



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

Issued by the Chief Inspector

Name of designated centre:	Newbridge Respite Centre
Name of provider:	The Cheshire Foundation in Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	05 October 2021
Centre ID:	OSV-0003448
Fieldwork ID:	MON-0034239

About the designated centre

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

This designated centre is a respite centre for adults with primarily physical disabilities and can accommodate respite breaks for up to five adults at a time. The accommodation comprises of five wheelchair accessible apartments with an en-suite, bathroom, kitchen and patio area. The apartments are accessed internally from an enclosed corridor and externally from an open courtyard. There is a communal kitchen and sitting room, utility room, a laundry room a reception area on entrance to main building, a staff office, and a quiet room (for staff), a general office, and three communal toilets one of which is wheelchair accessible. There are 15 staff members employed in this centre; the person in charge is employed on a full-time basis and there are senior care support workers, care support workers, one waking night staff, one administrator, one cleaning staff member and one maintenance person employed in this centre. There is a vehicle available to this service.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2
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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 5 October 2021	10:00hrs to 17:30hrs	Sarah Cronin	Lead

What residents told us and what inspectors observed

The inspection took place during the COVID-19 pandemic and therefore appropriate infection prevention and control measures were taken by the inspector and staff to ensure adherence to COVID-19 guidance for residential care facilities. This included the wearing of personal protective equipment (PPE) and maintaining a two metre distance at all times during the inspection day.

From what a resident told us and from what the inspector observed, it was evident that this was a well managed service that promoted person-centred care which was respectful of individuals and their right to determine their support. The centre is an adult respite service which is on the outskirts of a large town. The centre promoted best practice in accessibility with five large self-contained apartments, all of which had overhead tracking hoists, a counter top area with a sink, kettle and cooker which were at the correct height for people using wheelchairs. Each apartment had a sliding door onto a court yard area. Each apartment had their own television and DVD player and there were a number of movies available for residents to watch if they wished to do so. There was also a laptop available for residents to use. Seventy residents access this service throughout the year. The centre had remained open throughout 2020 at reduced capacity due to government restrictions. The designated centre supports residents to access local amenities such as a shopping centre, restaurants, pubs, a cinema and there was also a variety of activities in-house such as art, a bingo night, a karaoke night, take-away night and baking.

There were two residents staying in the centre on the day of inspection. One of the residents was in a day service during the day and had not returned by the end of the day. The inspector had the opportunity to speak with one of the residents during the day. The resident told the inspector that they had been accessing the service for thirteen years. The resident spoke highly of the service including the building and the food. They told the inspector that the staff were very kind and supported them through a difficult time. One of the phrases the resident used when asked what they enjoyed about the service was " here I can just be me". The resident reported that they had requested that DVD players would be provided in each residents room. This had been actioned by the provider.

It was evident to the inspector that this centre was one which was person -centred and consistently worked with residents to ensure that their needs were met and that they engaged in activities of their choice. On arrival to the centre, a check in form was completed with each resident which covered agreements contained in the contract of care, safety measures (such as fire safety), COVID-19, health care, medications and their preferences for activities during their stay. At the end of each residents stay, they were asked to complete a feedback form.

In summary, this was a well managed centre which was making every effort to ensure that residents had a safe, comfortable and enjoyable stay while ensuring their health and social care needs were met. Interactions throughout the day with

staff were kind and it was clear that the resident and staff members knew each other well. The next two sections of the report present the inspection findings in relation to the governance and management arrangements in the centre, and how these arrangements affected the quality and safety of the service being delivered.

Capacity and capability

The inspector found that the provider had a good management structure with clear systems and processes in place to ensure effective oversight was maintained over the quality and safety of the care of the residents using the service. There were clear lines of reporting in place. The management team were supported by a clinical partner, a quality partner and a HR partner. The person in charge was also a service manager. They were supported by two senior social care workers who managed the centre on a day to day basis including the management of staff. The clinical partner was on site at least once a week. There were emergency governance arrangements in place.

