Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	The Laurels
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	27 July 2021
Centre ID:	OSV-0004763
Fieldwork ID:	MON-0033340

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

This designated centre comprises of two separate houses where a full-time residential service with integrated day service is provided to two residents over the age of 18 years. The houses are a two-storey semi-detached house and a single-storey bungalow in different locations but both are located within the suburbs of the busy town. The service provided is individualised to each resident and is tailored to meet their specific needs. The model of care is social. The service is open seven days a week and the residents are supported by a staff team comprised of social care workers and support staff. The needs of the residents are complex and the support and care provided is informed and guided by a range of multi-disciplinary inputs sourced internally and, from community and hospital based resources. Management and oversight of the service is delegated to the person in charge supported by a social care worker. Residents are facilitated to identify what services and supports they want in place through a person centred planning process.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 July 2021	9:45 am to 4:15 pm	Mary Moore	Lead

What residents told us and what inspectors observed

This was an effectively managed service where consistent oversight was maintained of the support and care provided to each resident. Governance of the service was focused on each resident their needs, choices and preferences and, on ensuring they at all times received a safe, quality service. The service was operated in a way that kept residents safe and well but also respected and promoted their individuality, their choices and, their right to independence and self-determination. There was risk associated with this but the provider accepted and had the arrangements needed to safely manage this risk. Given the level of risk that presented with this culture of positive risk taking for residents, the inspector did find that there was some minor scope for improvement in some risk assessments. Overall, a high level of compliance with the regulations was found in what was a highly individualised and person-centred service.

Resident wishes and, infection prevention and control requirements informed how this inspection was conducted. For example, the inspection was undertaken in the context of the ongoing requirement for measures to prevent the accidental introduction and onward transmission of COVID-19. In addition, one resident reported via the person in charge that they did not wish to meet the inspector or for the inspector to visit their home; this request was respected. However, the inspector reviewed records pertaining to both houses and both residents. These records were reviewed and discussed with the person in charge in an off-site location facilitated by the provider. The inspector visited the other house and met with the resident living in that house and the staff on duty.

The person in charge introduced the inspector to the resident and, the inspector asked the resident if it was alright to view their home and, perhaps look at the many photographs that were evident in the house. The inspector noted that the resident was a little anxious but indicated by gesture that they were happy for the inspector to do this. The house presented well with evidence of the modifications that had been completed to enhance the suitability and accessibility of the house to the needs of the resident. For example, the en-suite facility had been extended to create more space and, refurbishment of the kitchen had incorporated suitable counter heights so that the resident could participate in the preparation of their meals. There was a spacious and very pleasant garden to the rear of the house and a new pathway had been laid so that the resident could safely access the seating area to the rear of the garden. The person in charge reported that this area was very beneficial in facilitating outdoor visits in the context of COVID-19. The inspector noted that the provider's fire safety measures included doors designed to contain fire and its products but self-closing devices were yet to be fitted to the doors.

The impact of COVID-19 on resident's lives was captured in the reports of service reviews completed by the provider and, in each residents personal plan. Residents did not like the impact on their lives such as the impact on their access to part-time work, to family and home, to community based activities and to friends. Measures to

protect residents and staff from the risk posed were guided by national and local policy but also by the specific circumstances of each resident, for example the high risk of serious illness posed given pre-existing health conditions. While keeping residents safe, measures were also implemented so that residents had continued access to family and home where this was very important to them and, access to their community. Technology was used to ensure that residents remained connected to services and friends such as the advocacy forum and on-line religious services. The resident that the inspector spoke with confirmed that they had been out that morning with staff and, were planning to go out again but had waited so as to meet the inspector. The inspector saw that accessible transport was provided. Staff were hoping to progress current requests from residents to visit Dublin Zoo and to attend a musical event with a friend.

The photographs mentioned above prompted much discussion of family as the resident became more relaxed with the presence of the inspector in their home. It was evident to the inspector that the residents role in the family as daughter, sister and aunt was valued and cherished with the resident enjoying regular visits home and, inclusion in family events. The resident had recently returned to the centre from a visit to home. The person in charge described how staff and family worked together so as to facilitate and maximise the safety of these visits. Prior to leaving the house the resident again by gesture, said that they liked their home and that they were happy.

While the inspector did not meet with any representatives records seen and discussion with the person in charge confirmed that there was ongoing consultation and discussion with them and, they had appropriate input in to the support and care that was provided. The feedback that both groups of representatives provided was very positive based on the report of the annual review.

