due to the historical nature of this service and the agreed closure plan for the centre, it is not anticipated that skill mix will be changed.
- However, all staff are being offered and provided with training programmes specifically designed to meet the needs of people with intellectual disabilities.
- To support the development of Support plans and PCPs, a Person Centred Planning facilitator has been engaged to complete same and work with staff to develop their understanding of processes.
- A transition team of suitably experienced staff with Intellectual Disability experience has been contracted to develop transition plans and plan for future services in the community where the assessed needs of the individuals will dictate the skill mix required in the various houses.



- The Transition team is providing individualised supports to the residents of the designated centre in line with their transition plans and PCP's.
- Through PCP's where additional one to one supports are required to support people to engage in social activities, this will be provided.

**Proposed Timescale:** 16/06/2015

### **Outcome 18: Records and documentation**

**Theme:** Use of Information

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

The risk management policy and emergency plan remained in draft format.

**Action Required:**

Under Regulation 04 (1) you are required to: Prepare in writing, adopt and implement all of the policies and procedures set out in Schedule 5 of the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013.

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

All Policies and Procedures as required under Regulation 04 (1) are in place including the Risk Management PPPG. However, the Risk Management PPPG has been revised to reflect changes in practice so the revised PPPG will be in place by Friday 19th June 2015.

**Proposed Timescale:** 19/06/2015