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:	Camphill Community Kyle
Name of provider:	Camphill Communities of Ireland
Address of centre:	Kilkenny
Type of inspection:	Unannounced
Date of inspection:	11 December 2019
Centre ID:	OSV-0003625
Fieldwork ID:	MON-0026867

About the designated centre

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

Camphill Community Kyle provides long-term residential services for a maximum of 17 residents, over the age of 18, of both genders with intellectual disabilities, physical disabilities and autism. The centre is located in a rural setting and comprises six units of two-storey detached houses and standalone apartments with each accommodating between one and five residents. All residents have their own bedrooms and other facilities throughout the centre include kitchens, dining rooms, sitting rooms, utility rooms, bathrooms and staff offices. In line with the provider's model of care, residents are supported by a mix of paid staff (including a nurse, social care staff and care assistants) and volunteers.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	16

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
11 December 2019	10:15hrs to 18:15hrs	Conor Dennehy	Lead
11 December 2019	10:15hrs to 18:15hrs	Conor Brady	Support

What residents told us and what inspectors observed

Inspectors met 10 of the 16 residents who were living in this designated centre. While not all of these residents directly indicated their views on the services they received, the inspectors engaged with residents in various ways. For example, some residents spoke to inspectors and one resident had a meal with an inspector while other residents were observed in their interactions with staff and volunteers on duty as they went about their day.

The residents who spoke with inspectors talked very positively about life in the designated centre. In particular these residents indicated that they liked living in the designated centre, liked the support they received from staff and volunteers and also that they felt safe. It was seen that residents appeared happy and seemed comfortable with members of the centre's workforce who engaged with residents in a pleasant and warm manner throughout the inspection.

Inspectors found that residents lived in a homely environment and, on the day of inspection, it was noted that residents were very active and supported to engage in various activities within workshops offered by the provider in the surrounds of the designated centre and away from the centre also. For example, it was seen that residents were involved in gardening and basketry while some residents, with the support of staff members, went for meals out and swimming during the inspection.

Capacity and capability

The provider had ensured that, in general, good compliance levels had been maintained since the previous inspection in April 2019. However it was noted though that the provider was not carrying out, in a consistent or timely manner, key requirements of the regulations to monitor the quality and safety of care and support provided to residents. Some improvement was also required in maintenance of staff and volunteer files.

Within the designated centre there was a clear organisational structure provided for to support the running of the centre. As part of this a person in charge was in place who was supported by a deputy person in charge along with four house-coordinators, each of whom were responsible for different units of the centre. To ensure that the person in charge maintained oversight of the designated centre as a whole, a weekly management meeting took place where various issues including safeguarding, risks and residents were discussed. In addition within the different units of the centre, staff team meetings took place on a monthly basis which were also attended by the person in charge.

The person in charge had been appointed to the role in December 2018 and since their appointment it was noted that the overall compliance levels for this centre had generally improved. Inspectors were satisfied that the person in charge had the necessary skills, experience and qualifications to perform the role. The person in charge managed the designated centre's workforce which, in line with the provider's model of care, was comprised of paid staff members and volunteers. The supervision arrangements for the centre's workforce was also overseen by the person in charge and evidence was seen that both staff and volunteers had received multiple formal supervisions throughout 2019.

Files were maintained for all staff members and volunteers involved in the centre. Such files are important to demonstrate that the provider has followed appropriate recruitment procedures and kept accurate records regarding their workforce. Inspectors reviewed a sample of such files and noted that they contained much of the required information such as evidence of Garda Síochána (police) vetting amongst others. It was noted though that one staff file did not contain full correspondence, reports and records of their employment with the provider, while one volunteer file did not contain roles and responsibilities that were set out in writing.

However, inspectors were provided with training records for all staff and volunteers which indicated that the majority had received training in a range of areas including manual handling, medicines and first aid. This provided assurances that the centre's workforce were equipped with the necessary skills and knowledge to support residents. It was noted that those who had responsibility for supervising staff and volunteers were also provided with relevant training in this area. Staff members spoken with during this inspection demonstrated a good knowledge and understanding of residents' needs. Positive interactions between staff, volunteers and residents were observed throughout this inspection.

While there were indications that the overall stability of this designated centre had been supported by the presence of the person in charge and the workforce arrangements in place, it was noted that the provider was not effectively discharging their regulatory responsibilities to maintain oversight of the designated centre. Under the regulations the provider is required to carry out unannounced visits to the designated centre every six months to review the quality and safety of care and support provided to residents. Such visits should be reflected in a written report with an action plan developed to respond to any issues identified. It had been highlighted during previous HIQA inspections in April 2018 and April 2019 that the provider had not been carrying out such unannounced visits as required.

