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:	Cloghan
Name of provider:	Health Service Executive
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	21 February 2022
Centre ID:	OSV-0008154
Fieldwork ID:	MON-0035405

About the designated centre

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

The centre is located within a small campus setting which contains three other designated centres operated by the provider. Cloghan provides full-time residential care and support to 3 residents. The designated centre comprises of a four bedded bungalow. The centre is located in a residential area of a town and is in close proximity to amenities such as shops, leisure facilities and coffee shops. Residents are supported by a staff team of both nurses and care assistants.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	3

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 (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
Monday 21 February 2022	09:30hrs to 17:56hrs	Stevan Orme	Lead

What residents told us and what inspectors observed

During the course of the inspection, the inspector found that care and support provided to residents at Cloghan was reflective of their assessed needs. Care and support provided ensured residents were supported to make personal choices about how they wished to spend their day as well as goals they wished to work towards in the year. Practices at Cloghan also ensured that residents were kept safe from harm where risk had been identified. However, improvements were required to risk management and staffing arrangements at the centre, as well as further action to achieve compliance in governance and oversight arrangements, staff training and the physical condition of the centre's premises which will be described during the course of the report.

Prior to the inspection, in December 2021 as part of the provider's submitted management improvement plan to the Health Information and Quality Authority to address previously identified regulatory non-compliance both at Cloghan and across the Ard Griene Court campus, the provider had registered Cloghan as a standalone designated centre in its own right. Previously, Cloghan was part of a two premises centre within the campus complex.

On the day of inspection, all three residents were at the centre, although the inspector only had the opportunity to meet with two of the residents as the third was self-isolating in their bedroom due to COVID-19.

The centre was very spacious in design and adapted to meet the needs of residents, with each resident either having access to their own en-suite bathroom or a communal bathroom which they solely used close by. Residents' bedrooms were personalised in accordance with their choices and needs, with family photos and personal items on display. Residents also had access to two lounge areas at the centre which were homely in nature and again included photos of the residents engaged in past activities or with their families. Two residents were relaxing in one of the lounge areas during the inspection along with a staff member, and a calm atmosphere was present throughout the inspector's visit. Residents appeared to be at ease with staff supporting them, and staff provided care and support in a timely and dignified manner in accordance with residents' wishes.

Residents had access to all parts of the centre, and during the inspection one resident was supported by staff to look through the kitchen cupboards and check all items within were in order which was an activity they frequently did according to staff and was reflected in their care plan.

Another resident briefly spoke about activities they enjoyed at Cloghan, and told the inspector with the support of staff about how they kept in contact with their family either through visits to their home town and video calls.

However, although the centre's premise met the assessed needs of the residents

and according to staff had some interior areas recently painted, the inspector observed that further improvement was required to its general condition of the premises, which will be described later in the report.

Throughout the inspection, staff were observed to be following public health guidance in relation to COVID-19 and infection prevention and control procedures. Staff were observed wearing appropriate face masks throughout the day and on arrival at the centre, the inspector's temperature was taken and recorded. The centre was well stocked with personal protective equipment (PPE) and hand sanitizer was readily available. Furthermore, information on topics such as the signs and symptoms of COVID-19, hand washing techniques and cough etiquette were displayed at key points around the centre.

In summary, the inspector found that residents' needs were supported at Cloghan in line with their care plans and agreed interventions; however, further improvements were required which will be described later on in the report.

Capacity and capability

Governance and management arrangements at the centre following the provider's registration of Cloghan as a standalone designated centre, had ensured that residents received care and support in accordance with their assessed needs and were kept safe from harm. However, further action was required to ensure that oversight arrangements were effective in the identification and management of risk and ensured the day-to-day operations of the centre was compliant with both regulation and the provider's own policies.

Prior to December 2021, Cloghan had been part of a two premises designated centre within the Ard Greine Court campus, however as part of the provider's accepted management improvement plan to address significant non-compliance with the regulations, applications had been received to separate the two premises into two standalone designated centres.

As a result of changes to Cloghan's registration, the provider had put in place a clear governance and management structure for the new centre, with its own person in charge who was supported by a Clinical Nurse Manager (CNM1). The described management structure was shared with another designated centre within the Ard Greine Court campus, although it was evident during the inspection that management support was available to staff at Cloghan on a daily basis, including access to the campus' Director of Nursing.

