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:	Lannagh View Residential Service
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Announced
Date of inspection:	26 July 2021
Centre ID:	OSV-0001771
Fieldwork ID:	MON-0033189

About the designated centre

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

This centre is a five bedded bungalow located in a quiet residential area outside a large town in Co. Mayo. It is in close proximity to shops, parks, bars, restaurants and the theatre. The centre provides a residential service to adults aged 18 or over, both male and female who have and intellectual disability with varying levels of support needs. This also include people who have Autism, Downs Syndrome, and Acquired Brain Injuries. This centre operated on a full-time basis, 7 nights for 52 weeks per year. There is a minimum of two staff members on duty at any one time, and there is a waking night and a sleep in staff on duty at night.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	4

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended. To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Monday 26 July 2021	09:00hrs to 17:00hrs	Thelma O'Neill	Lead

What residents told us and what inspectors observed

Overall, the inspector found that the residents in this centre were supported to enjoy a good quality of life and to have meaningful roles and relationships in their local community. Residents were found to be well supported by staff and it was evident they were well cared for and staff were very familiar with their care and support needs. However, the suitability of the premise was found to be a concern due to the changing health needs of the residents, and the lack of space in the house impacted on the residents' quality of life.

The inspector got the opportunity to meet the four residents who lived at the centre before they went to their day activities. Residents communicated with the inspector on their own terms and appeared to be happy and comfortable with staff in their home environment. The inspector observed two residents sitting in the dining room having their breakfast and another resident in the sitting room waiting for the bus to collect them for day activities. The fourth resident was relaxing in their bedroom. All residents appeared relaxed and staff supporting them were very friendly and helpful.

One resident spoke about activities that they enjoyed, including their interest in music, and playing and the tin-whistle. Another resident did not communicate verbally; however the inspector observed them being supported by staff and they appeared relaxed and content with the supports given. Staff who were supporting residents were observed to be knowledgeable about residents' individual needs and supporting them in line with their care plans.

The inspector completed a walk around of the centre, and found the internal layout of the house was small with one sitting room and small kitchen, utility room, dining room, five bedrooms including one staff bedroom and two bathrooms. The rooms were nicely decorated and clean; however, there was limited space in the house, taking into consideration the care and support needs of the residents. Some areas of the house were not conducive to residents with mobility issues. The inspector observed two staff members physically supporting residents to mobilise around the centre, but due to the lack of space, they had to walk backwards holding the resident's hands while navigating around furniture and the narrow hallways. Residents bedrooms were personalised and there was adequate storage space to store their personal possessions. However, one of the resident's who had a visual impairment, did not have magnetic door hold openings to allow them to have safe access/ egress to their bedroom.This had not been adequately risk assessed to ensure the residents care and support needs could be met.

One resident had access to the main bathroom directly from their bedroom, however this door was kept locked due to risks relating to behaviours of concern around the use of the facilities. This restrictive practice was notified to HIQA, as required by the regulations. The inspector also observed the utility room was small and contained the washing machine, dryer, fridge, kettle and two large filing cabinets which stored residents' personal documents. This was identified by the

inspector as a risk, as the filing cabinets were not fire proofed and the person told the inspector they were placed there due to storage issues in the office/ staff bedroom area. The inspector noticed that access to the back yard was through the kitchen/ utility area and the person in charge said residents had no difficulties using this route through to the outside area. The garden was observed to be nicely decorated, with a seating area and flowers pots.

The inspector also spoke with two staff and the person in charge as part of the inspection. The staff demonstrated very good knowledge about residents' needs, likes and communication preferences. Staff told the inspector about the activities that residents enjoyed, including shopping, and meeting friends.

Since the last inspection, there was a new admission to the centre, which was deemed an emergency admission. However, the inspector observed from reading documentary notes and from speaking with staff, that the resident had displayed frequent behaviours of concern that were negatively impacting on their peers' quality of life.This included disrupting them watching the television or eating their meals. Some of these behaviours were of a safeguarding nature. This issue will be discussed later in the report.

Overall, this centre was a nice centre, however, the provider had not adequately accessed the capacity of the centre to meet the changing needs of the residents in terms of a new admission to the centre and the design and layout of the premise. These issues will be further explored in the next two sections of the report.

Capacity and capability

The inspector found that there was a clear governance and management structure in place in the centre which ensured good oversight and monitoring of the service by the management team. However, improvements were required in a number of areas such as premises, protection, staff training, notifications, staffing, risk management, and governance and management arrangements.

There was a clearly defined management structure in place that identified the lines of accountability and responsibility which ensured staff were aware of their responsibilities and who they were accountable to. The person in charge reported to the regional service manager, who in turn reported to the Director of Operations. There was evidence that the service manager was in regular contact with the centre. This demonstrated clear lines of reporting and accountability systems for the operational management of the centre.