During the current inspection, it was observed that the provider had conducted one such unannounced visit in April 2019 after the last HIQA inspection. While this was evidenced in a written report with a corresponding action plan, it was nearly eight months since this had been completed. Overall the provider had only carried out one six month unannounced visit since May 2017. It was also noted that it had been over 12 months since an annual review, another key regulatory requirement, had been carried out. During the current inspection though it was seen that work on an annual review had commenced with residents and their families consulted as part of

this. Some provision had also been made for specific audits in areas such as health and safety to be carried out but some improvement was needed regarding the frequency and standard of auditing.

Regulation 14: Persons in charge

The person in charge had the necessary experience and qualifications to meet the requirements of the regulations and to perform the role. The person in charge was responsible for this designated centre only and demonstrated a good knowledge of residents' needs.

Judgment: Compliant

Regulation 15: Staffing

A sample of staff files were reviewed which contained much of the documents required such as proof of identity, two written references, evidence of Garda vetting and full employment histories. One staff file did not contain full correspondence, reports and records of their employment with the provider. Planned and actual rosters were maintained in the centre which indicated that efforts were made to ensure a consistency of staff support. Overall appropriate staffing arrangements were in place to support residents which included the provision of nursing staff.

Judgment: Substantially compliant

Regulation 16: Training and staff development

Training in areas including supervision, manual handling, medicines and first aid were provided to staff members. Arrangements were in operation to ensure that staff members received regular formal supervisions.

Judgment: Compliant

Regulation 23: Governance and management

The provider had not been carrying out, in a consistent or timely manner, key requirements of the regulations to monitor the quality and safety of care and support provided to residents. For example, it had been over 12 months since the

previous annual review had been completed while only one provider unannounced six monthly visit for the centre had been carried out since May 2017.
Further improvement was regarding the frequency and standard of auditing.

Judgment: Not compliant

Regulation 30: Volunteers

Volunteer files were reviewed which included evidence of supervision and Garda vetting. It was noted though that not all volunteers files contained written roles and responsibilities.

Judgment: Substantially compliant

Regulation 34: Complaints procedure

Information on how to raise complaints was on display throughout the designated centre. A log of any complaints raised was maintained in the designated centre which described the nature of the complaints raised raised and the actions taken in response to them.

Judgment: Compliant

Quality and safety

Residents were supported to experience a good quality of life and to enjoy the best possible health. It was noted though that some improvement was required in relation to aspects of the safeguarding arrangements for the designated centre.

During this inspection residents were observed to be well supported and provided with a very good standard of care and support. Residents had various activities available to them and each resident had an individual social activity plan in place including the things that they most enjoyed. In reviewing residents' records it was clear they enjoyed a good quality of life and were very involved in and consulted with their care. Various activities such as arts and crafts were facilitated while residents were also supported to go on holidays. Residents had specific goals identified for things that they wished to do or things to help them develop. It was noted though that some improvement was required to ensure goals were set to an appropriate standard and consistently monitored.

Such goals were contained within residents' individual personal plans which are required by the regulations. Such plans are important in identifying residents' needs and outlining the supports they require to provide for these. It was seen that personal plans had been informed by comprehensive assessments of need which focuses on various areas such as residents' health and their abilities. These assessments had been carried out within the previous 12 months as required. It was noted though that, while residents were involved in the development of their personal plans, some annual reviews of these plans had not taken place in over 12 months while parts of some residents' personal plans had not been reviewed in a timely manner either. Overall though, it was seen that arrangements were in place to provide for residents' needs. For example, residents to supported to enjoy the best possible health.

Fire and safety management in the centre was reviewed and measures were in place to protect residents. Fire safety systems such as alarms, firefighting equipment and containment measures were provided for. Such systems were being checked at regular intervals to ensure that they were in proper working order. During the inspection it was observed that evacuation routes were clear and guidance was in place to safely evacuate the centre. While fire drills were being carried out some improvement was required as some drill records did not include persons present for the drills while a drill with the lowest levels of staff had not been completed for all units of the centres. Fire safety training had been provided to the majority of staff and volunteers but it was noted that one staff member had yet to receive such training.

Records reviewed also indicated that one staff member had not received safeguarding training at the time of this inspection. It was noted though that the remainder of staff and volunteers working in the designated centre had undergone this training which is important to ensure that an appropriate response to any safeguarding concern is followed. Staff and volunteers spoken with demonstrated good knowledge of safeguarding reporting and structures within the centre. A good knowledge on the various types of abuse and how to report and record concerns was demonstrated by staff members and volunteers. While all residents met and spoken with presented as safe and well cared for, the inspectors were concerned with a number of safeguarding matters on this inspection.