Following the centre's reconfiguration, the provider had ensured that Cloghan had its own dedicated staff team comprising of both nurses and health care assistants, and in the event of planned and unplanned absences, a core group of five temporary workers were available to meet the needs of residents and ensure consistency of care. Residents' needs were met during the day and at night-time by

two members of staff at all times, which was either a combination of a nurse and health care assistant or two health care assistants. However, review of staff rosters at the centre found five occasions since December 2021, where night-time staffing had been reduced to one staff member due to staff being relocated across the campus to cover unplanned staff absences in other designated centres. This action was not in line with staffing arrangements as described in the centre's statement of purpose, and had not been risk assessed to ensure residents at the centre were kept safe and arrangements were in place in the event that the second member of staff should be required back at Cloghan. In addition, although the centre's daily nursing report summaries reflected that night-time staff had been relocated from Cloghan for all or a proportion of their night-time shift, this was not recorded on the centre's staffing roster.

Since the previous inspection of Cloghan when it was part of another designated centre on the campus, improvements had occurred with staff access to training in line with the mandatory requirements of the provider as well as specific needs of residents. Records showed that overall staff had all undertaken up-to-date training in line with the needs of the centre, however some training was still outstanding, with one staff still to undertake sexuality training and a further four staff to complete online training on open disclosures. In addition, a review of the centre's induction checklist, showed that out of the five dedicated temporary staff for the centre, only one had signed that they had completed the centre's induction checklist.

However, although training was outstanding for some staff and records had not been completed fully for temporary staff, staff who spoke with the inspector during the inspection including a temporary worker were knowledgeable on all aspects of residents' care and support at Cloghan including the management of behaviours that challenge and current safeguarding risks.

Oversight of the designated centre by management was monitored through a suite of audits into all aspects of care and support practices at the centre, which occurred either monthly, quarterly or annually dependent on their purpose. Audits were completed by both the person in charge and CNM1, as well as nominated staff within the centre. A review of audits showed that they were in the main completed fully and in line with the centre's annual audit schedule, however the inspector noted that the monthly accident and incident reporting audit had not been completed in December 2021, even though three incidents of behaviours of concern had occurred. It was also noted that although comprehensive in nature, audits undertaken at the centre were generic in nature and used across the campus, and were not specific to issues and the needs of the Cloghan. In addition, completed audits had not identified areas for improvement or action observed by the inspector during the day such as the absence of risk assessments relating to staffing levels and residents use of the Internet.

Oversight arrangements at the centre had however been strengthened in relation to the review of trends of accidents and incidents and the examination of the effectiveness of safeguarding plans, through the implementation of a Quality and Safety Meeting at the campus. Records showed that these meeting involved both

campus staff and multidisciplinary professionals, and evidenced that incidents and safeguarding risks at Cloghan were reviewed to ensure care and support practices meet residents' needs.

Actions from the completed audits as well as relevant issues from the previously completed provider unannounced visits and annual review of care and support when Cloghan was part of another designated centre on the campus had been transferred on to a Quality Improvement Plan (QIP) for the centre in order to ensure they were addressed following registration. A review of the QIP showed that it was regularly updated and reviewed by the Director of Nursing, with actions being completed within agreed time frames, however risks identified during the inspection as previously described such as occasions of a reduction in night-time staffing had not been captured.

In summary, although improvements were evident in the care and support provided to residents at Cloghan since its registration as a standalone designated centre, further actions was required to strengthen the governance and management arrangements at the centre, to both sustain and ensure further compliance with the regulations.

Regulation 15: Staffing

The provider had not ensured that the centre's staffing arrangements at night-time were consistently implemented in line with its statement of purpose. In addition, where staffing levels were below the required level at night-time due to staff being relocated to other designated centres within the Ard Greine Court campus this had not been reflected on the centre's rota.

Judgment: Not compliant

Regulation 16: Training and staff development

Although staff had access to a range of training both in line with the provider's policies and residents' specific needs, not all staff had completed all required training such as sexuality and open disclosure.

Judgment: Substantially compliant

Regulation 23: Governance and management

Governance and management arrangements had improved at the centre following

its registration as a standalone centre in December 2021, and a dedicated management structure was in place involving both a person in charge and CNM1. However, management audits were generic in nature and not specific to the needs of the centre and had not identified risks relating to occasions of reduced night-time staffing, uncompleted audits, and confirmation of temporary staff induction.

Judgment: Substantially compliant

Quality and safety

Residents received a good standard of care and support in accordance with their assessed needs at Cloghan, with appropriate interventions being in place were risks relating to safeguarding and behaviours of concern had been identified. Supports provided to residents ensured that they were kept safe from harm and supported them to enjoy activities based on their personal interests, likes and choices. However, improvements were required in relation to risk management as discussed earlier in this report and the general condition of the centre's premises.

Each resident had a detailed and comprehensive care plan, which provided clear guidance to staff on supports they required in areas such as healthcare, communication, sexuality and social activities. The effectiveness of each resident's care plans was reviewed annually by staff and multidisciplinary professionals in conjunction with the resident; if they choose to attend the meeting, and their representatives. In addition, residents were supported to work towards a range of personal goals throughout the year which reflected both their social and development needs such as planning overnight stays and making purchases for their bedrooms. In addition, residents had access to an accessible version of their personal plan which illustrated how their needs would be meet by staff, this document was called 'My Profile' and also included information on the residents' like and dislikes and family support networks.

