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:	Creg Services
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Galway
Type of inspection:	Short Notice Announced
Date of inspection:	05 August 2020
Centre ID:	OSV-0005007
Fieldwork ID:	MON-0029805

About the designated centre

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

Creg services provides a residential service to adults. Residents of this service require a high level of support from staff in the context of their assessed needs. Residents may also have medical needs and a combination of nurses, social care workers and care assistants work in this centre. The centre comprises of two houses, which are located on the outskirts of a city where public transport links such as trains, taxis and buses are available. The centre also provides transport for residents to access their local community. Each resident has their own bedroom and an appropriate number of shared bathrooms are available for residents to use. Suitable cooking and kitchen facilities are also available and reception rooms are warm and comfortably furnished. A social model of care is offered to residents in this centre and most residents are receiving an integrated type service with both day and residential supports, provided in the designated centre; some residents attend separate off-site day services. One staff member supports residents, in each house, during night time hours and two-to-three staff members support residents, in each house, during the day. The day to day management of the centre is assigned to the person in charge supported by a team leader in each of the two houses.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	10

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
Wednesday 5 August 2020	10:45hrs to 16:15hrs	Mary Moore	Lead

What residents told us and what inspectors observed

This inspection was undertaken in the context of the ongoing requirement for measures to prevent the introduction of and the onward transmission of COVID-19. The inspector therefore only visited one of the two houses that comprise this centre and was mindful of the time spent in the house itself having given due consideration to the challenges that presented to maintaining a physical distance from both residents and staff. Residents in this house in the context of their assessed needs are limited in their ability to self-protect and are highly dependent on staff and others such as the inspector to keep them safe from the risk of COVID-19; staff were diligent in this regard. The inspector used the recommended level of personal protective equipment and had the opportunity to meet with all of the five residents, four in the house and one in the garden.

The initial observation was that the house was busy and space was limited with all residents and staff present and attending to the usual morning routines. This will be discussed again in the body of the report below. Residents are mobile and active and while most do not communicate verbally the inspector saw how they effectively communicated by gesture what is was that they wanted or needed; staff clearly understood and correctly interpreted these gestures and cues. Despite the need for the use of a face mask, residents did not present as uncomfortable with the presence of the inspector who was not known to them. The inspector was greeted with warm smiles, one resident wanted to know the inspectors name, spoke of their plan to move to their new house and invited the inspector to call to that house for coffee. Staff described how one resident was challenged by the use of face coverings particularly where the person was not known to them. Later in the garden and at a very safe physical distance the inspector removed their face mask so that the resident could see the inspector's face and facial expressions; the inspector received a broad smile in return and the resident continued with the activity at hand.

Though the opportunity to observe and engage was limited due to COVID-19 protective measures, the inspector was satisfied that staffing levels and arrangements, residents' needs and the support that they required, were as described and as documented in the records reviewed such as the personal plans. There was evidence of robust but proportionate measures to protect residents from the risk of COVID-19 while ensuring that their overall well-being was not unduly impacted by these measures, for example by ensuring the residents continued to enjoy visits and access to their local community.

Capacity and capability

The inspector found that this was a well-managed service that was effectively overseen and where the provider took corrective action as needed to improve the safety and quality of the service. However, it has been established for sometime now that the assessed needs of residents are not always compatible and this incompatibility impacts on the quality and safety of the service that is provided in both houses. For example, behaviour expressed in the context of assessed needs can act as a trigger for behaviour in a peer in response. There are other assessed needs for which environmental interventions are required so as to promote and protect certain residents from risk of injury but that may not necessarily be required for the safety of all residents, for example restricted access to the kitchen. The provider has, through a process of objective assessment of needs and risks devised a substantive plan to address this incompatibility of needs in both houses. There is a very high possibility that this plan will improve the appropriateness, quality and safety of residents lives individually and collectively.

