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:	St John of God Kildare Services – DC8
Name of provider:	St John of God Community Services Company Limited By Guarantee
Address of centre:	Kildare
Type of inspection:	Unannounced
Date of inspection:	21 November 2019
Centre ID:	OSV-0003788
Fieldwork ID:	MON-0024691

About the designated centre

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

St John of God Kildare Services DC 8 is a large single story building that has been renovated to provide care for up to 14 residents, on its own site on the outskirts of a large town in Co. Kildare. The centre is divided into three apartments supporting both males and females who present with physical and intellectual disabilities. In addition, seven placements are dedicated to residents with a diagnosis of dementia. These residents have identified clinical supports, for example, psychiatry and psychology input available to them through the clinical team. Residents are supported by nursing staff, health care assistants and social care workers. A large sensory garden on its grounds has been recently added to the existing environment. The centre is accessible to local towns, shopping, public transport and community facilities.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	12

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
Thursday 21 November 2019	09:00hrs to 17:00hrs	Erin Clarke	Lead

What residents told us and what inspectors observed

The inspector of social services observed very positive interactions between residents and staff. It was clear residents were comfortable in the company of staff. Staff engaged positively with residents and demonstrated that they knew and understood the individual communication needs of residents. Although a number of residents were unable to tell the inspector about their views of the service, the inspector observed warm interactions between the residents and staff caring for them and that the residents were in good spirits.

One resident informed the resident that they liked their bedroom and was looking forward to attending work that day. They looked to staff for reassurance that this would occur and staff were observed providing this reassurance in line with the resident's assessed needs.

Residents were engaged in a good range of activities in the community which were assessed to meet the individual resident's ability and needs. On the day of the inspector some residents were leaving the centre to attend a musical in a theatre, while others were attending day services.

Staff spoken with outlined how they advocated on behalf of the residents and how they felt that each of the residents enjoyed living in the centre.

The inspector viewed the complaints log and some complaints had been recorded by staff on behalf of residents, which were also responded to by staff. The inspector found that these complaints had since been resolved since the date of the complaint.

Capacity and capability

The provider had ensured that, overall, this was a well resourced centre which was meeting the residents' individual needs. The centre had undergone significant decongregation and renovation with a newly opened dementia-specific unit to meet the needs of residents within the wider organisation. It was noted though, while overall adequate arrangements were made for the management and staffing of the centre, improvement was required concerning the oversight arrangements of the centre, monitoring systems, annual review of the quality and safety of the centre and training requirements of staff.

While there was evidence of good management structures and systems in the centre these were not always effective in ensuring certain areas of service provision were meeting the regulations. For example, the provider’s quality team conducted

unannounced audits on behalf of the provider as required by regulations. These were comprehensive in nature and effective at recognising areas for improvement and non-compliance with regulations. These included residents' personal plans, restrictive practices and the complaints process. While an action plan had been developed to address individual failings, it did not lead to a review of the systems to ensure these required changes were implemented across all areas. Therefore there were repeated failings identified by the inspector on the day of inspection as previously highlighted. Local audits to identify issues in a timely manner were limited, which had also attributed to these failings.

The report of the annual review of the quality and safety for 2018 had been completed, and family representatives had been invited to submit their views as part of the consultation process. Improvement was required with the development of the report as it provided generic information and focused on the systems in place rather than the yearly outcomes and key issues relating to residents' quality of life and service.

The person in charge had been in this role since October 2017 and was also responsible for another centre. They were supported in the management of the centre by a CNM3 (clinical nurse manager grade 3) and two CNM2 (clinical nurse manager grade 2) Staff spoken with, were clear on the lines of accountability in the centre. Staff were also able to accurately describe the specific needs of the residents and the supports required to provide for these. The Inspector also observed staff members engaging with residents in a positive, respectful manner and providing appropriate support if required. From a review of rosters, appropriate numbers of staff were available to provide support to respite residents availing of this centre. Nursing staff was also was available in line with the provider's statement of purpose.

Training records for 31 staff had been received post-inspection and reviewed by the inspector. There were significant gaps identified in the records received for mandatory training. Seven staff members required refresher training in fire safety and one staff member did not have a record of attending this training. 14 staff were identified as requiring training in managing behaviours that challenge and safeguarding training was also required by two staff and refresher training for an additional two staff. Hoists were observed during the inspection that required trained staff to operate; the records received indicated that only six staff had undergone this training.