Where residents had behaviours which challenged, up-to-date behaviour support plans had been developed in conjunction with the provider's senior clinical psychologist as well as staff who were qualified in behaviour management. Plans were detailed and clearly guided staff on supports to be offered to residents' at times of distress. In addition, behaviour support plans were subject to regular review by the aforementioned behaviour specialists to ensure their effectiveness. Staff were knowledgeable about behavioural supports to be provided to residents in line with their needs, and had also undertaken the provider's positive behaviour management training. Where the management of behaviours that challenge required the use of restrictive practices such as the administration of medication or environmental restrictions (e.g. locked bedroom cupboards), this was clearly risk assessed, with protocols in place to ensure a consistent approach by staff, and to ensure the least restrictive practice was adopted.

In addition to the management of challenging behaviour, where safeguarding risks had been identified at the centre, appropriate and responsive actions were in place. Safeguarding risks were assessed by the centre's designated safeguarding officer and staff, with preliminary screenings being completed which included interim safeguarding plans to ensure residents were kept safe form harm. The preliminary screening were forwarded to the local safeguarding and protection team for review. Reviewed safeguarding plans clearly identified the risk and the subsequent response to mitigate its impact such as increased staff supervision. The inspector observed that both staff knowledge and practices on the day of inspection reflected actions detailed in current safeguarding plans for the centre. In addition, arrangements were in place at the centre to investigate any alleged incidents of historical safeguarding risk, with arrangements being robust in nature and involving scrutiny independent of the designated centre.

On the day of inspection, all three residents were at Cloghan, with one resident self-isolating due to COVID-19. However, discussions with staff and reviewed records, showed that residents were given choice on daily activities they wished to engage in. Due to the COVID-19 pandemic, residents' were not accessing external day services to the campus, however, they were able to access a range of activities they enjoyed. Records showed that residents enjoyed going on trips to local towns for coffee as well as personal shopping. Residents were also supported to maintain regular contact with their families either through home visits or video calls. The Director of Nursing also spoke about an initiative undertaken at the campus recently to access facilities at a local leisure facility to provide residents' with activities away from the campus, with one of the residents from Cloghan taking up this opportunity and accessing Chair Yoga sessions.

Residents were also supported to make choices about food provided at Cloghan. Although meals were provided through the campus' centralised kitchen, residents were offered choice through the kitchen's daily menu, and staff told the inspector that residents could also have a different options provided which was not listed on the menu if wished. Staff however told the inspector that in the main, residents appeared to enjoy the centralised kitchen's meals. In addition, the centre had a fully working kitchen and well stocked fridge and kitchen cupboards with a range of frozen meals if residents' did not want the provided meal or sought snacks throughout the day. Staff also spoke about arrangements with the local supermarket to ensure that the kitchen was well stocked and residents had snacks and treats they enjoyed.

As stated earlier in this report, further improvement was required to risk management arrangements at the centre. In addition, to a risk assessment not being in place for the occasions since December 2021 where night-time staffing had been reduced to one person, the centre's management had not ensured that a risk register was available for Cloghan in line with the provider's risk management policy, although a review of completed and up-to-date risk assessments illustrated that all identified risks were being addressed, apart from the risk identified by the inspector.

Furthermore, although addressed by management on the day of inspection, no risk assessment had been completed in relation to residents' use of personal computer

tablets and mobile phones in relation to Internet access in line with the provider's own policy. Staff told the inspector that although residents each had their own personal tablet which they used to contact their families for video calls, these were kept in the centre's office when not in use and all residents required staff supervision when using them. Risk assessments were developed by the provider and viewed by the inspector prior to concluding the inspection, and were found to both reflect staff knowledge and practice in this area of risk.

Both staff and the centre's management told the inspector about recent redecoration that had been completed at Cloghan, which included painting of communal areas. However, further improvements were required to the general condition of the building. The inspector observed both damage and gaps in the wooden flooring in a resident's bedroom and the corridor area especially leading to one of the centre's fire exits. In addition, rust damage was evident on several radiators throughout the centre as well as a showier chair and toilet handrail in a bathroom used by one resident. In addition, paintwork to a kitchen wall required redecoration due to damage.

In conclusion, although residents' needs were meet in accordance with their support plans and they were kept safe from harm. Improvements were required to ensure the good condition of the premises and all risks were assessed and appropriate interventions put in place.

