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:	Skylark 3
Name of provider:	Brothers of Charity Services Ireland CLG
Address of centre:	Limerick
Type of inspection:	Announced
Date of inspection:	17 May 2022
Centre ID:	OSV-0007415
Fieldwork ID:	MON-0035109

About the designated centre

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

Skylark 3 provides a full time residential service to 8 gentlemen over the age of 18 with a primary diagnosis of intellectual disability. The centre which is located in Limerick city consists is a two 2 storey detached house in close proximity to one another. Each house provides single rooms for all residents. The houses has a kitchen, dining area, bathroom and toilet facilities as well as areas for relaxation and socialisation. The houses has an outdoor area with sitting area. All bedrooms are single occupancy. Residents have open access to a secure back garden. The purpose of the centre is to make every effort to provide each resident with a safe, homely environment which promotes independence and quality care based on the individual needs and requirements of each person. To achieve the purpose of the designated centre a person centred approach is adopted by staff and management. The centre is managed by a person in charge and a team of social care workers and care staff.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	6

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
Tuesday 17 May 2022	09:30hrs to 17:30hrs	Laura O'Sullivan	Lead

What residents told us and what inspectors observed

This was an announced inspection to support the renewal of the registration of the centre for a further three years. The inspector had contacted the person in charge on the day prior to the inspection. This was an opportunity to discuss a commencement time of the inspection and documentation to have ready for review.

The inspector was greeted by the person in charge, person participating in management and a staff member on arrival to the centre. They were requested to complete a COVID 19 questionnaire, take their temperature and complete hand hygiene. A brief meeting was held to discuss the current support needs in the centre. The inspector was informed that residents had left the centre to begin their day activities' but were looking forward to meeting the inspector on their return. Five residents had completed the HIQA questionnaire and overall positive responses were given. One resident did say that they would like to get a sports channel for the centre. All residents reported knowing who to make a complaint to and being comfortable in doing same.

While the residents were out of the centre the inspector completed a review of governance systems utilised within the centre to maintain oversight. Through the appointment of a clear governance structure and effective monitoring tools, the centre overall was safe and an effective service was in place. Some minor improvements were required to ensure that these monitoring tools were utilised to identify all areas of noncompliance. This will discussed later in the report.

The centre presented as two large detached homes located on the outskirts of a large city. Both houses had similar layout and presented with amply communal and private areas for residents. Each home had a large garden to the rear which residents enjoyed during the summer months. Some residents did show the inspector their bedrooms upon their return others choose not to and this was respected. Communal areas were tastefully decorated with a homelike environment promoted.

Residents returned to the centre at differing times in the afternoon and went about their day in the centre. One resident was making a large jigsaw which is one of their favourite things to so. Another resident was getting the tea ready and told the inspector that they all do their fair share of house work, like making the dinner, taking the bins out and washing the ware. Another resident told the inspector about their friend who was not in the centre at the moment as they were unwell. They had all gone to visit them and kept in contact with them on their mobiles.

Residents spoke of being happy in the centre and enjoying going out and about. One resident was looking forward to going shopping the next day to get their new mobile phone. This was one of their personal goals. Interactions observed between residents and staff were all positive and respectful in nature. Staff were familiar to

residents and they appeared comfortable in their company.

The next two sections of the report will present the findings of the inspection in relation to the governance and management in the centre and the impact on the residents currently residing in there.

Capacity and capability

The inspector reviewed the capacity and capability of the service provided to residents within No.3 Skylark. Overall, a good level of compliance was evidenced. This was an announced inspection completed to assist in the registration renewal of the centre for an additional three year cycle. The registered provider had completed this application in a complete and correct manner.

The registered provider has appointed a suitably qualified and experienced person in charge to the centre. They possessed a keen awareness of their regulatory responsibilities including the notification of incidents. The appointed individual also had a good knowledge of the needs of residents. The person in charge maintained oversight of the centre.

The registered provider had ensured a clear governance structure was in place within the centre. The person in charge reported directly to the person participating in management whom provided additional governance support to the centre and staff team. Clear communication was evident between all members of the governance team through regular face-to-face meetings and through the completion of formal supervision meetings. All members of the governance team had a clear understanding of their role and responsibility within the centre. The person in charge was known to the residents who interacted positively with them throughout the inspection. Regular governance meetings occurred with members of the organisational governance structure within the local area to promote learning and awareness of national concerns and actions,

The registered provider had ensured the implementation of regulatory required monitoring systems. This included an annual review of service provision completed in February 2022 by the person in charge. The person in charge was addressing actions which had identified through a robust action plan. The most recent unannounced visits to the centre had been completed by the in the days prior to the inspection and the report was forwarded to the inspector on the following day when completed. These were found to be comprehensive in nature. However, some minor improvements were required to ensure all areas of concern were identified and addressed. For example, documentation of healthcare supports and review of protocols in place. Residents and their families were consulted with regard to both monitoring events.

