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## Grangebeg Camphill Community, OSV-0003621, 19 July 2018

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

Name of designated centre:	Grangebeg Camphill Community
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	19 July 2018
Centre ID:	OSV-0003621
Fieldwork ID:	MON-0021813

## About the designated centre

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

Grangebeg Camphill Communities was set up in 2006 and provides residential services to 10 residents. There is also a day programme operated by the service and there were 10 day attendees at the time of this inspection. The service is provided across two large buildings used for residential services on a large rural site with adjoining day services, farmyard and farm buildings.

The designated centre was issued a warning letter by HIQA in May 2018 due to levels of non compliance with the Regulations and Standards. No admissions were permitted to the centre pending further HIQA inspection.

**The following information outlines some additional data on this centre.**

Current registration end date:	06/05/2020
Number of residents on the date of inspection:	10

## How we inspect

To prepare for this inspection the inspector or 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
19 July 2018	09:00hrs to 17:00hrs	Conor Brady	Lead

## Views of people who use the service

Inspectors spoke with ten residents who used this service who were all highly complimentary of the centre, staff and the time they spent there.

In addition, a number of day attendees (who were part of day programmes run by the provider) were also spoken with over the duration of the inspection. Residents gave inspectors a good insight into the recent changes that occurred in the centre in terms of staff and management personnel.

Residents were observed working on the farm, cooking, going on social outings, going to work, gardening and planting flowers. A resident proudly gave inspectors a tour of the gardens (large rural site) and showed a project that was underway to landscape and develop a garden of remembrance for residents who have passed away.

All residents were observed to be up and very active at the time of this unannounced inspection.

All residents spoken with appeared very relaxed and presented as very content with the service.

## Capacity and capability

The governance and management of the service had again changed since the previous inspection. The provider had appointed a Regional Manager with accountability and oversight over Grangebeg. The focus of the management team had been on the actions cited to the registered provider in a warning letter issued by HIQA in May 2018 regarding previous regulatory failings identified in this centre.

The person in charge had been allocated the support (on a short term basis) from a manager from another designated centre, in addition to the appointment of a new line manager. In addition, social care leaders were appointed in both houses. All of these managers were met as part of this inspection. The person in charge demonstrated good evidence of actions completed since the previous inspection.

The provider demonstrated progress in a number of areas since the previous inspection. For example, specific follow up pertaining to safeguarding concerns, risk management, staff supervision and specific accidents/incidents.

The person in charge had made a considered effort over this time period to enhance monitoring and practice supervision, key elements of risk management had been

improved and a wider emphasis was being put on safeguarding practice.

Overall the concerns highlighted in the warning letter issued to this registered provider following the previous inspection were found to have been acted on across a number of areas by the provider. However some areas were very much still in progress and required further attention and review by the provider and person in charge. While specific issues had been followed up and addressed, overarching management systems and consistent and robust oversight was required in this centre in the long term. This has been a difficulty for this provider in this designated centre since commencement.

The provider's management highlighted budget and staffing as their biggest challenges. The centre was operating below its WTE (Whole Time Equivalency) by five staff members. Staff recruitment practices required improvement regarding the use of agency staff. For example, agency staff having no evidence on files of training or not having staff files at all. Agency staff not being subject to appropriate levels of supervision/team meetings/training to ensure the appropriate dissemination of information.

The person in charge cited a number of areas she has addressed regarding staffing such as a complete reduction in the role of volunteers in supervising residents. However further improvement was required regarding recruitment, retention, appointment, staff numbers and supervision in place for the 24 hour period that this residential service operated. In addition, a health and safety manager position was not filled since being vacated on the previous inspection. This was deemed an important position in this service given the environmental risks apparent in this centre with the adjoining farm, machinery, livestock and associated environmental and occupational risks.

A review of resident contracts was required as not all residents had signed contracts in place and management had not aligned residential fees charged to residents to national guidance.

Risk management and safeguarding practices had improved in terms of the reviews and time invested by management since the previous inspection. However further system changes were required to ensure these changes were understood at ground/frontline level across all person working in the centre. For example, some staff spoken with were very knowledgeable however others had limited understanding of risk, safeguarding and regulation.

#### Regulation 14: Persons in charge

A full time person in charge was in place who met the requirements of the Regulations.

Judgment: Compliant

## Regulation 15: Staffing

The centre was not equipped with a full and suitable compliment of appropriately qualified staff.

Judgment: Not compliant

## Regulation 16: Training and staff development

All staff did not have records available to demonstrate they had undergone all appropriate training. Some staff were not able to demonstrate sufficient knowledge on key areas of risk, safeguarding, and the regulations and standards.

Judgment: Not compliant

## Regulation 23: Governance and management

The registered provider was not fully ensuring all aspects of service provision were consistently and effectively monitored. While progress had been made since the previous inspection further monitoring and resourcing were required in this centre to ensure care, monitoring and supervision were delivered in line with residents assessed needs on a continued basis.