However, the residents were at the centre of this service and there was much evidence of how their individuality and their rights were respected, protected and promoted. Where it was the expressed wish of the resident, residents had independence and control of their daily life, such as time alone without staff and, control of the support and care that they needed for their continued safety and well-being. The person in charge described and discussed with the inspector the arrangements in place so that a good balance was achieved between the providers duty of care and, the resident's right to make their own decisions and choices. In the context of the range of complex needs that presented, the inspector was assured that reasonable controls were in place. For example, staff spoke with and negotiated with residents and, gave them ample notice and information so that residents made good and informed decisions. There was evidence of consistent collaborative working and, communication between the service and other stakeholders such as clinicians; case conferences were convened if and when concerns arose. The person in charge had robust systems that ensured good oversight was kept of these arrangements, of resident health and well-being and, any associated and possible risks.

The next two sections of this report will expand on the findings of this inspection in relation to the governance and management arrangements in place in the centre,

and how these arrangements facilitated the quality and safety of the service being delivered.

Capacity and capability

As discussed in the opening section of this report there were management systems in place to ensure that the service provided was safe, consistent and appropriate to residents' needs. The centre presented as adequately resourced to deliver on its stated aims and objectives. The provider accepted and managed the risk associated with a culture of care that respected and promoted resident rights. There were systems of review that were focused on residents and on continually improving the service provided to them. Because of this effective and consistent governance the provider has, in this centre achieved and sustained a high level of compliance with the regulations. Two actions for improvement issued from this inspection, one in relation to the provision of self-closing devices for the fire resisting doors and, the addition of controls to some risk assessments in place.

The day to day management of the service was the responsibility of the person in charge supported by their line manager and a social care worker. It was evident throughout the inspection that the person in charge was familiar with each resident, their circumstances and needs and, had systems in place that ensured the service was effectively managed and monitored. The additional management burden that resulted from respecting resident choice and decision making was evident to the inspector but it was also evident that the person in charge was committed to this and, had the systems needed to ensure that residents were safe and adequately supported. The person in charge described how residents would not have the quality of life that they enjoyed if they were compelled to comply with support and instructions that were not in line with their wishes. There was a plan to enhance the social care worker resource so as to further strengthen the governance structure.

Given the independence that residents enjoyed robust systems of management and oversight were needed to manage any associated risk and, to ensure that the provider met its regulatory responsibilities. These systems were in place and were effectively and meaningfully utilised. This included a range of audits such as of medicines management and accidents and incidents that had occurred, regular staff meetings, formal and informal supervision of staff, collaborative multi-disciplinary working, continuous discussion and negotiation with residents and, as appropriate, their representatives. In addition, the provider completed on schedule the annual and six-monthly reviews required by the regulations. The inspector saw from the findings and reports of all of these reviews that management and oversight of the service was consistent and, was always seeking to improve the safety and quality of the service provided. For example, a review by the person in charge of medicines administered on an as needed basis led to a review of the plan of support, further clinical review and advice and, improved support that reduced the need for these

medicines.

Each resident lived on their own in their own home and, each house was staff based on the assessed needs and wishes of each resident. One house was staffed at all times while there was a period each day when the other house was unstaffed based on the expressed wishes of that resident. This request was facilitated based on the assessment and management of the associated risk, for example the residents ability to seek assistance if needed and, to safeguard themselves against risks such as their ability to evacuate in the event of fire or other such emergency. This risk was open and actively monitored by the person in charge. There was a staff on sleepover duty in each house at night. The inspector reviewed the staff rota for each house and saw that the staff team was consistent, the staffing arrangements were as described and, there was a process of induction for newly recruited staff.

Effective oversight was also evident in the record maintained of training attended by staff. The training programme reflected mandatory training such as safeguarding and fire safety, residents assessed needs such as the administration of rescue medicines and, new risks such as that posed by COVID-19. Staff had completed baseline and refresher training in hand-hygiene, using personal protective equipment (PPE) and, how to break the chain of infection. Staff training will be discussed again in the next section of this report when discussing the assessment of risk.

Regulation 14: Persons in charge

The person in charge worked full-time and had the required skills, qualifications and experience. The person in charge clearly understood the working of the governance structure and, their management and oversight responsibilities given their role in that governance structure. The person in charge effectively discharged their responsibilities, communicated with and, escalated matters as needed to their line manager. The person in charge supported by the provider was committed to promoting the rights of each resident for as long as it was possible and safe to do so.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels and arrangements were suited to the assessed needs of the residents. There was a planned and actual staff rota that showed the staff on duty by day and by night and the hours that they worked. The process of risk management supported staffing decisions.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to an appropriate and responsive programme of training. Staff attendance at baseline and refresher training was monitored.

Judgment: Compliant

Regulation 21: Records

Any records requested by the inspector to inform and validate these inspection findings were available. The records were well-maintained and supported the finding of effective management. For example, the findings and the corrective actions arsing from reviews were evident in the personal plan, in the records of staff meetings and, in the review of risk assessments.

