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:	Ennis Adult Residential
Name of provider:	RehabCare
Address of centre:	Clare
Type of inspection:	Short Notice Announced
Date of inspection:	15 October 2020
Centre ID:	OSV-0002644
Fieldwork ID:	MON-0030132

About the designated centre

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

The designated centre provides a residential service to four adults with a diagnosis of an intellectual disability and-or autism. The centre comprises of one house, which is located in a residential neighbourhood of a large town. Transport for residents to access their local community and their day services is provided. Each resident has their own bedroom and share communal space and an appropriate number of shared bathrooms with their peers. The house has an annexed apartment where a semi-independent living arrangement is facilitated for one of the four residents. Three residents attend off-site day services Monday to Friday and an integrated type service is provided for one resident where day service staff attend the designated centre Monday to Friday. The model of care is social and given the assessed needs of residents a minimum of two staff are on duty at all times with a waking staff and a sleepover staff on duty at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

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
Thursday 15 October 2020	10:00hrs to 15:30hrs	Mary Moore	Lead

What residents told us and what inspectors observed

Three of the four residents living in this centre are provided with an off-site day service Monday to Friday; the inspector met with the fourth resident who receives their day service in the house. The inspector noted how staff consulted with the resident and ascertained whether the resident wished to meet with the inspector or not. The resident recalled meeting with the inspector on a previous inspection and wished to meet the inspector again. Much of the discussion between the resident and the inspector revolved around the resident's love of animals as the resident enjoys speaking with those who share such interests. The resident led this engagement and choose what it was they wished to talk about. There was discussion of how family pets had been named and the importance of managed visits home to family and these beloved pets during the COVID-19 pandemic. Other interests such as art-work were spoken of, as was the importance to the resident of their personal space. Staff were seen to establish resident well-being, the resident reported no particular concerns or worries; staff discussed and agreed with the resident the plans and routine for the day. Given the assessed needs of the resident the inspector did not introduce the topic of COVID-19; this will be discussed again in the body of the report.

Capacity and capability

Overall the inspector found that this service was operated and resourced so as to provide each resident with a safe service that was responsive to their individual needs. However, this inspection also found gaps and areas that needed to improve so as to assure the provision of the best possible safe, quality service. These gaps indicated management systems that provided for a good level of service provision but that did not provide for and ensure consistent and effective oversight; this resulted in gaps in practice and also did not drive ongoing improvement, for example in fire safety, in personal planning and in infection prevention and control.

The most recent internal review of the quality and safety of the service completed on behalf of the provider in June 2020 had reached a similar conclusion. While no significant risks or concerns were noted by the auditor it was reported that local monitoring systems did not provide assurance of consistent and effective oversight. For example, audits required to be completed on a weekly basis had not been completed by delegated persons and monthly audits though completed had not identified the weekly deficit. The internal findings and these Health Information and Quality Authority (HIQA) inspection findings indicated a possible lack of capacity in management systems to ensure consistent, effective oversight. The person in charge had other areas of responsibility including another designated centre; the management structure was designed to provide day-to-day support for the person in

charge from a team leader. However, there had been no team leader in the service for a period of approximately six weeks, a team leader was now in place, but only for three days each week. It was not evident from these inspection findings if this was sufficient to ensure consistent and effective management and oversight. The inspector was advised that this management deficit had been escalated to more senior management by the person in charge.

There were many examples of good governance such as the provision of adequate front-line staffing resources; the provider ensured that staffing levels and arrangements were sufficient to meet the assessed needs of the residents. There was a minimum of two staff on duty at all times but three staff were normally on duty up to 21:00hrs when all residents were present in the house. There were systems that facilitated good staff management, for example all staff working in the centre both residential and day service staff reported to and were managed by the person in charge. All staff both residential and day service and the hours that they worked were listed on the staff rota. The rota confirmed the staffing levels and the consistency of staffing described to and observed by the inspector. The person in charge endeavoured to be present in the centre at least two days each week and staff spoken with confirmed that they had good access to and support from the person in charge. Formal staff supervisions were also taking place though it was reported that they were somewhat behind the required schedule, again this may be indicative of the possible lack of capacity in the management structure.