The person in charge maintained oversight of actions required within the centre. Centre level monitoring systems were being completed to identify concerns and

drive service improvements. These included regular fire checks and the completion of a medication audit and infection control audits. Where areas for improvement were identified, effective actions were implemented to ensure that these were addressed in a timely manner.

The registered provider had ensured the allocation of an appropriate skill mix of staff. Staff spoken with were very aware of the resident's needs and clearly articulated supports in place. Staff members were supported to have an awareness of their responsibilities and key tasks were discussed as part of supervisory meetings. Staff meetings were also completed to allow staff to voice any concerns in the operation of the centre. The provider had an actual and panned rota in place which was overseen by the person in charge.

Staff were facilitated and supported to attend training. A number of training courses had been deemed mandatory within the centre to meet the assessed needs of residents currently residing within the centre. This included safeguarding vulnerable adults from abuse, infection control and fire safety. The person in charge maintained oversight of staff training needs to ensure all training was planned in advance. Some minor gaps were evident in the training matrix including in the area of fire and managing behaviour of concerns. The person in charge had an action plan in place to address this and ensure all staff had received the required training by the end of June 2022.

The registered provider had ensured an effective complaints procedure was in place, including accessible information for residents and an organisational policy. Staff spoke clearly of the complaints policy and how they would address this. Resident spoken with knew who they would speak to if they had a complaint. There was no active complaint in the centre on the day of inspection.

Registration Regulation 5: Application for registration or renewal of registration

The registered provider had submitted an application to renew the registration of the centre for a further three year cycle. This application included such information as the statement of purpose, floor plans of the centre and the required application fee.

Judgment: Compliant

Regulation 14: Persons in charge

The registered provider had ensured the appointment of suitably qualified and experienced person in charge to the centre. They hold governance centre only and

are employed in a full time capacity.

Judgment: Compliant

Regulation 15: Staffing

The registered provider had ensured the appointment of a suitably qualified staff team to support the assessed needs of the residents. An actual and planned staff roster was developed and maintained by the person in charge.

Judgment: Compliant

Regulation 16: Training and staff development

The person in charge had not ensured the staff team were supported to attend training which was deemed mandatory to meet the assessed needs of residents currently residing in the centre.

Since the commencement of their role as person in charge formal staff supervisions had commenced.

Judgment: Substantially compliant

Regulation 19: Directory of residents

The registered provider had ensured the information required under Schedule 1 was present. This was reported in a number of areas and not within a specific directory of residents document.

Judgment: Compliant

Regulation 22: Insurance

The registered provider had ensured the centre was appropriately insured.

Judgment: Compliant

Regulation 23: Governance and management

A clear governance structure had been appointed to the centre. The registered provider had ensured the implementation of the annual review of service provision and a six monthly unannounced visit to the centre. Where actions had been identified these were addressed in a timely manner. Minor improvements were required to ensure monitoring tools were utilised to identify all areas for improvements for example errors in documentation within the centre. Residents were consulted in both monitoring tools.

Centre specific monitoring tools and checklists were completed to maintain daily oversight of operations.

Judgment: Substantially compliant

Regulation 3: Statement of purpose

The registered provider had ensure the development and review of the statement of purpose incorporating all information required under Schedule 1.

Judgment: Compliant

Regulation 34: Complaints procedure

The registered provider had in place a complaints process and procedure that was known to residents and the satisfaction of complainants was recorded. This included an organisational policy and staff awareness.

At the time of the inspection there was no active complaint in progress.

Judgment: Compliant

Quality and safety

It was evidenced during this inspection that the service provided to residents currently residing within No. 3 Skylark was person centred in nature. Residents were consulted in the day to day operation of the centre and in all areas of the daily life.

Residents were observed interacting with staff in a positive and jovial manner. Residents were supported in the area of activation and ensuring meaningful activities were supported on a daily basis while maintaining their independence. Regular house meetings were held to discuss the operations of the centre with all residents.

The inspector on the day of inspection reviewed the systems in place to ensure residents were protected from harm. All staff spoken with were clear on the process to follow and the governance team were actively addressing any areas of concern. All staff had received up to date training in the area of children's first and safeguarding vulnerable adults from abuse. All incidents were reported via the organisational reporting system by staff member present and reviewed by a member of the governance team. However, following an incident should consultation with the safeguarding designated officer occur this was not clearly documented. The rationale as to why an incident was not deemed to of a safeguarding or protection concern was not clearly documented. Whilst it was documented that a conversation with the relevant members of the multi- disciplinary team occurred the context of this was not present to promote clarity of concerns and review within the centre.