However, contingencies required to manage the risk of COVID-19 have delayed the implementation of this plan, for example the provider was unable to commence planned building works and also had to make provision for an isolation unit should there have been an outbreak of COVID-19 in its centres. The risk from COVID-19 is still active and the Health Information and Quality Authority (HIQA) fully understands the risk-based decisions made by the provider and the consequent delay to its plans. The provider had implemented interim measures such as providing additional transport to each house so that residents had increased opportunity to leave the house and regular monitoring of the level and nature of peer to peer incidents so as to measure the effectiveness of its interim measures. However, the provider does need to look at how it can put its plan back on schedule given the ongoing risk to resident safety and quality of life that presents as long as residents continue to live incompatibility together. Implementation of the plan would also reduce the daily burden on staff as they work to reduce and manage the risk posed by the incompatibility.

In the context of the COVID-19 pandemic the provider took action to ensure that governance of the centre was effective. For example, there was a centralised response to the pandemic that ensured that protective measures were consistently implemented across all centres. Staffing levels were increased to compensate for the loss to residents of access to off-site day services. The importance to residents of regular and familiar staff was clearly understood and the person in charge told the inspector that notwithstanding unexpected challenges that presented every effort was made to provide for this consistency while maintaining adequate staffing levels. The staffing levels and skill-mix as seen on the day of inspection reflected what was seen on the staff rota and in the statement of purpose and function (a record the provider is required to maintain and that sets out all of the information about the centre such as the type of service provided, how to make a complaint in addition to the details on staffing).

The provider had put alternative arrangements in place for the completion of its own reviews of the quality and safety of the service and had changed its lines of enquiry to reflect the COVID-19 pandemic. The review continued to seek and incorporate feedback from residents, staff and representatives and used indicators such as the

level of accidents and incidents to inform its findings and conclusions. The review, findings and action plan acknowledged the factors that continued to impact on the quality and safety of the service and the requirement for the provider to progress its own quality improvement plan as referred to above in paragraphs 1 and 2.

The inspector reviewed the records maintained of the training completed by staff. From the records the inspector was assured that training deficits identified by the last HIQA inspection had been addressed and had not been allowed to reoccur. The provider had put arrangements in place to ensure that staff had continued access to training during the pandemic such as safeguarding training, for example by utilising on-line learning resources. The staff training programme was also responsive to the current pandemic and all staff had completed education and training such as hand-hygiene, using personal protective equipment (PPE) and how the break the chain of infection. Staff met with and observed were diligent in meeting their individual responsibilities in this regard so as to protect residents, themselves and colleagues.

Regulation 14: Persons in charge

The person in charge worked full-time and met the requirements of the regulations in terms of qualifications, skills and experience. The person in charge took responsibility for the management of the centre taking into account their role in the management structure. The person in charge had effective systems for maintaining oversight and was supported in the day-to-day management of the centre by a team leader in each house. The person in charge had responsibility for four centres and was satisfied that she had the support that she needed from the team leaders and from the senior management team. The input of and oversight by the person in charge was evident on inspection.

Judgment: Compliant

Regulation 15: Staffing

Staffing levels, skill-mix and arrangements were suited to the assessed needs of the residents. There was evidence that the provider monitored the adequacy of these arrangements and made changes so as to best support residents, for example the provision of additional staff to support residents during the COVID 19 pandemic.

Judgment: Compliant

Regulation 16: Training and staff development

Staff had access to the education and training that they needed so as to provide residents with a safe and effective service.

Judgment: Compliant

Regulation 21: Records

All of the records requested by the inspector were available in the centre. The records were well maintained and it was easy to find the information needed in the records.