A record of training completed was in place for each staff listed on the staff rota. These records indicated that mandatory, required and desired training including safeguarding, fire safety and responding to behaviour of risk was complete and current for all staff employed. Where training was yet to be completed, for example one staff required training in the administration of medicines, the person in charge confirmed that there was always a staff trained in medicines management on duty and there were no prescribed emergency medicines. However, it was not possible for the inspector to verify that all staff had completed hand-hygiene training. This failing is addressed in Regulation 27: Infection Prevention and Control, but again this training verification deficit had not been identified by local monitoring systems.

Regulation 14: Persons in charge

The person in charge worked full-time and had the qualifications, skills and experience necessary to manage the designated centre. The person in charge was aware of and accountable for their regulatory responsibilities taking into account their role in the management structure of this service. The person in charge was open to the inspection findings and understood the scope that existed for improving both the quality and safety of the service.

Judgment: Compliant

Regulation 15: Staffing

The provider ensured that staffing levels were responsive to the number of and the assessed needs of the residents living in this centre. The staff rota was well-presented, reflected the staffing levels described and indicated that residents received continuity of support from an established staff team.

Judgment: Compliant

Regulation 16: Training and staff development

A record of training completed by each staff employed was maintained. Overall staff had access to the training that they needed to perform their work and to provide residents with a safe effective service. Hand-hygiene training that should have been completed and may have been completed but could not be verified is addressed in Regulation 27.

Judgment: Compliant

Regulation 23: Governance and management

Gaps identified by this HIQA inspection indicated management systems that provided for a good level of service provision but that did not provide for and ensure consistent and effective oversight; this resulted in gaps in practice, did not ensure optimum quality and safety and did not drive ongoing improvement, for example in fire safety, personal planning and in infection prevention and control. The most recent internal review of the quality and safety of the service completed on behalf of the provider in June 2020 had reached a similar conclusion. The internal findings and these Health Information and Quality Authority (HIQA) inspection findings raised a possible lack of capacity in management systems to ensure consistent and effective management and oversight.

Judgment: Substantially compliant

Quality and safety

Residents in this centre received a good service. Living with COVID-19 had

presented new challenges to how residents were supported and how they lived their lives. Support had changed in response to this challenge as the provider sought to keep residents safe while ensuring that they continued to enjoy a good quality of life. However, as discussed in the first section of this report there was evidence of management systems that did not always ensure effective and consistent oversight, this resulted in gaps that did not optimise the quality and safety of the service provided to residents.

For example the inspector discussed with staff the assessed needs and support requirements of all four residents and reviewed one personal plan in detail. The plan was comprehensive, personalised to the resident and therapeutic in its focus. The plan had been updated to reflect the impact of COVID-19 and the change in support that was necessary in response. Much of what had been identified by the recent internal review as needed in the plan appeared to have been addressed. There was evidence that staff used tools such as social stories to maximise the residents participation in the support that was provided and to explain the purpose of the support. There was evidence that residents representatives were appropriately consulted with and participated in decisions about the support provided. Members of the multi-disciplinary team were consulted with and provided guidance on the care and support provided. The daily notes completed by staff provided assurance that staff implemented this guidance or recorded any difficulties that arose in following the plan, for example if a resident refused a particular routine or support. However, it was not robustly evidenced how the provider maintained oversight of the plan, assured itself of the effectiveness of the support that was provided and that the best possible outcomes were being achieved with and for residents. For example the inspector saw a very comprehensive review of the personal plan completed in June 2019 but there was no associated action plan, responsible persons or time-frames to evidence progress on and the impact of what had been discussed and agreed at this review. One indicator of the success or not of one particular plan of support was the maintenance of a stable body weight. Records seen by the inspector indicated that this was not currently achieved indicating a possible lack of effectiveness or non-compliance with the plan.