Judgment: Compliant

Regulation 23: Governance and management

This was an effectively managed and consistently overseen service that delivered on its stated aims and objectives. Governance was focused on each resident and, on ensuring they were provided with a safe, quality, individualised service while respecting and promoting their rights.

Judgment: Compliant

Regulation 31: Notification of incidents

Based on the records seen in the designated centre there were arrangements in place that ensured HIQA was notified of events such as the use of any restrictive practice.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had accessible policy and procedure for receiving and managing complaints. There were no open complaints. There were internal procedures for monitoring the receipt and management of complaints.

Judgment: Compliant

Quality and safety

This service was planned and delivered to respond to the individual needs, abilities and choices of each resident. Resident wellbeing and welfare was maintained by a good standard of evidence-based care and support. Good risk management processes and, the consistent and effective management described in the previous section of this report ensured that residents were at the centre of the support provided, were safe and well while having good input and control over their routines and, decisions about their support and care. The inspector did find that some minor improvement would add to the robustness of the good and effective risk assessments that were in place.

Given the diversity of resident needs the inspector reviewed both baseline assessments, one personal plan and aspects of the other. Each assessment captured the essence of each resident, the support that they needed and, what was important to them in life. The plan set out the support that was needed including the support that ensured residents lived a good quality of life that supported their wishes and choices. Residents and as appropriate their representatives had input into decisions that were made about the support and care to be provided.

The plan captured the impact of COVID-19 on each resident and the measures taken to mitigate the impact. For example, outdoor visits with family were facilitated and visits to home with controls were recommenced as soon as was feasible and reasonably safe to do so. Staff encouraged the use of technology so that residents remained connected to family, friends and life in general. For example, viewing mass on- line, participating in the internal advocacy programme and, a variety of classes such as dance and cookery. Sometimes staff combined both approaches. The inspector noted a bracket on the wall near a window and the person in charge described how the resident had placed their personal tablet here during window visits with family so that photos could be shared and enjoyed.

Fundamentally the model of care was social but the plan and, discussions with the person in charge established that there were complex medical needs that had to be met so that residents enjoyed the best possible health. The person in charge had systems and arrangements that allowed residents to reasonably control and direct their care while ensuring adequate oversight of adherence to the care that was

needed and, oversight of resident wellbeing. Firstly, the person in charge clearly understood how best to communicate with the resident, explaining rather than instructing and, giving adequate time and notice, for example if there was a clinical appointment. Good communication and negotiation meant that staff had the monitoring and oversight that was needed with the consent of the resident. There was evidence of effective multi-disciplinary working that was monitored and co-ordinated as needed by the person in charge. The person in charge was planning ahead for increasing healthcare needs and, the ultimate objective was to support the resident to remain in their own home. This plan included preparing the resident for any increased support from staff that may be needed.

Fundamental to ensuring the safety of both residents and staff, particularly given the level of resident choice, control and independence facilitated, was effective, enabling, risk management practice. Potential hazards relating to how both residents lived their lives were identified. The risk assessment addressed these hazards and the controls to manage actual or potential risks. For example, the skills and ability that supported a resident to safely stay in their house without staff supervision. This identified for example the person's fire safety skills and telephone skills and, general awareness of risk and danger. Overall, the inspector found that hazard identification and management was purposeful and focused on the individuality of each residents needs, abilities and choices and, how to keep residents and staff safe. Regular review of any incidents that occurred was used to monitor the effectiveness of the existing controls. However, there was scope for improvement to ensure that risk identification and management processes included all possible risks, all controls and, all possible impact of controls. For example, while training for a staff in strategies for responding to behaviour of risk was scheduled, the risk of working without it and, the impact of completing on-line training in the interim had not been risk assessed. The risk assessment for time spent unsupervised by staff would have been enhanced by including the actions to be taken by staff if there was staff concern for resident safety or well-being prior to leaving the house. The risk assessment for the use of a stair-gate in one house to restrict access to the stairs did not consider how this might impact on resident access to staff.

As discussed regularly in this report resident's rights were respected and promoted and residents had minimal restrictions in their life. The stair-gate mentioned above was used in the context of the limitations of the resident's mobility and the fact that it was unsafe for them to access the stairs. All services needed by the resident were at ground floor level. The positive behaviour support plan was current and recently reviewed by the behaviour support team.

Reference has also be made throughout the report to the impact of COVID-19 and, the measures in place to both mitigate the impact and manage the risk to resident and staff health. These measures were informed by national and local guidance, the specific risks and circumstances arising in the centre and, were the subject of ongoing review.