Judgment: Compliant

Regulation 23: Governance and management

Overall the inspector found that this was a well managed service that was resourced to deliver on its objectives and where oversight was maintained in line with the individual roles and responsibilities of persons participating in its management. However, it has been established for sometime that the assessed needs of residents are not always compatible and this incompatibility impacts on the quality and safety of the service that is provided in both houses. Notwithstanding the delay that has resulted as a consequence of COVID-19 the provider does need to look at how it can put its improvement plan for this service back on schedule given the ongoing risk to resident safety and quality of life that presents as long as residents continue to live incompatibility together. Implementation of the plan would also reduce the daily burden on staff as they work to reduce and manage the risk posed by the incompatibility.

Judgment: Substantially compliant

Quality and safety

This was a well managed person centred service but as stated in the first section of this report the individual needs of residents are not compatible and this restricted the ability of the provider to provide each resident with the best possible quality, safe service. The provider does have a plan and based on records seen the plan has the potential to address the deficits in this centre and improve the safety and quality of residents lives.

In the interim the provider sought to provide residents with a good service and this was reflected in the feedback received from their representatives as cited in the recent internal review. The care and support provided to each resident was based on the ongoing assessment of their needs and as set out in the personal plan. The plan reviewed by the inspector was detailed but offered clear and succinct guidance. There was a clear sequence of assessment, planning and review. In addition the inspector found that there was a good link between different needs and plans of care and support, for example the possible impact of medicines prescribed to manage one need on other needs. Staff kept the plan under review and it was seen to be updated as needs changed, in addition the plan and its effectiveness was subjected to review by the multi-disciplinary team (MDT). This ensured that the plan was responsive to the residents needs and was informed by the appropriate clinician so that it was evidence based. What was observed and spoken about on inspection reflected what was written in the plan and this provided assurance that the person plan was an active record that guided daily practice in the centre.

For example residents in the context of their disability did present with behaviours that challenged and posed risk of injury to themselves and others including staff and peers. The needs of peers at times unintentionally triggered behaviours, for example increased levels of noise. This element of residents assessed needs contributed to their incompatibility and the risk posed to safety and quality of life in the centre. Residents had access to the clinical support that they needed such as psychology, psychiatry and an advanced nurse practitioner in behaviour support; a positive behaviour support plan set out for staff the strategies needed to both prevent and respond to behaviours. There was a good link in the plan between the behaviour and other needs such as sensory and communication needs. The plan offered good guidance to staff on therapeutic and protective interventions. However, the inspector did find that more reactive strategies such as chemical intervention while prescribed were not cited in the plan, there was a separate protocol. It was not clear however from the protocol seen, as to when in the management of behaviours chemical intervention should be considered by staff. Likewise there was reference in the plan to reactive physical interventions should staff be concerned for resident personal safety. It was not clear however, if staff could physically intervene if they deemed it necessary and safe in such risk based situations and if so, what the sanctioned intervention was.

As discussed in the first section of this report the provider had a substantive plan to address the incompatibility of residents needs, this plan included some residents moving to a new designated centre more suited to their needs. Plans to support these transitions had been prepared; the plan reviewed by the inspector was informed by knowledge of the residents assessed needs, input from the multi-disciplinary team (MDT) and consultation with the resident and their representatives. This was a good plan and was viewed as a positive development but its effectiveness and success would be better assured by inclusion of an assessment of compatibility with proposed housemates given the challenges that had arisen in this service.

There were interventions with a restrictive dimension such as restricted access to the main kitchen, restricted access to personal possessions and the main front door

was locked. Records seen set out the rationale for their use, the risk to resident safety if they were not used, the review and sanction of their use by the rights committee. There was evidence of alternatives, for example residents had access to secure and pleasant gardens to the side and rear of the property and supervised access to the kitchen. However, it was accepted in plans seen than on transition to their new home residents had the potential to experience less restrictions in their new environment and daily life.