The support that was provided to residents included support to minimise the occurrence and impact of behaviour of risk to self and others. The plan of support included interventions that had a restrictive component such as secured doors or restricted access to certain foods. Records seen indicated that psychiatry and behaviour support services inputted into the plan and to the review of restrictive practices. There was evidence that the impact on others was considered, that attempts were made to remove or reduce restrictions and where this was not possible efforts were made to limit their impact. For example staff ensured that residents had access to suitable safe foods and regular snacks, if the front door was locked residents had access to the rear garden; one resident had been taught to use a "thumb recognition" lock so they could lock and unlock their own bedroom door. Staff maintained records of behaviour related incidents and how they were responded to; the recorded responses were proportionate and therapeutic. However, it was evident particularly in the context of COVID-19 that residents and the staff supporting them required ongoing and consistent access to and input from behaviour support so as to ensure the best possible short and long-term outcomes

for residents. For example staff described how a resident had chosen to significantly alter and limit their routines. Staff described how they sought to support and provide reassurance and set weekly goals with the resident but ultimately the residents decisions, will and preference to engage or not was respected. This was a challenging and complex dilemma for staff that required consistent oversight and input so as to prevent regression and to ensure good, positive outcomes for the resident during and post COVID-19.

The provider was very aware at an early stage of the pandemic of the challenges that COVID-19 would bring to resident general welfare and development. The provider had taken measures to keep residents safe from the risk of COVID-19 so that residents could continue to access and benefit from their off-site day services. These measures included the provision of an individualised service that minimised crossover of staff and residents and crossover and contact between residents and their peers.

Risk assessment and resident safety underpinned such measures and other practices such as the use of restrictive interventions. There was an associated risk assessment for each assessed need that carried a potential for risk, for example the risk of leaving the centre without staff knowledge, the accidental introduction of COVID-19 perhaps following a visit home or the ingestion of unsafe food and items. Overall the inspector found that the risk register reflected the assessed needs of the residents as described by staff and as seen in the personal plan. The person in charge maintained oversight of the register and it was reviewed and updated as needed, for example in response to the COVID-19 pandemic.

There was one identified safeguarding risk for which there was an active safeguarding plan. The person in charge advised that while the plan was active the risk was low and the plan was protective rather than in response to a targeted risk. Staffing levels allowed for good supervision and all staff had completed safeguarding training.

The providers response to the risk posed by COVID-19 has to date contributed to the protection of residents and staff from the accidental introduction of and onward transmission of COVID-19. There was a national team that co-ordinated and oversaw the provider response, local COVID-19 teams and responsible persons. Staff said that they felt safe at work and were kept updated and informed of changes to policy and practice. The staff rota had been adjusted to reduce footfall and crossover of staff. Staff described how they sought to develop resident knowledge of the risk posed by COVID-19 and supported residents to perform hand-hygiene. There was an enhanced schedule of environmental cleaning and staff were seen to wear face masks practically at all times given the challenge of maintaining a safe physical distance from each other and from residents in the space provided by a busy domestic setting. Staff confirmed that they had adequate supplies of cleaning and sanitising products and personal protective equipment. However, this inspection did identify scope for improvement to assure the providers infection prevention and control measures. For example while staff had completed a range of infection prevention and control training modules it could not be verified for the inspector that all staff had completed the required stand-alone hand-hygiene module. Staff

had access to a disposable paper towel product but it was not in a proprietary dispenser and therefore carried some risk of transmission. Each resident had a contingency plan outlining how they were to be supported in the event of suspected or confirmed COVID-19. However, the inspector was not assured based on the assessed needs of residents that these plans to isolate residents in the house could be effectively and safely implemented without risk of transmission to others and other risks such as distress and anxiety that may require chemical intervention that had been prescribed as a precautionary measure. The person in charge agreed and said that the feasibility of implementing these plans had also recently been discussed amongst the staff team.