Judgment: Not compliant

## Regulation 24: Admissions and contract for the provision of services

All residents did not have updated and signed contracts in place. Contracts were not aligned to national guidelines regarding charges to residents and some residents were charged different amounts for the same service.

Judgment: Not compliant

## Quality and safety

Local governance had improved since the previous inspection and key improvements

in care and support of residents had been made since May 2018. However quality and safety in the long term in this centre is linked to consistent management, staffing and resourcing of the centre which was found to still require improvement.

From a general welfare perspective residents presented as well cared for and had good levels of activity and support. Residents presented as happy and content throughout the inspection. Residents informed the inspectors they were happy in the centre and there was plenty of activity observed in the centre throughout this inspection.

However professional care planning and delivery and the ongoing development of same (while improved) was required further. In addition, the consistent monitoring and provision of individually assessed care planning required further improvement. For example, ensuring care planning was assessment led from both health and social care perspectives and that these plans were reviewed and updated in line with residents needs. The person in charge highlighted this as under review and evidence of this was seen by inspectors.

Regarding safeguarding practices, a full review of all safeguarding incidents had been completed since the previous inspection. A number of these were still in process and investigations were nearing completion. Further training and emphasis had been put on safeguarding since the previous inspection with increased training provided and further on the agenda. Resident's financial records checked by inspectors were not all accurately reflecting amounts (some residents had more monies than was recorded in ledgers). A review to ensure residents finances were accurately recorded and maintained was required.

Risk management procedures were in place but implementation required review. While risk registers were in place and evidence of risk assessment was operational, steps were required to ensure all risks were assessed and control measures put in place. For example, there was an absence of appropriate assessment and follow for a resident at risk of falls, the centres pathways were incredibly uneven and the resident has a history of falls. While the person in charge and management team knew risk very well it was important that the staff and all persons (ancillary staff) working with residents knew and understood the relevant risks in the centre.

Social farming and the outdoors is clearly part of the service provision which is very beneficial for residents, however all risks associated with farming, machinery, tractors, vehicles and livestock need to be assessed and monitored appropriately for all residents with any access to same.

Medicines management systems had been audited and updated since the previous inspection. Storage and security arrangements had improved since the previous inspection. A staff member was observed signing medication as administered prior to administering same which is not in line with best practice. A number of medication errors were on viewed on record.

## Regulation 13: General welfare and development

Resident were well engaged and supported to live meaningful lives.

Judgment: Compliant

### Regulation 26: Risk management procedures

While specific actions given on the previous inspection were followed up further improvement was required regarding risk management implementation and staff understanding of risks in the centre. There was a vacant position in the area of health and safety since previous inspections. Due to the levels of environmental risks apparent this required review. Staff understanding of individual, behavioural and care and support risk required improvements.

Judgment: Not compliant

### Regulation 29: Medicines and pharmaceutical services

Medication was observed as signed off as administered prior to being administered which is not in line with best practice. Aside from this issue a new medication management had been put in place including new storage arrangements which was a much improved system.

Judgment: Substantially compliant

### Regulation 5: Individual assessment and personal plan

While a programme for review and development was in place and reviewed, all plans were not yet fully reviewed and updated. However progress had been made since the previous inspection.

Judgment: Substantially compliant

### Regulation 8: Protection

Safeguarding plans, measures and systems were all reviewed since the previous inspection. Some investigations were pending decisions and outcomes. There was an increased safeguarding awareness however further improvement was required in

some staff members safeguarding knowledge and to ensure all financial safeguards were in place for residents finances.

Judgment: Not compliant

## Appendix 1 - Full list of regulations considered under each dimension

Regulation Title	Judgment
<b>Capacity and capability</b>	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Not compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
<b>Quality and safety</b>	
Regulation 13: General welfare and development	Compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 29: Medicines and pharmaceutical services	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 8: Protection	Not compliant