Provider level oversight was achieved through a number of channels in this designated centre. The provider had carried out six monthly and annual reviews in line with the regulations. The annual review had included consultation with residents. Documentation viewed by the inspector indicated that improvements in recording these reviews had been made since the last inspection with actions assigned to specific personnel and these were time bound. The provider had an audit team in place which consisted of the Clinical Partner, a Quality Partner and a member of the risk management team. The audit team carried out a range of clinical, quality and safety reviews of the centre on a regular basis to monitor progress and to ensure residents were in receipt of safe, good quality care. These audits were reported to corresponding committees such as the quality , safety and risk committee. Quarterly reviews took place of incidents and accidents, complaints and other aspects of the residents care.

Information sharing was achieved through a number of management meetings. There were regular meetings between the two senior social care workers and the person in charge. The clinical lead met with the senior social care workers on a weekly basis to ensure the health care needs of the incoming group of residents were met. There was a regional services support meeting which took place regularly.

At centre level, there was a senior social care worker on site each day. They achieved oversight through audits in areas such as COVID-19, fire, complaints and medication. These were recorded on the provider's online system. Senior social care workers carried out the staff meeting each month and there was a standing agenda in place. The inspector met with one of the senior social care workers and found them to be knowledgeable about the residents and their needs and could clearly demonstrate their systems of oversight in the centre.

The provider had ensured that the centre was resourced with the appropriate level of staffing and a skill mix suited to the needs of each group of residents at any one time. Planned and actual rotas were well maintained and indicated a stable staff team with regular relief staff and an agency nurse used as required in line with residents' assessed needs. However, improvements were required in maintaining staff files in line with Schedule 2 of the regulations with photographic identification not present for some staff members.

Staff training needs were assessed and monitored by the provider's learning and development department. Records viewed indicated that all staff had completed mandatory training which was in date. Staff had completed a range of other courses to enable them to support residents with a variety of health care needs such as epilepsy, diabetes, bowel management and skin care. There were appropriate systems in place for the supervision of staff and performance management. There was a structured system of induction and probation for new staff.

The provider took a proactive approach to receiving feedback from residents. At the end of each stay, the resident was given a feedback form to complete. Where issues or concerns arose in the form, they were addressed immediately and a clear record was kept of these discussions. The complaints policy was clear and supportive of residents voicing their concerns.

In summary, this inspection had good levels of compliance which was reflective of the provider's capacity and capability to ensure the best outcomes for residents using this respite service.

Registration Regulation 5: Application for registration or renewal of registration

The provider submitted all the required information to the Office of the Chief Inspector in line with the regulations.

Judgment: Compliant

Regulation 15: Staffing

The provider had the appropriate number of staff and skill mix to ensure that the health and social care needs of residents were met. The planned and actual rosters were viewed. They were well maintained and indicated regular relief staff were used where required. The number of staff on duty at any time was dependent on the number of residents using the service. However, some of the staff files viewed did not contain all of the requirements of Schedule 2 such as photographic ID.

Judgment: Substantially compliant

Regulation 16: Training and staff development

The provider had a learning and development department who monitored the training needs of staff. All staff had completed mandatory training in areas such as fire safety, safeguarding, manual handling, first aid and medication management. These were all in date. They had also completed a number of other courses specific to resident's health care needs such as diabetes, skin care and ulcer prevention, bowel management and catheter care. Finally, staff had completed courses related to COVID-19 and infection prevention and control such as hand hygiene and donning and doffing of PPE. There were appropriate arrangements in place for the supervision of staff.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had valid insurance cover for the centre in line with this regulation.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found that the provider had a good management structure with clear systems and processes in place to ensure effective oversight was maintained over the quality and safety of the care of the residents using the service. There were clear lines of reporting in place. The person in charge was also a service manager. They were supported by two senior social care workers who managed the centre on a day to day basis including the management of staff.