An annual review of the quality and safety of care provided at the centre and unannounced provider visits on a six monthly basis to assess the quality and safety of the service had been completed, the latest being in March 2021. The provider had taken actions to address most of the issues identified on previous audits, however, some staff refresher training was still outstanding and was due to be completed by

the 28/5/2021. In addition, ongoing safeguarding concerns were not reported to the safeguarding team and the provider had failed to notify HIQA of ongoing safeguarding concerns occurring in the centre.

The person in charge was a qualified nurse, who worked as a Social Care Leader and worked full-time and had been working in the centre for a number of years. He had the skills and management qualifications to manage this centre. He also had responsibility for one other designated centre, which was located nearby, and he divided his time between the two centres. The person in charge covered some front-line shifts in the centre and it was evident that residents were familiar with him. The person in charge had conducted regular internal audits in areas such as infection control, finances and health and safety.

There was a consistent staff team in place which ensured good continuity of care, staff spoken with stated that they had been working in the centre for a number of years and were very familiar with residents' care and support needs. On review of the staff roster, there were two staff on duty daily, with additional staff support working some evenings, or as required, and a waking and sleepover staff at night. However, because of the changes in the assessed need of residents in the centre since the new admission, the staffing needs ratio had changed, and the staffing needs analysis needed review to ensure there was an appropriate and suitability skilled staffing in the centre at all times to meet all of the residents care and support needs, such as safeguarding risks, health risk and absconding due to specific behaviour of concern.

Staff received regular training as part of their continuous professional development and a review of training records demonstrated that staff were provided with mandatory and refresher training in areas such as fire safety, safeguarding, managing behaviours of concern and safe moving and handling. The person in charge had completed a training needs analysis which identified further training that was required to support individual residents with their specific care needs. A review of training records indicated that staff had received training to support residents with identified needs. However, some of the training courses were only partially complete and other staff had not received any refresher training.These included training in safe medication management, managing behaviours of concern, safe moving and handling, and epilepsy management. Also, the inspector found from a review of the epilepsy training records for five staff; four staff did not have training in epilepsy management for six years and one staff had not had training in five years. This was required as three residents had a diagnosis of epilepsy in the centre.

Regulation 14: Persons in charge

The person in charge work full-time and had the qualifications, skills and experience to manage the designated centre.

Judgment: Compliant

Regulation 15: Staffing

The inspector found that the staffing arrangements in the centre required reviewed, based on the changing needs of the residents and new admission to the centre.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Staff were provided with mandatory and refresher training as part of their professional development. However, some staff refresher training was out-of-date in areas such as medication management, managing behaviours of concern, epilepsy and manual handling. In addition, some of the training was only completed on-line and staff had not completed the practical element of the training.

Judgment: Substantially compliant

Regulation 23: Governance and management

Although there was a good management structure and oversight arrangements in the centre, the provider had not ensured that the centre was in compliance with the regulations. for example, protection, staffing, staff training, fire safety, notifications and the suitability of the premise in relation to the care and support needs of the residents.

Judgment: Substantially compliant

Regulation 31: Notification of incidents

The inspector found that all incidents of concern that were required to be notified to the Chief Inspector were not completed as required by the regulations. For example, safeguarding concerns.

Judgment: Not compliant

Quality and safety

Overall, residents well-being and welfare was maintained by a good standard of evidence based care and support. The inspector found that residents received a person-centred, quality service. However, the inspector found that some improvements were required with regard to protection, risk management and the premises, .

There was a policy in place for the management of risk in the centre, including the procedures to guide staff about what to do in the event of adverse events. These procedures were generally well maintained by the person in charge including the use of individual risk assessments and a centre specific risk register. While ongoing incidents were recorded on the risk management system, the provider had not adequately reviewed the suitability or compatibility of the new admission to the centre, due to the number of safeguarding incidents occurring in the centre that were negatively impacting on the other residents quality of life. In addition, the provider had not adequately assessed the staffing needs, and the environmental issues such as storage issues in the centre, and the need for additional communal space such as a relaxing room/ visitors room. In addition, one resident who had a visual impairment and required staff support when entering their bedroom did not have magnetic door holders in place to support them access and egress from their bedroom safely. This had not been adequately risk assessed.