# Compliance Plan for Grangebeg Camphill Community OSV-0003621

Inspection ID: MON-0021813

Date of inspection: 19/07/2018

## 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 (Orange)
<p>Outline how you are going to come into compliance with Regulation 15: Staffing:</p> <p>At the time of inspection, we were depending on agency to cover 50-60 hours per week Currently Grangebeg reliance on agency staff has reduced to a minimal level. The staffing teams in the designated Centre are:</p> <p><b><u>Ard Glas Staff team:</u></b> Currently employed CCOI 8 WTE residential staff: 1 WTE House coordinator; 1 WTE Deputy House Co-Ordinator) 3 WTE Social Care workers; 3 WTE Social Care Assistants</p> <p><b><u>Ard Keen:</u></b> Currently employed CCOI 8 WTE Residential Care Staff: 1 WTE House coordinator; 1 WTE Deputy House Co-Ordinator, 3 WTE social care workers; 3 WTE Social Care Assistants</p> <p><b><i>Total WTE of direct Social Care Support staff for the whole designated Centre = 16</i></b></p> <p><b><i>In place Since 14<sup>th</sup> August 2018</i></b></p> <p><b><i>Skills Mix</i></b>  <i>Staff team is currently made up of 8 Social Care Workers (Qualified at FETAC Level 8 and &amp; 7) and 6 Social Care Assistants all with Fetac level 5 with a minimum experience of 2 years. We also have a RNID who oversees the medication management system and supports the staff team in meeting the health needs of our residents.</i></p> <p><b><i>Consistency</i></b>  <i>The majority of our staff members work on a full-time basis, therefore supporting the continuity of care to our residents.</i>  <i>11 of our support staff including our RNID have been here for over 1 year, 5 for over 6 months and 3 for 3 months. We also have three short term co-workers living with our residents who provide 24-hour filial support which is key in maintaining a sense of stability within their homes.</i></p> <p><b><i>Roster</i></b></p>	

*The roster is managed by both Deputy and House Co-coordinators, it is a core item for discussion on the weekly management meeting, plus a weekly operational review of the rosters is held between the PIC and House Co-coordinators. The dependence on agency has dramatically reduced as our WTE has increased.*

***CCOI Operational and financial review***

*CCOI are undertaking an operational and financial review of Grangebeg with the expectation of agreeing WTE for the community. This will be completed by 30<sup>th</sup> November 2018.*

- A schedule 2 folder is in place for all agency staff hired by Grangebeg.

**Completed: 20<sup>th</sup> July 2018**

Regulation 16: Training and staff development	Not Compliant
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Outline how you are going to come into compliance with Regulation 16: Training and staff development:

- A Staff training audit was completed in 25<sup>th</sup> May 2018. Arising from that a new training management tool was introduced to enable accurate monitoring and management of training. A training plan is in place and being actioned.
- Safeguarding training completed for 16 of the 18 Social care staff employed in the designated Centre since 12/09/2018
- HSE adult safeguarding training scheduled for 6<sup>th</sup>/7<sup>th</sup> November for remaining staff and volunteers
- Supervision schedules in place and being implemented for all staff since 31<sup>st</sup> May 2018.
- Audit of supervision schedule to be undertaken and completed by PIC by 30<sup>th</sup> November
- Schedule 2 folder in place for all staff including agency is in place since 20<sup>th</sup> July 2018
- Capacity building with staff teams through team meetings where standard agendas include safeguarding/Compliance an item on the agenda. PIC attending staff meetings and undertaking critical learning review from incidents where needed.
- WTE is currently 16; reliance on agency staff significantly reduced by 5<sup>th</sup> October 2018
- A review of training schedule will be completed by 31/10/2018

Regulation 23: Governance and management	Not Compliant
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Outline how you are going to come into compliance with Regulation 23: Governance and management:

CCOI completed a 'service review' with a core focus on leadership and management roles and functions in the service and effective use of resources. This was conducted by the Regional Manager and PIC. The overarching aim being to enable the PIC to have effective oversight and management of the service.

Significant changes have taken place at senior management level/governance level in

CCOI since the inspection of 19/07/18. These have impact in terms of support and oversight to the PIC. These changes include the appointment of a CEO, CFO and HR manager combined with the Operations manager and 2 Regional managers and a quality and safety Lead. A weekly meeting with this team with TOR and agenda is in place. Key items and actions regarding quality, safety and risk for services (including Grangebeg) are discussed and actioned at this meeting.

- New regional Manager undertaking supervision and support with the PIC – commenced 16/07/2018.
- Review of key roles and functions completed by PIC. Defined roles and responsibilities assigned to a dedicated House Coordinator and deputy House Coordinator in each home. Action completed September 2018.
- **CCOI Operational and financial review**

*CCOI are undertaking an operational and financial review of Grangebeg with the expectation of agreeing WTE for the community. **This will be completed by 30<sup>th</sup> November 2018.***

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Regulation 24: Admissions and contract for the provision of services	Not Compliant
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Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services:

An Organizational Review on Contract of care of residents will be agreed nationally between CCOI and the HSE. (31<sup>st</sup> December 2018)

- Once this organizational review is completed residents in Grangebeg will be issued with new contracts and will be to be supported to sign their own contract where possible once agreed nationally (31<sup>st</sup> December 2018)

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Regulation 26: Risk management procedures	Not Compliant
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- Outline how you are going to come into compliance with Regulation 26: Risk management procedures:

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Grangebeg is set within the context of Social Farm and garden which is a key asset to its residents and day service attendees and to the whole community in terms of food production. Health and safety are vital, and the community has a strong legacy of a high standard of health and safety.