Provider level oversight was achieved through a number of channels in this centre which included audits and the review of these audits by relevant committees. The provider had carried out six monthly and annual reviews in line with the regulations. The annual review had included consultation with residents. Documentation viewed by the inspector indicated that improvements had been made since the last inspection with actions assigned to specific personnel and these were time bound. A number of management meetings took place at different intervals to ensure the sharing of relevant information and to drive quality improvement. The day-to-day running of the centre was carried out by two senior care workers. They did audits in

a number of areas and reviewed these regularly with senior management to ensure required actions took place.

Judgment: Compliant

Regulation 24: Admissions and contract for the provision of services

All residents were provided with a contract of care which contained all charges. This had been improved upon since the last inspection. The contract of care was discussed at each check in for residents.

Judgment: Compliant

Regulation 3: Statement of purpose

The statement of purpose contained the required information outlined in Schedule 1 of the regulations and accurately reflected the services provided in the centre.

Judgment: Compliant

Regulation 31: Notification of incidents

The inspector found that all notifiable incidents were submitted to the Office of the Chief Inspector within the required time frames set out in the regulations.

Judgment: Compliant

Regulation 34: Complaints procedure

The provider had a comprehensive complaints policy and associated procedures in place. There was a proactive approach to seeking feedback from each resident after their stay. All complaints or compliments were logged on a complaints database with the outcome recorded and whether this was satisfactory to the complainant. All complaints were analysed at provider level to identify quality improvement initiatives. The procedure was available in audio and booklet form for residents to access.

Judgment: Compliant

Regulation 4: Written policies and procedures

The inspector viewed the providers policies and procedures as required in Schedule 5. These were present, in date and regularly reviewed in line with the provider's time frames. However, the risk management policy did not meet regulatory requirements.

Judgment: Compliant

Quality and safety

The inspector found that this designated centre was striving to provide a safe, high quality and person centred service to the residents. The culture of the centre promoted independence and self-determination of residents. This was evident through discussion with the resident, discussions with staff, the provider's documentation and in particular, the check in and check out processes ensured the resident voice was central to their care and support.

Residents using the service presented with a variety of health care needs. An annual review of 'best possible health assessment ' took place. Where residents had higher clinical support needs (e.g. one resident had a P.E.G. in place), it was standard practice to access an agency nurse throughout their stay. Assessments were carried out prior to and on arrival to the centre and corresponding care plans were in place. These plans were reviewed and amended to reflect changes. Residents support needs and their preferences around care routines were discussed on arrival to each stay.

The provider had developed a clear system for the management of risk. Risks were appropriately identified and assessed with control measures in place to mitigate risks. There was a standard procedure in place for the escalation of high rated risks to senior management. Provider level oversight of risk was achieved through a national health and safety risk management committee. Incidents and accidents were recorded on the provider's online system and learning from incidents was identified and shared with staff. Individual risk assessments were also reviewed as part of the check in process, particularly in relation to COVID-19, manual handling needs, medication and fire. These were discussed with each resident. However, the risk management policy did not meet the criteria specified in the regulations. This was an outstanding action from the previous inspection. The risk register required improvement. Many of the risk assessments were out of date and not reviewed in line with the provider's specified time lines.

The premises promoted accessibility throughout and was very well equipped to maximise the independence of residents with physical disabilities. The premises was in a good state of repair and very clean. The provider employed a private company which carried out maintenance and testing of equipment in the centre which included servicing equipment such as hoists, beds and mattress pumps and ensuring the cleaning and disinfection of cold water tanks on a quarterly basis.

The Health Information and Quality Authority (HIQA) preparedness and contingency planning self assessment form had been completed. This was to ensure that appropriate systems, processes and pathways were in place to support residents and staff and to manage the service in the event of an outbreak of COVID-19. On arrival to the centre, the inspector noted that the centre had a visitor's book, a questionnaire relating to COVID-19 and a temperature check. Temperatures of staff and residents were done twice daily and logged. The provider carried out a COVID-19 questionnaire with residents on arrival. In the event a resident was not vaccinated, the provider required them to submit a negative COVID-19 test result prior to their stay. Risk assessments relating to COVID-19 were in place for individual residents and staff members. The centre had weekly COVID audits in place. The provider had set up a specific section on the intranet for staff on the management of COVID-19. This had up to date guidance and resources available. At handover, staff were asked about any possible symptoms of COVID-19. There was a large amount of PPE available to staff and adequate amounts of hand hygiene facilities. The inspector spoke with household staff who informed the inspector about the increased cleaning schedules and waste and laundry management. Each resident's apartment had its own washing machine and bed linen for each room was also washed in these rooms. As previously stated, the provider employed an external company who carried out maintenance. Water safety and disinfection of cold water tanks was carried out quarterly. Staff members ran water of unused apartments on a daily basis. A water sample was sent for testing each quarter to ensure it remained safe to use.