The provider was aware of its responsibility to protect residents from harm and abuse including the risk of harm from a peer; the plan to address this is referenced throughout this report. Records seen indicated that all staff had completed safeguarding training; some residents needs limited their ability to self-protect and self-report. There was evidence that staff did exercise their individual responsibility to report any concerns they had about the quality and safety of the service, the reporting procedure was correctly used and the provider responded in a timely manner, reviewed the concerns raised and took any necessary action. The person in charge confirmed that there were no obstacles to staff raising any concerns, that there was ready access to and support available as needed from the designated safeguarding officer and that there was increased awareness and improved reporting of issues that arose as a result of incompatible needs.

Currently the providers plan provides for reducing the occupancy of one house, the house visited by the inspector, from a maximum of five to four residents. Based on the observations of the inspector the provider should give due consideration to formalising this reduced occupancy so as to further improve the quality of the service provided. It is a pleasant house that has been well maintained and offers many positives such as the self contained apartment and the large garden. Reduced occupancy would reduce activity and noise levels for residents, circulation areas are narrow and the utility area and the staff office are very compact spaces. The staff office is also effectively a thorough fare, with despite its limited space, three doors leading into it, two of which were in active use, one from the kitchen and the other leading to the utility room. This is not an ideal layout in terms of providing staff with an effective workspace or for maximising infection prevention and control procedures.

The assessed needs of residents included health care related needs. The personal plan included the plan of care to meet these needs so that residents enjoyed good health. The staff skill-mix included nursing staff. Staff were seen to monitor resident health and were attuned to possible indicators of ill-health such as an increase in behaviours. Staff ensured that they sought the clinical advice and review needed by residents, for example from the General Practitioner (GP) and the wider MDT.

The identification of hazards and the assessment of the associated risk underpinned the care and support provided to residents. The register of risks reflected the risks in the centre and the controls in place to reduce the risks. For example there were risk assessments to support the use of restrictive interventions and the provider formally acknowledged the risk to resident safety posed by needs that were not compatible. Interim controls included access to and regular review by the MDT,

adequate and consistent staffing and the provision of additional transport to each house. The person in charge monitored accidents and incidents, their frequency and intensity, to measure the effectiveness of controls. The acknowledged outstanding control was the implementation of the providers improvement plan. The risk register had been updated to reflect the risk posed by COVID-19 as had each residents risk management plan.

The providers response to the COVID-19 pandemic was co-ordinated by a centralised team that circulated relevant policies and guidance to each centre. This ensured the consistency of the providers response and that staff were guided by the most recent national guidance. An audit of staff compliance with required infection prevention and control measures had been completed with a high level of compliance found. That would concur with the findings of this HIQA inspection; for example the inspector found a high level of staff awareness of their individual responsibility, full compliance with training requirements, access to and the use of PPE, monitoring of resident, staff and visitor well-being, good attention to hand-hygiene and an enhanced schedule of environmental cleaning.

The inspector reviewed the fire safety register for this house and saw that the fire detection and alarm system, emergency lighting and fire fighting equipment were inspected and tested at the required intervals. Staff monitored this schedule of visits during the restrictive period of the COVID-19 pandemic and ensured that they were completed as soon as it was safe to do so. The inspector saw that staff carried master keys for opening locked doors; this reduced risk in the event of an emergency. Records seen indicated that different staff undertook simulated evacuation drills with residents at regular intervals.The drills were simulated to represent different scenarios such as night-time staffing levels. Though some prompting and guidance from staff was needed all residents were seen to respond to the alarm or the request to evacuate. The inspector did recommend that the fire policy and risk assessment should include the desired evacuation time for each house.

Regulation 10: Communication

Some residents were non-verbal communicators. The role of behaviour in communicating needs and wants and what certain behaviours were communicating was clearly described for staff in the personal plan. Narrative notes seen and observations on inspection demonstrated that staff responded to such cues.

Judgment: Compliant

Regulation 11: Visits

Staff spoken with were very aware of the importance to both residents and their families of having ongoing contact and the impact the restrictions imposed on visiting in response to COVID 19 had had. Staff had during this period supported other forms of contact and visits to the centre and to home had now recommenced in line with revised and relaxed guidance. Staff had access to this guidance, communicated with families and made pragmatic decisions in the context of residents needs to ensure that visits were undertaken in a safe manner and in a way that was of benefit to both residents and their families.