Inspectors were informed that there were 23 active safeguarding cases under investigation in the designated centre at the time of inspection. All of these matters had been reported to the Health Service Executive (HSE) safeguarding team and where required, An Garda Síochána. In reviewing safeguarding documentation and speaking with the person in charge and a regional safeguarding manager, inspectors found that these pertained to a range of safeguarding concerns and alleged abuses. Some of these matters were found to be retrospective and related (in some instances) to safeguarding concerns that were ongoing over a period of years. However, inspectors were not satisfied that all safeguarding matters reviewed were appropriately managed.

For example, ineffective safeguarding plans were in place regarding areas of evidence based risk, financial safeguarding and safeguarding follow up to specific

areas of concern. Inspectors were particularly concerned, that in one incident, a serious safeguarding concern was referred to the HSE safeguarding team in 2017 but had not been followed up appropriately at the time. As a result this concern had been recently re-referred to the HSE. On the day of inspection an emergency safeguarding plan was being devised requiring reported Garda and court intervention regarding an ongoing safeguarding concern.

In addition, the Chief Inspector of Social Services had been formally notified by the provider (in the weeks leading up to this inspection) of seven retrospective instances of alleged substantive financial abuse. This matter was under provider internal investigation at the time of this inspection and was not the first instance/occurrence of retrospective financial safeguarding. It was noted though, that since the previous HIQA inspection in April, the local oversight of residents' day-to-day spending and finances had improved to ensure that any discrepancies were noted and addressed.

Overall staff knowledge of residents was found to be very good and staff spoken with demonstrated that they were caring and considerate of residents needs, wishes and preferences. The use of external advocacy had been sought and sourced on a number of occasions. Personal and intimate care plans in place were found to be of a very good standard. However improvement was required regarding the staff guidance and recording of personal and intimate care to ensure it was consistently provided. Some residents personal information was found to be on display on communal bathroom walls which was not found to be respectful of residents' privacy and dignity.

Regulation 26: Risk management procedures

Recently reviewed risk assessments were in place related to identified risks potential impacting residents. Arrangements were also in place for any accidents and incidents to be recorded and reviewed. Health and safety audits were also noted to be carried out.

Judgment: Compliant

Regulation 28: Fire precautions

Evacuation routes were clear and guidance was in place to safely evacuate the buildings. Fire safety systems were in place and were being regularly serviced. The majority of staff and volunteers had received fire training but one staff member had yet to receive this. Fire drills were being carried out but improvement was required in the maintenance of drill records and to ensure that a drill with the lowest levels of staff was completed in all buildings of the centre.

Judgment: Substantially compliant

Regulation 5: Individual assessment and personal plan

Residents had individual personal plans in place which were informed by relevant assessments. Residents were involved in the development of such plans but it was seen that some annual reviews were not taking place in a timely manner while parts of some plans had not been reviewed in over 12 months. Residents had goals identified but it was noted that some residents' goals were basic in nature. Overall, though it was seen that arrangements were in place to provide for residents needs.

Judgment: Substantially compliant

Regulation 6: Health care

The health care needs of residents were outlined in their personal plans. Residents were supported to access a range of allied health professionals such as general practitioners, psychiatrists and speech and language therapists. Interventions, such as vaccines, were also facilitated.

Judgment: Compliant

Regulation 7: Positive behavioural support

Behaviour support plans were in place to guide practice and support residents to engage in positive behaviour. Such plans had been developed with input from a behavioural specialist. Staff members spoken with demonstrated a good understanding of the contents of such plans while records reviewed indicated that staff and volunteers were provided with relevant training in de-escalation and intervention.

Judgment: Compliant

Regulation 8: Protection

There were inadequacies in terms of some safeguarding plans. A serious allegation from 2017 had not been followed up in a timely way and further retrospective safeguarding concerns have materialised. Quality improvement was also required in

the area of the provision of personal and intimate care. One staff member had yet to receive safeguarding training.

Judgment: Not compliant

Regulation 9: Residents' rights

Access to advocacy services was actively facilitated. Residents were seen to be treated respectfully throughout the inspection and were consulted in relation to the running of the designated centre through regular resident meetings. During these meetings residents discussed various issues such activities and food menus. It was noted that efforts were made to promote resident's privacy but some personal information relating to residents was seen to be on display in communal bathrooms.