The provider had suitable fire safety arrangements and maintained oversight of these. Staff and residents participated in regular simulated evacuation drills. One resident had attended fire safety training and was reported to be competent in

understanding the working of the fire detection and alarm system. Each resident had a personal emergency evacuation plan (PEEP). The person in charge audited the findings of the evacuation drills. Good consistent evacuation times were achieved in both houses. Effective oversight was again evident as the finding that some staff needed to participate in a drill was highlighted and addressed with the staff in question. There were certificates confirming that the fire detection and alarm system, the emergency lighting and, fire fighting equipment were inspected and tested at the prescribed intervals. The inspector noted and the provider was aware that while doors designed to contain fire and its products were provided, they were not fitted with a self-closing device.

Regulation 10: Communication

Staff were familiar with the diverse communication needs and style of each resident. The person in charge described how understanding these needs supported good and effective communication such as allowing sufficient time for residents to reflect on what was discussed. Residents did have access to the internet and a range of media; engagement with these had mitigated some impacts of COVID-19 restrictions.

Judgment: Compliant

Regulation 11: Visits

Facilitating safe visiting to the centre and to home was informed by guidance, the importance of such visits to resident well-being, an assessment of the risk that presented to all parties and, the implementation of controls in response to the level of risk that presented.

Judgment: Compliant

Regulation 17: Premises

The location, design and layout of the house visited by the inspector was suited to the needs of the resident. The house had been modified and adapted internally and externally to enhance its suitability and its accessibility. The resident was seen to be provided with the equipment that was needed for the well-being and comfort and, equipment that promoted their independence and functioning. The house was well maintained and visibly clean.

Judgment: Compliant

Regulation 18: Food and nutrition

The personal plan included any specific dietary requirements and preferences. Dietetic advice was sought and informed the plan. Staff sought to support residents to make good lifestyle choices so that they enjoyed the best possible health. Residents had choice and input into the meals provided, participated in the shopping for groceries and in the preparation of their meals.

Judgment: Compliant

Regulation 26: Risk management procedures

As discussed in the main body of this report there was scope for improvement to ensure that risk identification and management processes included all possible risks, all controls and, all possible impact of those controls.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider had effective procedures to reduce the risk of the accidental introduction and onward transmission of COVID-19. These procedures, plans and risk assessments were the subject of ongoing and regular review and were responsive to the specific needs and circumstances of the centre.

Judgment: Compliant

Regulation 28: Fire precautions

Self-closing devices designed to close fire-resistant doors in the event of fire were needed in both houses.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Each resident had a personal plan that detailed their needs and abilities, their personal choices and preferences. The plan outlined the support required to maximise resident well-being, safety, personal development and quality of life. The plan was developed based on the findings of an assessment and ongoing consultation with residents and, as appropriate their representatives. The plan and its effectiveness was the subject of regular review by the staff team.

Judgment: Compliant

Regulation 6: Health care

Each resident had access to the range of healthcare services that they required. Residents were facilitated to self-direct aspects of their care. The person in charge had systems in place that ensured resident health and well-being was appropriately monitored and maintained while respecting resident right to self-determination.

Judgment: Compliant

Regulation 7: Positive behavioural support

The positive behaviour support plan was current and had been reviewed in consultation with the behaviour support team. The review of incidents monitored the effectiveness of the plan. Residents had minimal restrictions on their choices and routines.

Judgment: Compliant

Regulation 8: Protection

The provider had safeguarding policy and procedures that were discussed with residents. All staff had completed safeguarding training. The person in charge maintained effective oversight of the service including announced visits to each house. The person in charge also had the use of an office in one house. The person in charge described to the inspector how residents could and would report or communicate if they were unhappy either verbally or through the use of behaviour.

Judgment: Compliant

Regulation 9: Residents' rights

This centre was operated in a way that respected and promoted the individuality of each resident. Residents rights and, their ability to make good decisions and choices was respected and supported by effective communication and ongoing negotiation. Residents were supported to safely exercise independence, choice and control. The biography of each resident and what was important to them was integrated into the support provided so that residents had a good quality of life and lived a life that was meaningful to them. Residents and as appropriate their representatives were active participants in the support and care provided.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Compliant
Regulation 21: Records	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 17: Premises	Compliant
Regulation 18: Food and nutrition	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for The Laurels OSV-0004763

Inspection ID: MON-0033340

Date of inspection: 27/07/2021

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant 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 document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: Review of risk registers in both houses to include but not limited to updated or revised controls in relation to; Staff training measures in place in lieu of formal training while awaiting a place on training course, changing needs of individual in relation to health and required supports / future supports, revised risk assessment indicating use of restrictive practice to ensure most up to date reflection of the situation in terms of access to staff while restriction in use. Both registers fully completed by 30/09/2021	
Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: Door closers installed in one location. Completed. Door closers ordered and due for installation in second location before 31/10/2021.	

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Substantially Compliant	Yellow	30/09/2021
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the	Substantially Compliant	Yellow	30/09/2021

	resident's quality of life have been considered.			
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Substantially Compliant	Yellow	31/10/2021