The inspector viewed transition plans for residents that had recently moved into the centre. Residents had the opportunity to visit the centre and choose their own bedroom. Residents expressed their happiness throughout the transition process. Three contracts of care were examined by the inspector and found that these referred to previous designated centres that the residents had transitioned from. The registered provider had not ensured the development of a service provision agreement between the organisation and the resident before the transition. Fees to be charged in the contracts were also not aligned to practice. For example, one contract of care referred to a long stay charge fee which was no longer in place.

The provider's systems for managing complaints required improvement. For

example, an unresolved concern made by a family member was noted by the inspector in the annual review but had not been responded to. The inspector viewed a number of complaints made by staff advocating on behalf of residents. The quality team had correctly identified that some of these complaints were of a safeguarding nature and safeguarding procedures should be followed; however, no plan of action was put in place to address this. Also, the response from management to staff in addressing the complaints was to remind staff of the local arrangements to respond to complaints instead of addressing the nature of the complaints.

Registration Regulation 7: Changes to information supplied for registration purposes

The systems in place to notify the Office of the Chief Inspector of registration notifications required improvement.

Judgment: Not compliant

Regulation 14: Persons in charge

The inspector found that the person in charge met the requirements of this regulation with regard to their qualifications, background, knowledge and experience.

Judgment: Compliant

Regulation 15: Staffing

The staffing compliment in the centre appeared appropriate to the assessed needs of the residents. There was a regular staff team working in the centre which also incorporated a panel of relief staff.

Judgment: Compliant

Regulation 16: Training and staff development

To ensure that the residents' needs were met appropriately and continuously, gaps in training needed to be addressed.

Judgment: Not compliant

Regulation 23: Governance and management

The provider had carried out an annual review and unannounced visits as required. Evidence was seen that some of the individual issues highlighted in these were acted upon, however this did not lead to a review of systems. This impacted on the compliance levels found across some regulations inspected against. Improvement was required to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.

Judgment: Not compliant

Regulation 24: Admissions and contract for the provision of services

It was identified that there were no signed written agreements in place regarding the terms of residing in the centre for residents that had transferred into the centre.

Judgment: Not compliant

Regulation 3: Statement of purpose

The statement of purpose contained the requirements of Schedule 1.

Judgment: Compliant

Regulation 34: Complaints procedure

There was a complaints procedure and policy in place in the centre. The inspector viewed the complaints log and it was found that staff had raised complaints on behalf of residents that could not advocate for themselves. Some improvement was needed in capturing and responding to all complaints. The inspector viewed one complaint made by a family member in the annual review that had not been recorded as a complaint.

Judgment: Substantially compliant

Quality and safety

The centre had undergone extensive renovations, and decongregation since a notice of the proposal to cancel registration was issued to the provider in March 2018. The centre had a new focused dementia-specific service. This was established to provide specialist long-term care to small groups of residents with dementia who wish to live in a homely, personalised and safe environment. The inspector found good areas of practice relating to the design and layout of the purpose-built units. Signage and cueing systems were implemented to best help residents navigate their environment unobstructed. The inspector found that the service provided was tailored to individual resident needs, and the provider had taken action to address the previous failings. However, there was improvement required in a number of regulations under quality and safety as to assure consistency in practice. The inspector recognised that the centre had gone through significant change over the previous year that untimely resulted in an improved living environment for residents.

Where required residents had positive behaviour support plans in place, the inspector reviewed a sample of these plans and found them to outline guidance for staff on promoting positive behaviour. The supports that were outlined in the support plans were known to staff members spoken with. However, as discussed previously, some staff had not received training to respond to behaviour that is challenging to support residents to manage their behaviour. A human rights committee was in place at an organisational level to govern the use of restrictive practices. The quality team had identified that one psychotropic medication required referral to the committee and notification to the Office of the Chief Inspector.

Regarding safeguarding practices, improvement was required to ensure that all residents were safeguarded from abuse and the provider had effective systems in place to support staff to identify and report any concerns they had regarding the safety and welfare of residents.
The provider had ensured that adequate measures were in place to protect residents and staff from the risk of fire. Fire safety systems in place in the designated centre included a fire alarm system, emergency lighting and fire extinguishers. Such equipment was being serviced at the required time frames while internal staff checks were also being carried out. Fire exits were observed to be unobstructed on the day of inspection. Residents had personal evacuation plans in place which outlined the supports to be provided to residents to assist them in evacuating the centre. Staff spoken to were aware of the contents of these plans; however, training records reviewed indicated that not all staff had received up to date fire safety training.