During this HIQA inspection the inspector also identified gaps in the providers fire safety measures and while some of these were addressed during the inspection the gaps were again indicative of a lack of informed consistent and effective oversight. For example the stairwell was the main escape route from the first floor but the space under the stairs was used to store combustible items such as paper and textiles. While promoting resident independence and privacy, consideration had not been given to ensuring that staff could access the annexed apartment from the outside in the event that the internal access route was inaccessible. Three simulated evacuation drills had been completed to date this year and while these were successful none of them had tested the scenario of minimum staffing and maximum occupancy. The completion of such a drill had been an action from the June 2020 internal review. The premises was fitted with emergency lighting, a fire detection and alarm system and fire fighting equipment; these were inspected and tested at the prescribed intervals and most recently in September 2020. Each resident had a personal emergency evacuation plan and one such plan specified the possible requirement for an incentive to evacuate. The inspector saw that these items were in the location specified in the plan.

Regulation 26: Risk management procedures

This HIQA inspection did identify risks that had not been identified and these are addressed in Regulation 28 Fire Precautions. Overall the identification, assessment, management and monitoring of risk informed the care and support that was provided to residents so that they were safe in their home and in the community.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had responded in a timely and effective manner in response to the risk posed to residents and staff by COVID-19. However, there were gaps as it could not be verified for the inspector that all staff had completed the required stand-alone

hand-hygiene module. Staff had access to a disposable paper towel product but it was not in a proprietary dispenser and therefore carried some risk of transmission. Each resident had a contingency plan outlining how they were to be supported in the event of suspected or confirmed COVID-19. However, the inspector was not assured based on the assessed needs of residents that these plans to isolate residents in the house could be effectively and safely implemented for all residents without risk of transmission to others and other risks such as distress and anxiety that may require chemical intervention that had been prescribed as a precautionary measure. The person in charge agreed and said that the feasibility of implementing these plans had also recently been discussed amongst the staff team.

Judgment: Substantially compliant

Regulation 28: Fire precautions

During this HIQA inspection the inspector identified gaps in the providers fire safety measures and while some of these were addressed during the inspection such as the storage under the stairs and staff access to the apartment these gaps were indicative of a lack of informed, consistent and effective oversight. Three simulated evacuation drills had been completed to date this year and while these were successful none of them had tested the scenario of minimum staffing and maximum occupancy.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

It was not robustly evidenced how the provider maintained oversight of the personal plan, assured itself of the effectiveness of the support that was provided and that the best possible outcomes were being achieved with and for residents. For example the inspector saw a very comprehensive review of the personal plan completed in June 2019 but there was no associated action plan, responsible persons or time-frames to evidence the progress and the impact of what had been discussed and agreed at this review.

Judgment: Substantially compliant

Regulation 6: Health care

From records seen it was evident that staff monitored resident well-being and

sought to ensure that residents had access to the healthcare services that they needed such as their General Practitioner. This monitoring now included monitoring each day to detect possible symptoms of COVID-19. There appeared to have been some difficulty in ensuring that residents had access to and received consistent mental health support but the impact of this was monitored by staff and access was at the time of this inspection addressed.

Judgment: Compliant

Regulation 7: Positive behavioural support

The support that was provided to residents included support to minimise the occurrence and impact of behaviour of risk to self and others. The plan of support included interventions that had a restrictive component such as secured doors or restricted access to certain foods. Records seen indicated that psychiatry and behaviour support services inputted into the plan and to the review of restrictive practices. There was evidence that the impact on others was considered, that attempts were made to remove or reduce restrictions and where this was not possible efforts were made to limit their impact. However, it was evident particularly in the context of COVID-19 that residents and staff supporting them required ongoing and consistent access to and input from behaviour support so as to ensure the best possible short and long-term outcomes for residents.