Judgment: Compliant

Regulation 13: General welfare and development

The assessed needs of many residents compromised their ability to understand and to have the skills needed to protect themselves from the risk of COVID 19, for example the need for physical distancing. This risk in conjunction with the closure of favoured amenities resulted in staff coming up with alternative solutions that ensured that residents had the opportunity for meaningful and safe community access. Staff planned for trips and outdoor activities and had also created a step challenge between houses. The person in charge reported that in many ways this had resulted in healthier choices and activities with benefits for residents, for example in relation to better weight management. Residents also had the benefit of a large garden with therapeutic equipment to meet their sensory needs and raised planting beds where herbs and vegetables were growing. On the day of inspection getting out and about was clearly important to some residents and was facilitated by staff. An additional vehicle suited to residents needs had been provided and it was confirmed that there were always approved drivers on duty.

Judgment: Compliant

Regulation 26: Risk management procedures

The inspector was assured that centre and resident specific risk identification and management informed the provision of services, support and care to residents. There was an outstanding risk control, the providers improvement plan for the centre; this is addressed in Regulation 23. There were no additional risks identified by this inspection that had not already been identified and managed by the provider.

Judgment: Compliant

Regulation 27: Protection against infection

The provider had implemented effective measures informed by national guidance to reduce the risk of the introduction of and the onward transmission of COVID 19. Staff were seen to be very aware of the vulnerability of this cohort of residents and were diligent but proportionate in their measures to protect them.

Judgment: Compliant

Regulation 28: Fire precautions

Based on the records seen the provider had effective fire safety management systems.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The personal plan detailed the residents needs and abilities and outlined the support and care required to maximise their well-being, safety, personal development and quality of life. The plan was developed based on the findings of an assessment; the plan and its effectiveness was the subject of review as needed by staff and by the wider MDT.

Judgment: Compliant

Regulation 6: Health care

There was evidence of assessment and ongoing monitoring by staff of resident health and well-being. Staff ensured that residents had access to the healthcare services that they needed.

Judgment: Compliant

Regulation 7: Positive behavioural support

Reactive strategies such as chemical intervention while prescribed were not cited in the behaviour support plan, there was a separate protocol. It was not clear however

from the protocol seen, as to when in the management of behaviours this intervention should be considered by staff. Likewise there was reference in the plan to reactive physical interventions should staff be concerned for resident personal safety. It was not clear however, if staff could physically intervene if they deemed it necessary and safe in such risk based situations and if so, what the sanctioned intervention was.

The effectiveness and success of planned transitions would be better assured by inclusion in the transition plans of an assessment of compatibility with proposed housemates given the challenges that had arisen in this service when behaviour was exhibited that impacted on peers.

Judgment: Substantially compliant

Regulation 8: Protection

The provider had safeguarding procedures that sought to protect residents from harm and abuse including peer to peer harm. These procedures were enacted in response to any concerns raised.

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	Substantially compliant
Quality and safety	
Regulation 10: Communication	Compliant
Regulation 11: Visits	Compliant
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Creg Services OSV-0005007

Inspection ID: MON-0029805

Date of inspection: 05/08/2020

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: The PIC shall ensure that the implementation of planned transitions within the Designated Centre occur in a planned and timely manner by the 18/08/20. This will work towards reducing and managing the risk posed by incompatibility. Plans for an extension to one house within the Designated Centre are in the advanced stages, with planning permission obtained and works tendered with an anticipated completion date for all works of February 2021	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: The PIC shall ensure that all aspects of documentation relating to the individuals behavioural support plan is subject to review, to include the reactive strategies such as chemical intervention where deemed appropriate.	

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	28/02/2021
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their	Substantially Compliant	Yellow	07/08/2020

	behaviour.			