Judgment: Substantially 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	Compliant
Regulation 23: Governance and management	Not compliant
Regulation 30: Volunteers	Substantially compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Substantially compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Not compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Camphill Community Kyle OSV-0003625

Inspection ID: MON-0026867

Date of inspection: 11/12/2019

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: Regional Manager will ensure that one staff's correspondence, reports and records of their full employment within Camphill will be transferred to Kyle Community HR File. Completion Date: 31.01.2020	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: The Service Provider CCOI has approved the Role of a third Regional Manager, this new post will support CCOI to meet key requirements of the regulations to monitor the quality and safety of care. This will support the provider's schedule of unannounced six-monthly visits to Kyle Community. This additional resource will improve the frequency and quality of auditing for the Service Provider Completion Date: 29.05.2020 Annual Review will be completed by Person in Charge and Regional Manager. Completion Date: 31.01.2020	
Regulation 30: Volunteers	Substantially Compliant
Outline how you are going to come into compliance with Regulation 30: Volunteers: PIC to conduct HR Audit on all current volunteers. Induction Pathways to be reviewed for Volunteers to ensure all files contain a written Roles and Responsibilities. Completion Date: 28.02.2020	

Regulation 28: Fire precautions	Substantially Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
Kyle Health and Safety Officer will train all team members of the importance of accurate report writing of fire drills. Scheduled Fire Drills with the lowest levels of staff for all units of the Centre have been planned.
Fire safety training for a relief staff to be completed. Induction Pathway to be reviewed for Relief staff to prevent delays in Fire Safety training.

Completion Date: 31.05.2020

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:
Scheduled Annual Reviews have been planned for all residents for Calendar Year 2020.
Quarterly Circle of Support Meetings for all residents is planned to ensure review of personal plans.

Completion Date: 31.01.2020

Ongoing training for all team members at mandatory monthly team meetings attended by PIC/ Deputy PIC to promote goal setting, evidence progress or any barriers.

Completion Date: 20.09.2020

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
The Provider CCOI has taken the following actions to ensure compliance:

Full implementation of new live digital safeguarding tracker put in place as of 01/01/2020 to be maintained by the Designated Officer to support local management of safeguarding and allow for increased remote oversight by CCoI Regional safeguarding lead, Principle Social worker and Regional manager.

Designated officer role specific monthly training ‘in house’ and fortnightly phone in team meetings for reflection, support, and learning to support quality improvement to safeguarding responses
Additional Designated Officer to be trained in to ensure safeguarding responses are robust and timely.

The Principal Social Worker (National Safeguarding lead) will provide direct support, oversight and supervision to the safeguarding function up to 17/04/2020.
Appointment of a Regional Safeguarding Lead, to be in post and functioning 17/04/2020.

The National team of CCOI will provide support, oversight and governance to Camphill Kyle through the following processes:

●Monthly meetings by senior roles in Clinical, Safeguarding, and operations to review and action higher risk safeguarding and clinical needs.
●CCoI National Safeguarding Team implementation of safeguarding training needs projections tracker introduced 01/01/2020.
●CCoI National Safeguarding Team schedule of safeguarding training course to meet training needs projections.
●CCoI National Safeguarding Team review of safeguarding training registers quarterly

Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:
On the day of inspection 11.12.2020 the personal information on display in a communal area was removed.
Completion Date: 11.12.2020

All residents are linked to an Independent Advocate

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 15(5)	The person in charge shall ensure that he or she has obtained in respect of all staff the information and documents specified in Schedule 2.	Substantially Compliant	Yellow	31/01/2020
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Substantially Compliant	Yellow	30/04/2020
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre	Substantially Compliant	Yellow	30/01/2020

	and that such care and support is in accordance with standards.			
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and put a plan in place to address any concerns regarding the standard of care and support.	Not Compliant	Orange	29/05/2020
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	31/05/2020
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures,	Substantially Compliant	Yellow	31/05/2020

	building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.			
Regulation 30(a)	The person in charge shall ensure that volunteers with the designated centre have their roles and responsibilities set out in writing.	Substantially Compliant	Yellow	28/02/2020
Regulation 05(6)(c)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall assess the effectiveness of the plan.	Substantially Compliant	Yellow	31/03/2020
Regulation 05(6)(d)	The person in charge shall ensure that the personal plan is the subject of a review, carried out annually or more frequently if there is a change in needs or circumstances, which review shall take into account changes in circumstances and	Substantially Compliant	Yellow	20/09/2020

	new developments.			
Regulation 08(2)	The registered provider shall protect residents from all forms of abuse.	Not Compliant	Orange	30/01/2020
Regulation 08(6)	The person in charge shall have safeguarding measures in place to ensure that staff providing personal intimate care to residents who require such assistance do so in line with the resident's personal plan and in a manner that respects the resident's dignity and bodily integrity.	Substantially Compliant	Yellow	31/01/2020
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	28/02/2020
Regulation 09(3)	The registered provider shall ensure that each resident's privacy and dignity is respected in relation to, but not limited to, his or her personal and living space, personal communications, relationships,	Substantially Compliant	Yellow	30/01/2020

	intimate and personal care, professional consultations and personal information.			