The inspector found safeguarding incidents were occurring regularly in the centre, which were associated with the behaviour of concern of one individual, including inappropriate exposure and psychological abuse, such as shouting and turning on/off light switches. These incidents frequently occurred in communal areas of the centre, when residents were watching television or eating their meals. There was evidence that the resident of concern frequently refused to cease this behaviour, or leave the communal area, which resulted in the residents at risk frequently having to move to another room such as their bedroom, or dining room. While support measures were in place to minimise the the impact of these safeguarding issues, the resident did not have an allocated 1:1 staff supervision. In addition, while incidents were recorded and reported through the organisations incident management system, the inspector found the provider had not implemented the Adult Safeguarding policy, by completing preliminary screenings for the residents at risk, and they had not reported the incidents to HIQA as required. Furthermore, the provider had not completed a re-assessment of the resident of concern suitability and compatibility to live in this centre and the impact these behaviours were having on the other residents quality of life.

The inspector found residents' individual needs were assessed, and support plans were in place to support residents health care needs.These included fall management plans, choking prevention plans and epilepsy management plans. Residents had assessments for specific aids and appliances to support mobility, and reduce risks from epilepsy seizures, such as the use of epilepsy alarm monitors and

floor mats and specialised meals for residents at risk of choking.

Infection control practices at the centre were comprehensive in nature and had been enhanced in light of the provider's COVID-19 policies and the implementation of public health restrictions. Staff had received COVID-19 related training and had easy access to both PPE and alcohol sanitizer supplies at the centre.

The premises was found to be welcoming with flowers planted to the front of the house and it looked clean, well maintained and homely. The centre had five bedrooms, (4 residents and 1 staff bedroom/office) and one sitting room, kitchen and dining room, and two bathrooms. Residents bedrooms were decorated in line with their likes and preferences. The inspector observed residents mobilising around the centre, there was limited space for residents and staff to walk side by side in the dining room or hallways. Two staff were observed supporting residents by facing the residents and supporting them with their hands out stretched and walking backwards around furniture in the the dining room, and hallway due to the narrow space of the corridor. It was evident that the residents' care and support needs had increased in recent months and particularly since there had been a new admission to the centre. While the provider had assessed the capacity of this centre as four beds, the inspector found this required review going forward, taking into account the current needs profile of residents living in the centre as well as the design and layout of the premises.

Furthermore, one resident had restricted access to the kitchen facilities, due to behaviours of concern, however, this was appropriately risk assessed and they had a behaviour support plan in place to manage this risk. The inspector saw there was also a lack of appropriate storage space in the centre to store residents' files and documentation, as the documents were stored in the utility room, which was not risk assessed and could be deemed be a fire safety risk.There was only one sitting room, and this was identified as an issue, as the residents did not have an alternative room to relax in if they wished, or to meet visitors when they came to visit.

The centre had systems in place for the detection, containment and prevention of fire, and regular fire safety checks were completed. There was a centre emergency evacuation plan in place and fire evacuation notices on display around the house. Staff received training in fire safety and regular fire drills were carried out. Residents had personal emergency evacuation plans in place and staff who the inspector spoke with were knowledgeable about residents' support needs during an evacuation of the centre.

There was good evidence that residents with acute and complex medical needs having access to multi-disciplinary reviews and supports. In addition, residents that displayed behaviours of concern had behaviour support plans in place that were up to-date and regularly reviewed.

The inspector found that residents had access to suitable laundry facilities and that there was sufficient storage in place for residents' personal possessions in their bedrooms.

Regulation 17: Premises

While the premise was a clean and of sound construction, the current design and layout did not adequately meet the current number of residents living in the centre and their assessed needs. For example, there was no spare sitting room or visitors room, to allow residents to have some quite time alone whenever they choose. This was needed due to the noise of other resident's in the centre. In addition, the centre did not have appropriate storage arrangements in place for managing residents documentation.

Judgment: Substantially compliant

Regulation 26: Risk management procedures

The provider had not adequately risk assessed and managed the safeguarding risks escalated since a new admission to the centre. While a review of the incidents had occurred by the MDT, and the staffing and behaviour support plan was reviewed, they were not effective as incidents continued to increase following the reviews. In addition, the provider had not adequately assessed the environmental issues such as storage issues in the centre, and the need to provide a magnetic door holder to support a resident with a visual impairment access/egress their bedroom.

Judgment: Substantially compliant

Regulation 27: Protection against infection

Infection control practices at the centre were comprehensive in nature and had been enhanced in light of the provider's COVID-19 policies and the implementation of public health restrictions. Staff had received COVID-19 related training and had easy access to both PPE and alcohol sanitizer supplies at the centre.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

Residents individual assessments were found to be comprehensive and nursing

interventions were well documented and kept up to-date. Residents personal plans for social activities were also in place and there was clear evidence of person centred planning (PCP) meetings with the residents and actions plans with timely goals set to achieve over the summer.