Regulation 17: Premises

Although the centre's premises had been recently painted, further improvement was required to its overall condition. The inspector observed damage to floor coverings, paintwork and evidence of rust damage on radiators and bathroom aids at the centre.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

Risk management arrangements in place at the centre had not ensured that a risk relating to the reduction of night-time staff at the centre was appropriately identified, assessed and managed. In addition, the provider had not ensured that a risk register of all risks identified at the centre was in place as required under its own risk management policy.

Judgment: Not compliant

Regulation 5: Individual assessment and personal plan

Detailed care plans were in place which reflected residents' assessed needs and clearly guided staff to ensure a consistency of approach. Care plans were subject to regular review to ensure their effectiveness in meeting residents ' needs, with accessible care plans available to residents to increase their knowledge on how their needs would be met at the centre.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents needed support with challenging behaviour, detailed behaviour support plans were in place which were developed in association with behaviour specialists and ensured a consistent approach by staff. Plans were further subject to regular review to ensure their effectiveness in meeting the residents' needs.

Judgment: Compliant

Regulation 8: Protection

Safeguarding arrangements in place at the centre were comprehensive with all staff having received up-to-date training to ensure their knowledge reflected current health and social care practices. Where concerns of this nature had arisen at the centre comprehensive and proportionate safeguarding plans had been implemented under advice to manage the situation and reduce identified risks and future occurrences.

Judgment: Compliant

Regulation 9: Residents' rights

Residents were actively encouraged by staff to make decisions about their lives and the day-to- day running of the centre through their involvement in annual reviews of their care plans, participation in regular house meetings, and making choices about food choices and activities they wished to do during the day.

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 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Cloghan OSV-0008154

Inspection ID: MON-0035405

Date of inspection: 21/02/2022

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	Not Compliant
Outline how you are going to come into compliance with Regulation 15: Staffing: 1. The Person in charge/ Director of Nursing has completed risk assessment in relation to minimum staffing on night duty – Completed 24/02/22 2. The Person in charge/ Director of Nursing has completed a review and updated the statement of purpose to reflect the minimum staffing levels within the centre – Completed 25/02/22 3. The Director of Nursing has issued a memo and spoken with staff to reiterate the necessity of ensuring that the rota is reflective of the staff on duty within the centre – Completed 14/03/22	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The Person in charge/ Director of Nursing has completed a further review of the training matrix – Completed 14/03/22 2. The Person in charge will schedule all staff for training on supporting adults sexuality in residential settings – Date for completion: 31/03/22 3. The person in Charge will schedule all staff for outstanding training - Date for completion: 31/05/22	

Regulation 23: Governance and management	Substantially Compliant

Outline how you are going to come into compliance with Regulation 23: Governance and management:
1. The Regional Director of Nursing in liaison with the CNM3 for quality safety and risk will be conducting a review of the audits in place within all centre – Date for completion: 30/04/22
2. The Person in Charge/Director of Nursing have completed a risk assessment in relation to minimum staffing within the centre and this is now available onsite – Completed 24/02/22
3. The Person in Charge/Director of Nursing have completed a protocol in relation to minimum staffing within the centre and this is now available onsite – Completed 24/02/22
4. The Person in charge will ensure that all staff inductions are signed and retained in the centre – Completed 14/03/22

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
1. The person in charge/Clinical Nurse manager 1 have completed a review of all works required within the centre – Completed 24/02/22
2. The person in charge has escalated the schedule of works required to the maintenance manager – Completed 24/02/22
3. The person in charge/ Director of Nursing will ensure that all identified works are completed within the centre – Completion date 30/04/22

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
1. The Person in Charge/Director of Nursing have completed a risk assessment in relation to minimum staffing within the centre and this is now available onsite – Completed 24/03/22
2. The Person in Charge/Director of Nursing have completed a protocol in relation to minimum staffing within the centre and this is now available onsite – Completed 24/03/22

3. The Person in charge has commenced the process of compiling a risk register for the centre – Date for completion: 28/03/22
4. The Director of Nursing will ensure that all risk assessments are reviewed in a timely manner – Date completed 14/03/22 and ongoing

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(1)	The registered provider shall ensure that the number, qualifications and skill mix of staff is appropriate to the number and assessed needs of the residents, the statement of purpose and the size and layout of the designated centre.	Not Compliant	Orange	14/03/2022
Regulation 15(4)	The person in charge shall ensure that there is a planned and actual staff rota, showing staff on duty during the day and night and that it is properly maintained.	Not Compliant	Orange	14/03/2022
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training,	Substantially Compliant	Yellow	31/05/2022

	as part of a continuous professional development programme.			
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Substantially Compliant	Yellow	30/04/2022
Regulation 23(1)(a)	The registered provider shall ensure that the designated centre is resourced to ensure the effective delivery of care and support in accordance with the statement of purpose.	Substantially Compliant	Yellow	30/04/2022
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	30/04/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the	Not Compliant	Orange	10/03/2022

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