The inspector noted clear improvements in medicines management since the last inspection. There were appropriate systems in place for the receipt, storage and administration of medication. Stock was checked on arrival and at check out and this was clearly recorded in each residents' file. The prescriptions on file for a sample of residents matched the medication administration record for residents. Residents had assessments carried out on self-administration of medication and this included their preferences about support they required. Medication errors were clearly recorded and tracked on a monthly basis with detail on the type of error made for example refusal, staff error, medication variance. Medication audits were regularly carried out and this information was included in the annual report. There was a system in place to ensure staff remained competent in the area of medication administration. PRN protocols were in place for those residents who required it, with input from the resident's GP and from the clinical partner.

Fire safety management systems were reviewed and found to be compliant with regulations. There were appropriate fire detection and containment systems in place along with emergency lighting and fire fighting equipment. Fire evacuation was routinely discussed with residents at check in. The provider had appropriate systems

in place to ensure that residents were protected from abuse. The resident told the inspector they felt very safe in the centre and they could speak to staff if they had concerns. Staff members were knowledgeable about the different types of abuse and their responsibilities around safeguarding.

Regulation 17: Premises

The centre promoted best practice in terms of accessibility and was suitable for people with a range of physical support needs. Doors were an appropriate width enabling easy access to every room throughout the centre. Each apartment had its own front door and had a kitchen area with a hob, kettle and sink, all of which were at the correct height. Overhead hoists were available and each resident had their own en suite. Residents had ample space to store their personal belongings.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had good risk management systems in place in order to identify, assess and manage risks throughout the designated centre. There was a clear escalation pathway and adverse incidents were analysed routinely. Documentation was furnished to the inspector to indicate that the centre's vehicle was regularly serviced, insured and roadworthy.

The provider's risk management policy did not contain required information set out in Schedule 5. For example, the policy did not contain measures and actions to control specified risks such as accidental injury to residents, visitors and staff, aggression and violence and self-harm. The risk register had not been updated in line with the provider's identified review dates in a number of areas.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The provider maintained oversight of infection prevention and control measures in the centre through audits, record keeping of visitors, staff temperature logs and had clear procedures for staff to follow in a number of areas. There were adequate PPE supplies and hand washing facilities throughout the centre. There were appropriate systems in place for waste and laundry management. Residents were required to complete a declaration form prior to and on arrival to the centre and there was a clear contingency plan in place should they have become symptomatic during their

stay. Water checks were also in place. The premises was clean and there was a cleaning schedule in place for all regularly touched surfaces and additional measures were taken when occupancy was changing in an apartment.

Judgment: Compliant

Regulation 28: Fire precautions

The provider had good fire safety management systems in place. There were detection and containment systems and fire fighting equipment in place. Documentation was provided to show evidence of regular visual checks, servicing and maintenance of this equipment. The inspector viewed ten residents' personal emergency evacuation plans. On arrival to the centre at each stay, these plans were discussed and documented with each resident. Staff carried out a 'competency assessment' to ensure residents can use the call-bells system. Residents also had the option of wearing a wrist band with a button which was connected to a pager system.

Due to the layout of the building, it was possible for residents to safely exit their apartments via patio doors leading to a courtyard. Drills took place on a quarterly basis and the inspector viewed records of these drills which included night time simulated drills. These indicated reasonable evacuation with the minimal staffing complement. There was evidence of learning from drills. Fire wardens were identified on the safety notice board in the centre. All staff had completed relevant training.