Judgment: Compliant

Regulation 6: Health care

There was good evidence that residents with acute and complex medical needs having access to multi-disciplinary reviews and supports.

Judgment: Compliant

Regulation 7: Positive behavioural support

Residents that displayed behaviours of concern had behaviour support plans in place that were up to-date and regularly reviewed.

Judgment: Compliant

Regulation 8: Protection

While measures were in place to minimise the risks and impact of other residents, the provider had not ensured staff had followed their safeguarding policy and adequately assessed and managed the risks in the centre; for example, the residents impacted by safeguarding risks did not have safeguarding plans in place.

Judgment: Substantially compliant

Regulation 28: Fire precautions

The provider had appropriate fire safety arrangements in place to ensure safe evacuation and fire equipment was available in the centre and staff had training fire safety.

Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 - 2015 as amended and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Substantially compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 31: Notification of incidents	Not compliant
Quality and safety	
Regulation 17: Premises	Substantially compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 5: Individual assessment and personal plan	Compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Substantially compliant
Regulation 28: Fire precautions	Compliant

Compliance Plan for Lannagh View Residential Service OSV-0001771

Inspection ID: MON-0033189

Date of inspection: 26/07/2021

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: Lannagh View is a highly staffed service with 3 staff on duty during the day and 2 at night (1 night duty & 1 sleep in). This is based on needs assessments completed for each individual in the service. This will be reviewed on a continual basis.	
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: PIC has liaised with the Training Department with regards to the outstanding training needs for the service. Some of this training has already been completed and further training will be delivered over August - October.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The PIC will continue to complete the service audits which will be reviewed by the Area	

Manager. Supervision will continue on a monthly basis to ensure continuity of service and review any actions identified. The provider will continue to carry out 6 monthly unannounced inspections of the service and will engage with allied professionals for areas of expertise as required.

Regulation 31: Notification of incidents	Not Compliant

Outline how you are going to come into compliance with Regulation 31: Notification of incidents:
Safeguarding concerns are being notified to the Chief Inspector as they occur. With reference to the restrictive practices, these are returned on a quarterly basis as required

Regulation 17: Premises	Substantially Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
As outlined during the inspection an overview of service provision will be completed in the local area. Consultation groups of residents, families and staff together with the organisational support structures will review the current services in place and plan to ensure we're meeting individual needs in a manner that is responsive and in keeping with their choosing.

Regulation 26: Risk management procedures	Substantially Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
All incidents of Peer to Peer are reported to the Designated Officer and HIQA respectively. Critical incident reviews are held in consultation with the staff team, Behaviour Support Specialist and Designated Officer. Safeguarding plans are in place for all individuals as agreed with the Designated Officer and Safeguarding Team. The admission policy was enacted and followed in relation to new admission encompassing transition plan, compatibility study, social stories prior to the individual moving in. Suitable storage has been identified for the service and maintenance will have addressed this by end of August.

Regulation 8: Protection	Substantially Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
All residents in Lannagh View have a safeguarding plan in place. They were reviewed by the Designated Officer and the Safeguarding Team. The Designated Officer has conducted an unannounced visit to the service and has met with the staff regarding safeguarding. As outlined previously the following safeguards are in place

1. Guidelines are in place to support staff in the management of the identified behaviours and issues.
2. Daily shift plan in place to minimize impact on residents & to provide additional support & supervision through out the day.
3. Reassurance and debriefing of residents.
4. Behaviour Support intervention & support.
5. Meetings held with Designated Officer.
6. Safeguarding plans developed and agreed by designated officer and safeguarding team which is updated on a on-going basis.
7. Continued liaison with the relevant MDT supports for all residents.
8. At housemates meetings the area of safeguarding will be an agenda item going forward to residents if they so wish can express their feelings.

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.	Substantially Compliant	Yellow	10/08/2021
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.	Substantially Compliant	Yellow	15/09/2021
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre	Substantially Compliant	Yellow	31/12/2021

	are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.			
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	30/09/2021
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.	Substantially Compliant	Yellow	10/08/2021
Regulation 31(1)(f)	The person in charge shall give the chief inspector notice in writing within 3 working days of the following adverse incidents occurring in the designated centre: any allegation, suspected or confirmed, of abuse of any	Not Compliant	Orange	27/07/2021

	resident.			
Regulation 31(3)(a)	The person in charge shall ensure that a written report is provided to the chief inspector at the end of each quarter of each calendar year in relation to and of the following incidents occurring in the designated centre: any occasion on which a restrictive procedure including physical, chemical or environmental restraint was used.	Not Compliant	Orange	28/07/2021
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Substantially Compliant	Yellow	28/07/2021
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 response to abuse.	Substantially Compliant	Yellow	30/09/2021