Each resident had guidance and support present to support with behaviours which may be of concern. Regular input was presented by the behavioural support specialist and staff spoken with could clearly articulate these supports. Nonetheless, where a resident had signed a protocol to adhere to minimise the occurrence of behaviours of concern this had not been reviewed to take into account their current living arrangement and had not been reviewed with the resident tin over two years. The guidance for staff relating to this behaviour was reactive in nature. This is despite the behaviour occurring on two occasions in the past six months.

Each resident within the centre had been supported to develop and review a personal plan. These plans were found on the day of the inspection to focus on the healthcare needs of the residents rather than presenting a holistic approach to supports. Multi- disciplinary guidance was present as required to support residents in their healthcare needs. However, some guidance regarding specific healthcare concerns required review to ensure this reflected the current needs of residents and was reviewed accordingly during the changing needs.

Residents were supported to lead a meaningful and active life both within the centre and their local community. Resident's told the inspector they enjoyed their community and were well known in the local area including the local coffee shop and church. Through person centred planning meetings held annually residents were supported to set personal goals for the coming years. These were regularly reviewed by the resident and their keyworker to ensure progression of the goals. One of these goals the resident spoke to the inspector about, that they were going to town the following day to purchase their new mobile phone.

The registered provider ensured that there was a risk management policy in place. Effective systems were in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies required review. Comprehensive individual risk assessments were in place and regularly reviewed.

This included independent time in the centre and the use of public transport. Whilst a review of all risk assessments was completed this did not incorporate a review of the risk rating attached to the identified risk. For example, if the occurrence of a risk had reduced the risk rating was not reviewed to reflect this.

The registered provider had ensured that effective fire safety management systems are in place some improvements were required in the area of evacuation. All residents spoken with could clearly articulate the evacuation procedures which corresponded to the fire evacuation plan and personal emergency evacuation plan in place. Some clarity was required of what measures were to occur should residents and staff be unable to re-enter the house after an emergency evacuation. A phone number was provided of a local hotel to utilise but no guidance on how to get here, or what alternatives are available.

The registered provider ensured that residents who may be at risk from a health care associated infection were protected and that precautions and systems were in place in relation to the COVID-19 pandemic. A cleaning schedule was in place for staff to adhere to the staff team and residents maintaining oversight of the cleanliness of the centre. Staff were observed adhering to national and organisational guidance with respect to COVID 19 including the use of face masks, social distancing and hand hygiene. Clear guidance was in place should a resident or staff present with symptoms.

Regulation 13: General welfare and development

The registered provider ensured that each resident had appropriate care and support to access activities of choice and recreation.

Judgment: Compliant

Regulation 17: Premises

The designated centre was well maintained and appropriate to the assessed needs of residents. The residents were supported to maintain the premises and to decorate their home in accordance with their unique tastes and interests.

Judgment: Compliant

Regulation 20: Information for residents

The registered provider had ensured the development of a guide in respect of the designated centre. This was made available to the resident.

Judgment: Compliant

Regulation 26: Risk management procedures

The registered provider ensured that there was a risk management policy in place. Effective systems were in place for the assessment, management and ongoing review of risk, including a system for responding to emergencies required review. Comprehensive individual risk assessments were in place and regularly reviewed.

Whilst a review of all risk assessments was completed this did not incorporate a review of the risk rating attached to the identified risk.

Judgment: Substantially compliant

Regulation 27: Protection against infection

The registered provider had ensured that procedures consistent with those set out by guidance issued by the Health Protection and Surveillance Centre were in place. The centre presented as clean with a cleaning schedule in place to maintain this level of cleanliness at all times.

Staff were observed adhering to national and organisational guidance with respect to COVID 19 including the use of facemasks, social distancing and hand hygiene

Judgment: Compliant

Regulation 28: Fire precautions

The registered provider had ensured that effective fire safety management systems are in place some improvements were required in the area of evacuation. All residents spoken with could clearly articulate the evacuation procedures which corresponded to the fire evacuation plan and personal emergency evacuation plan in place. Some clarity was required of what measures were to occur should residents and staff be unable to re-enter the house after an emergency evacuation.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

The registered provider had in place a comprehensive personal plan for each resident that reflected the nature of residents' assessed needs and the supports required. These plans tended to focus on the health care needs of the residents and not the holistic supports that were being provided.

Judgment: Substantially compliant

Regulation 6: Health care

The registered provider had ensured each resident was supported to achieve the best possible health. Where supports were required for residents to maintain their health care needs guidance was in place. This guidance however required review to ensure all documentation reflected the current health care needs of all residents.

Judgment: Substantially compliant

Regulation 7: Positive behavioural support

Each resident had guidance and support present to support with behaviours which may be of concern. Regular input was presented by the behavioural support specialist and staff spoken with could clearly articulate these supports. Nonetheless, where a resident had signed a protocol to adhere to minimise the occurrence of behaviours of concern this had not been reviewed to take into account their current living arrangement and had not been reviewed with the resident tin over two years.