Judgment: Compliant

Regulation 8: Protection

The provider had policy and procedures for the prevention and response to any suspected or alleged abuse. While there was an active safeguarding plan it was protective in nature and there was no ongoing concern for resident safety.

Judgment: Compliant

Regulation 9: Residents' rights

The care and support provided was delivered in a manner that respected the assessed needs and wishes of each resident. This was evident in the arrangements that the provider had put in place to ensure that residents could safely access their day service, their community and home while living with COVID-19. There was evidence that staff used communication tools to maximise resident understanding of

and participation in the support that was provided and their representatives as appropriate were also consulted with. The provider operated an advocacy forum and the advocacy offer had visited the centre in November 2019. It was evident that as long as they were safe residents could exercise choice and control in their daily routines. There was one arrangement as a consequence of COVID-19 that will require consistent oversight and appropriate clinical input. This is required to ensure that residents have the support that they need to understand and manage their anxieties and make good decisions. Such input will also support staff and ensure that in respecting a residents right to make decisions and have control over their life this is balanced against the risk of possible long-term negative quality of life outcomes.

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 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Substantially compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Ennis Adult Residential OSV-0002644

Inspection ID: MON-0030132

Date of inspection: 15/10/2020

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 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • Team leader hours to increase to 35 per week from 02.11.20, this will enhance oversight in the service. • Going forward Weekly/Monthly audits to be completed consistently by the Team Leader and the PIC. • Residents support plans and action plans to be reviewed monthly by PIC, Team Leader and Keyworkers. Multi-disciplinary review bi-annually to include BT, OT, SLT and Dietician/Nutritionist input. • IPC and Handwashing training completed by all staff and training records have been updated. • Fire Drill to be completed with minimum staffing level, simulating an hours of darkness fire drill. To be completed by 4th December.	
Regulation 27: Protection against infection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 27: Protection against infection: • IPC and Handwashing training has been completed by all staff and training records	

updated.

• Paper towel dispensers are now in place in all bathrooms.

• Isolation plans reviewed and updated to reflect the individual needs of the residents.

• Alternative accommodation has now been identified in the event that one resident is required to self-isolate. PIC will review isolation plans with staff team on an ongoing basis.

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions: Fire Drill to be completed with minimum staffing levels, simulating an hours of darkness fire drill. To be completed by 4/12/20.

Each staff member carries a key for the front door of the adjoining apartment to ensure access out of the apartment is not impeded.

Items removed from the area under the stairs and this will be monitored on the monthly health and safety inspection going forward.

Regulation 5: Individual assessment and personal plan	Substantially Compliant

Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:
• Residents support plans and action plans to be reviewed monthly by PIC, Team Leader and Keyworkers. Multi-disciplinary review bi-annually to include BT, OT, SLT and Dietician/Nutritionist input. BT to attend staff meetings on a quarterly basis. A review of plans took place on 02/11/2020, the MTD review will be completed by 31/01/2021.

• Short/Medium and Long term goals to be identified for each resident, these will be documented in action plans with staff responsibility and timelines assigned. This will be completed by 30/11/2020.

• Monitoring of progression of goals will be completed as part of the monthly keyworker

sessions and as part of the local service monthly audit.

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 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	31/01/2021
Regulation 27	The registered provider shall ensure that residents who may be at risk of a healthcare associated infection are protected by adopting procedures consistent with the standards for the prevention and control of healthcare associated infections	Substantially Compliant	Yellow	23/10/2020

	published by the Authority.			
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Substantially Compliant	Yellow	15/10/2020
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.	Substantially Compliant	Yellow	04/12/2020
Regulation 05(7)(c)	The recommendations arising out of a review carried out pursuant to paragraph (6) shall be recorded and shall include the names of those responsible for pursuing objectives in the plan within agreed timescales.	Substantially Compliant	Yellow	31/01/2021