- A Health and Safety Officer has been internally appointed and engaged with IOSH training 6<sup>th</sup> October 2018. Endeavoring to be in post by 20<sup>th</sup> November 2018
- The PIC through the Safety Officer will oversee the management of the health and safety agenda as an ownership functions within each unit (day and residential) A Staff member within the following sectors: Farm, Ard Keen, Ard Glas, Day Services to be given leadership and accounting responsibility for health and safety promotion. (Completed by 30<sup>th</sup> December 2018)

- 6 Monthly external health and safety audit completed on the 12<sup>th</sup> September 2018. An action plan against recommendations is in place.
- Individual residents fall  
In relation to a specific resident with fall risk identified within the report. This resident had a full in-patient review of their falls from both a psychological and physical perspective in May 2018. Their living environment was changed (Moving to the lower floor of the house to a larger room, next door to an adjusted bathroom and beside the ground floor fire exit. Their falls assessment was updated (25<sup>th</sup> July 2018)
- An Occupational Therapy assessment was completed recommending minor changes to their living environment and validating their current living arrangements as positive and enabling. 3/10/2018
- In terms of addressing trip and fall risks in the general external environment, resurfacing of paths and walkways is underway and will be completed by 30<sup>th</sup> November 2018.
- Review of all risk assessments have been completed by PIC and a further adjustment to be undertaken in relation to each individual resident to be completed by 30<sup>th</sup> November 2018
- Emergency plan to be updated and in place by 17<sup>th</sup> November

Regulation 29: Medicines and pharmaceutical services	Substantially Compliant
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Outline how you are going to come into compliance with Regulation 29: Medicines and pharmaceutical services:

- Implementation and monitoring of a safe medication management system is overseen by Medication Management officer overseen by PIC and reported to the management group.
- Monthly Audits are completed and communicated to House Co-Ordinator and discussed at team meetings, Management meetings and individual supervision
- Robust medication management training in place which has been quality checked by PIC and adjusted.
- Medication incident analysis undertaken when a staff member is the agent of medication error.
- Meeting with GP practice has been completed to formalize the signing of Kardex and medication self-administration assessments (September 2018)
- Meeting with pharmacy completed and protocols agreed in July 2018
- Scheduled staff support and supervision in relation to medication management

August 2018

- PIC and medication management coordinator to undertake weekly random administration checks over the next 8-week period to 5<sup>th</sup> December 2018 and action learning arising through this practice oversight.

Regulation 5: Individual assessment and personal plan	Substantially Compliant
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<p>Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan:          At the time of the last inspection the annual review calendar has been initiated with 4 out of 10 completed</p> <ul style="list-style-type: none"> <li>• 9 of the residents have up to date comprehensive needs assessments and personal plans 2<sup>nd</sup> October 2018)</li> <li>• 1 resident awaiting a final date for annual review (Completed by 31<sup>st</sup> October)</li> </ul>	
Regulation 8: Protection	Not Compliant
<p>Outline how you are going to come into compliance with Regulation 8: Protection:</p> <ul style="list-style-type: none"> <li>• Audit of residents finances to be undertaken by PIC and completed by 30<sup>th</sup> November)</li> <li>• Safeguarding plans and incidents are monitored and reviewed on a weekly basis at every management meeting May 2018</li> <li>• Audit of safeguarding plans undertaken by the DO and PIC to ensure that a physical copy of safeguarding plan was in appropriate resident's files and staff are inducted in them (Completed 17<sup>th</sup> September 2018)</li> </ul>	

## 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
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				<b>with</b>
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	30 <sup>th</sup> November 2018
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	20 <sup>th</sup> July 2018
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Yellow	10 <sup>th</sup> October 2018
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Not Compliant	Yellow	10 <sup>th</sup> October 2018
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.	Not Compliant	Orange	30 <sup>th</sup> November 2018
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.	Not Compliant	Yellow	30 <sup>th</sup> Novmebr 2018
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident	Not Compliant	Yellow	31 <sup>st</sup> December 2018

	in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.			
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Not Compliant	Yellow	31 <sup>st</sup> November 2018
Regulation 29(4)(b)	The person in charge shall ensure that the designated centre has appropriate and suitable practices relating to the ordering, receipt, prescribing, storing, disposal and administration of medicines to ensure that medicine which is prescribed is administered as prescribed to the resident for whom it is prescribed and to no other resident.	Substantially Compliant	Yellow	2 <sup>nd</sup> October 2018
Regulation 05(1)(b)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out subsequently as required to reflect changes in need and circumstances, but no less frequently than on an annual basis.	Not Compliant	Yellow	31 <sup>st</sup> October 2018
Regulation 08(7)	The person in charge shall ensure that all staff receive appropriate training in relation to safeguarding residents and the prevention, detection and	Not Compliant	Yellow	10 <sup>th</sup> November 2018

	response to abuse.			
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