Judgment: Compliant

Regulation 29: Medicines and pharmaceutical services

The inspector noted clear improvements in medicines management since the last inspection. There were appropriate systems in place for the receipt, storage and administration of medication. Stock was checked on arrival and at check out and this was clearly recorded in each residents' file. The prescriptions on file for a sample of residents matched the medication administration record for residents. Residents had assessments carried out on self-administration of medication and this included their preferences about support they required.

Medication errors were clearly recorded and tracked and medication audits were regularly carried out. PRN protocols were in place for those residents who required it, with input from the resident's GP and from the clinical partner.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

An assessment of need was carried out for each resident prior to their stay and their care needs were discussed once again when they checked in. The inspector viewed the files of ten residents. These indicated that residents had individualised care plans in place which were amended where required to reflect the any changes in their support needs. Risk assessments were also reviewed as part of the check in process, particularly in relation to COVID-19, manual handling needs, medication. Residents support needs and their preferences around care routines were discussed on arrival to each stay.

Judgment: Compliant

Regulation 6: Health care

Residents of the respite service were supported to have best possible health while they were in the centre. While the staffing in the centre was led by social care, there was daily access to the Clinical Partner who was a qualified nurse. A weekly meeting took place with the clinical partner and senior care workers to ensure that all clinical needs of residents arriving the following week were identified and care plans updates. An annual review of 'best possible health assessment ' took place. Where residents had higher clinical support needs (e.g. one resident had a P.E.G. in place), it was standard practice to access an agency nurse throughout their stay.

Judgment: Compliant

Regulation 8: Protection

The provider had appropriate systems in place to protect residents from abuse. There was a safeguarding policy in place and all staff training was up to date. The provider had developed clear guidance to support management to discuss safeguarding during supervision sessions. On arrival, body mapping was done where required for residents. Staff whom the inspector spoke with were knowledgeable about types of abuse and the process for reporting any concerns. One staff member told the inspector about a recent safeguarding incident which had occurred and how they had seen the policy followed through. Documentation reviewed indicated that improvements had been made in recording measures , with incidents appropriately documented and the outcome of investigations recorded clearly. Residents retained their own medication and finances in a locked press in their rooms. Assessments

were in place for residents' ability to manage both of these items and support plans were in place where required.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Compliant
Regulation 24: Admissions and contract for the provision of services	Compliant
Regulation 3: Statement of purpose	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Regulation 4: Written policies and procedures	Compliant
Quality and safety	
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 29: Medicines and pharmaceutical services	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 8: Protection	Compliant

Compliance Plan for Newbridge Respite Centre OSV-0003448

Inspection ID: MON-0034239

Date of inspection: 05/10/2021

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 15: Staffing	Substantially Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: <ul style="list-style-type: none">• An audit of all personnel files is in process and all Schedule 2 requirements will be in place by 30/11/2021.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: <ul style="list-style-type: none">• The risk management policy was amended following a previous inspection and includes required information set out in Schedule 5. This and all policies are available for all staff on the Cheshire website but the service mistakenly had the earlier version filed in the hard copy Schedule 5 folder. This has now been rectified.• The Risk Register has been updated and will be maintained on an ongoing basis in line with individual risk assessment review dates.	

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 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Not Compliant	Orange	30/11/2021
Regulation 26(1)(c)(i)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: the unexpected absence of any resident.	Not Compliant	Orange	05/11/2021
Regulation 26(1)(c)(ii)	The registered provider shall ensure that the risk management policy, referred to	Not Compliant	Orange	05/11/2021

	in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: accidental injury to residents, visitors or staff.			
Regulation 26(1)(c)(iii)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: aggression and violence.	Not Compliant	Orange	05/11/2021
Regulation 26(1)(c)(iv)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to control the following specified risks: self-harm.	Not Compliant	Orange	05/11/2021
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and	Substantially Compliant	Yellow	05/11/2021

	ongoing review of risk, including a system for responding to emergencies.			
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