Judgment: Substantially compliant

Regulation 8: Protection

The inspector observed on the day of inspection that there were systems in place to ensure residents were protected from harm. All staff spoken with were clear on the process to follow and the governance team were actively addressing any areas of concern.

However, following an incident consultation with the safeguarding designated officer occurred, this was not clearly documented. The rationale as to why an incident was not deemed to of a safeguarding or protection concern was not clearly documented. Guidance on the need for this clarity had been communicated by the governance team in the weeks prior to the inspection.

Judgment: Substantially compliant

Regulation 9: Residents' rights

Residents were supported to make choices and decisions in their home which were listened to with regard to activities and personal goals. The registered provider ensured that each resident's privacy and dignity was respected at all times.

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	
Registration Regulation 5: Application for registration or renewal of registration	Compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 19: Directory of residents	Compliant
Regulation 22: Insurance	Compliant
Regulation 23: Governance and management	Substantially compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Compliant
Regulation 20: Information for residents	Compliant
Regulation 26: Risk management procedures	Substantially compliant
Regulation 27: Protection against infection	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Substantially compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Substantially compliant
Regulation 9: Residents' rights	Compliant

Compliance Plan for Skylark 3 OSV-0007415

Inspection ID: MON-0035109

Date of inspection: 17/05/2022

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 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 booked staff in for up and coming training with the training department.	
Regulation 23: Governance and management	Substantially Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: • PIC will ensure after each six monthly-unannounced inspection report all items outlined on the report will be actioned within a timely manner. • Where actions cannot be actioned these will be escalated using the risk management process.	
Regulation 26: Risk management procedures	Substantially Compliant
Outline how you are going to come into compliance with Regulation 26: Risk management procedures: • PIC & Area manager will review all risk assessment ratings and monitor the risk ratings.	

Regulation 28: Fire precautions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 28: Fire precautions: • The protocol has been revised which guides staff how to access alternative accommodation in the case staff and residents are unable to re-entre the house in an emergency situation .	
Regulation 5: Individual assessment and personal plan	Substantially Compliant
Outline how you are going to come into compliance with Regulation 5: Individual assessment and personal plan: • During the quarterly reviews of residents Person Centered Plans PIC will support staff to explore holistic priorities with residents and add the new priorities to the existing Person Centered Plans.	
Regulation 6: Health care	Substantially Compliant
Outline how you are going to come into compliance with Regulation 6: Health care: • PIC has reviewed health care plans and modified plans to reflect the current care needs of the residents within the designated center.	
Regulation 7: Positive behavioural support	Substantially Compliant
Outline how you are going to come into compliance with Regulation 7: Positive behavioural support: • PIC has linked with MDT and reviewed and updated the protocol in place with the	

resident. Additionally, the PIC will ensure this protocol is monitored and reviewed quarterly or when an event arises both within the center or community.

Regulation 8: Protection	Substantially Compliant
Outline how you are going to come into compliance with Regulation 8: Protection: • PIC will ensure when recording responses on AIRS that there is a more detailed record of the follow-up in relation to the challenging behavior incident. Details will be highlighted and noted within the responses as to why a certain rationale was adopted or implemented in line with agreed protocol.	

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 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	01/09/2022
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	16/06/2022
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre	Substantially Compliant	Yellow	30/06/2022

	for the assessment, management and ongoing review of risk, including a system for responding to emergencies.			
Regulation 28(3)(d)	The registered provider shall make adequate arrangements for evacuating, where necessary in the event of fire, all persons in the designated centre and bringing them to safe locations.	Substantially Compliant	Yellow	20/05/2022
Regulation 05(4)(a)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which reflects the resident's needs, as assessed in accordance with paragraph (1).	Substantially Compliant	Yellow	30/08/2022
Regulation 05(4)(b)	The person in charge shall, no later than 28 days after the resident is admitted to the designated centre, prepare a personal plan for the resident which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.	Substantially Compliant	Yellow	30/08/2022

Regulation 06(1)	The registered provider shall provide appropriate health care for each resident, having regard to that resident's personal plan.	Substantially Compliant	Yellow	20/06/2022
Regulation 07(1)	The person in charge shall ensure that staff have up to date knowledge and skills, appropriate to their role, to respond to behaviour that is challenging and to support residents to manage their behaviour.	Substantially Compliant	Yellow	20/06/2022
Regulation 07(3)	The registered provider shall ensure that where required, therapeutic interventions are implemented with the informed consent of each resident, or his or her representative, and are reviewed as part of the personal planning process.	Substantially Compliant	Yellow	20/08/2022
Regulation 08(3)	The person in charge shall initiate and put in place an Investigation in relation to any incident, allegation or suspicion of abuse and take appropriate action where a resident is harmed or suffers	Substantially Compliant	Yellow	18/05/2022

	abuse.			