The inspector completed a full walk through of the designated centre in the company of the person in charge. The designated centre was found to be very clean throughout and maintained to a high standard. It was found that residents were supported to decorate their bedrooms and shared spaces to reflect personal taste, interests and styles. Each resident had their own bedroom, and there was evidence of appropriate furnishings, sufficient storage, and adequate shared and private

accommodation. Practices relating to the management and oversight of residents personal belongings who had transitioned internally into the centre required review and strengthening. There were some discrepancies noted on the personal inventories of residents that had recently moved into the centre. Clarity was also required in the procedures for purchasing furniture and soft furnishings, for example, curtains, in the absence of a detailed contract of care.

The inspector reviewed a sample of documentation relating to residents, including assessments and personal plans. On the day of the inspection there were some gaps in the documentation pertaining to personal plans. Not all residents had a comprehensive assessment of their health, personal and social care needs completed prior to admission to the centre. It was identified through the providers own monitoring systems that health action plans were not in place for all identified health care needs and this remained outstanding.

Residents were supported to engage in goals that promoted community inclusion such as local walks, shopping, going to the cinema and attending rugby matches. These goals were supported by named individuals and a time-bound action plan. In a sample of personal plans viewed, the inspector found that progress in achieving person goals was being well-recorded and that many of the goals had been achieved, while others were in progress.

A risk management policy in was place which outlined the measures and actions to control specified risks. A centre risk register was in place along with risk assessments relating to individual residents. Such risk assessments were noted to have been recently reviewed while staff present in the centre demonstrated a good understanding of any risks present in the centre.

Regulation 12: Personal possessions

Improvement was required to ensure all residents retained control of their personal property and possessions.

Judgment: Substantially compliant

Regulation 17: Premises

The inspector observed that the centre premises supported the resident's needs in a homely and comfortable manner. Since the previous inspection a number of home improvements had been undertaken and completed in keeping with the resident's individual profile.

Judgment: Compliant

Regulation 26: Risk management procedures

The provider had a risk management policy in place and all identified risks had a risk management plan in place. The provider had ensured that all risk management plans had been regularly reviewed. The provider ensured that there was a system in place in the centre for responding to emergencies.

Judgment: Compliant

Regulation 28: Fire precautions

There were appropriate fire precaution measures in place for the prevention, detection and response to fire. Appropriate equipment, emergency lighting and fire evacuation drill were evident.

Judgment: Compliant

Regulation 5: Individual assessment and personal plan

The admission process required review to ensure all residents had a comprehensive assessment of need which informed an associated plan of care prior to admission.

Judgment: Substantially compliant

Regulation 6: Health care

Overall the health and well being of the residents was promoted in the centre. Each resident had access to a general practitioner of their choice. Where treatment was recommended by allied health professionals such treatment was facilitated. Not all residents' needs in relation to healthcare were adequately documented and outlined to support staff provide the required care and support. This is addressed under regulation 5.

Judgment: Compliant

Regulation 7: Positive behavioural support

Where residents presented with behaviour that challenges, the provider had arrangements in place to ensure these residents were supported and received regular review. Not all staff had received up-to-date training in the management of behaviour that challenges. Improvement was also required in the documentation of the use of alternative measures so as to ensure the least restrictive procedure is used, and also to evidence that the organisation's behaviour standards committee was fulfilling its oversight objective.

Judgment: Substantially compliant

Regulation 8: Protection

To meet the full requirements of this regulation, some staff required training in relation to safeguarding residents and the prevention, detection and response to abuse. Further knowledge and understanding was required in systems for managing allegations and oversight of outcomes of allegations.

Judgment: Not 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	
Registration Regulation 7: Changes to information supplied for registration purposes	Not compliant
Regulation 14: Persons in charge	Compliant
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Not compliant
Regulation 23: Governance and management	Not compliant
Regulation 24: Admissions and contract for the provision of services	Not compliant
Regulation 3: Statement of purpose	Compliant
Regulation 34: Complaints procedure	Substantially compliant
Quality and safety	
Regulation 12: Personal possessions	Substantially compliant
Regulation 17: Premises	Compliant
Regulation 26: Risk management procedures	Compliant
Regulation 28: Fire precautions	Compliant
Regulation 5: Individual assessment and personal plan	Substantially compliant
Regulation 6: Health care	Compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Not compliant

Compliance Plan for St John of God Kildare Services – DC8 OSV-0003788

Inspection ID: MON-0024691

Date of inspection: 21/11/2019

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**
Registration Regulation 7: Changes to information supplied for registration purposes	Not Compliant
Outline how you are going to come into compliance with Registration Regulation 7: Changes to information supplied for registration purposes: An NF31 was submitted in respect of the non-compliance regarding designated centre on 28/11/2019.	
Regulation 16: Training and staff development	Not Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: 1. The training records and the attendance sheets are currently being reviewed to ensure that all staff that completed the training is accurately reflected. Any gaps will be addressed with training scheduled and concluded by 31/3/2020. 2. All outstanding personnel will be scheduled to attend the mandatory training or the refresher training in Fire Safety, Safeguarding and Manual Handling by 31/3/2020. 3. All outstanding staff will be scheduled for training in Management of Actual and Potential Aggression (MAPA) by 31/3/2020. 4. The operation of the hoisting equipment is included in the Manual Handling training programme. The operation of the specific hoist model is also part of the DC on-site induction.	

Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: 1. The Annual Review of Quality and Safety will be completed by 30/4/2020. It will focus on the outcomes and key issues related to residents' quality of life and service. 2. A review of relevant systems will be carried out following the audits carried on behalf of the provider to prevent reoccurring non-compliance. 3. A number of local audits will increase in 2020. Schedule of internal audits will be developed by 31/3/2020.	
Regulation 24: Admissions and contract for the provision of services	Not Compliant
Outline how you are going to come into compliance with Regulation 24: Admissions and contract for the provision of services: 1. Service Provision agreements have been revised and are in the final draft stage. These will be issued and signed by 31/03/2020.	
Regulation 34: Complaints procedure	Substantially Compliant
Outline how you are going to come into compliance with Regulation 34: Complaints procedure: 1. All formal and informal complaints will be recorded on the DC complaints log and followed up as per the Policy on Consumer Feedback. 2. Any outstanding complaints will be addressed and closed by 31/03/2020	
Regulation 12: Personal possessions	Substantially Compliant
Outline how you are going to come into compliance with Regulation 12: Personal	

possessions:
1. The Inventory of Assets of the residents already transitioned to the Designated Centre will be reviewed and updated by 31/3/2020.
2. Any new transitions will include the review of the Inventory of Assets owned by Residents.
3. Any concerns related to potentially missing items will be followed up by PIC.

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:
1. All individual assessments and personal plans are being reviewed and updated to ensure compliance with the regulation 5 before 28/02/2020

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
1. All staff will be scheduled to attend the training in Management of Actual and Potential Aggression (MAPA) by 31/3/2020.
2. The use of psychotropic medications will be reviewed before 31/1/2020 and if required their use will be reported to the relevant committee as per the Policy on Restraint Reduction.
3. Any psychotropic medication used as chemical restraint for the individual will be notified to the Authority before 31/1/2020.

Regulation 8: Protection	Not Compliant

Outline how you are going to come into compliance with Regulation 8: Protection:
1. The existing complaints were reviewed and no current complaints of a safeguarding nature were identified.
2. All new complaints of a safeguarding nature will be screened by the Designated

Officer, reported to the HSE protection teams and notified to HIQA as per the Policy on Safeguarding Vulnerable Persons.

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
Registration Regulation 7(3)	The registered provider shall notify the chief inspector in writing of any change in the identity of any person participating in the management of a designated centre (other than the person in charge of the designated centre) within 28 days of the change and supply full and satisfactory information in regard to the matters set out in Schedule 3 in respect of any new person participating in the management of the designated centre.	Not Compliant	Orange	28/11/2019
Regulation 12(1)	The person in charge shall ensure that, as far as reasonably practicable, each	Substantially Compliant	Yellow	31/03/2020

	resident has access to and retains control of personal property and possessions and, where necessary, support is provided to manage their financial affairs.			
Regulation 16(1)(a)	The person in charge shall ensure that staff have access to appropriate training, including refresher training, as part of a continuous professional development programme.	Not Compliant	Orange	31/03/2020
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	31/03/2020
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 and that such care and support is in accordance with standards.	Substantially Compliant	Yellow	30/04/2020
Regulation	The registered	Not Compliant	Orange	31/03/2020

23(3)(b)	provider shall ensure that effective arrangements are in place to facilitate staff to raise concerns about the quality and safety of the care and support provided to residents.			
Regulation 24(3)	The registered provider shall, on admission, agree in writing with each resident, their representative where the resident is not capable of giving consent, the terms on which that resident shall reside in the designated centre.	Not Compliant	Orange	31/03/2020
Regulation 24(4)(a)	The agreement referred to in paragraph (3) shall include the support, care and welfare of the resident in the designated centre and details of the services to be provided for that resident and, where appropriate, the fees to be charged.	Not Compliant	Orange	31/03/2020
Regulation 34(2)(b)	The registered provider shall ensure that all complaints are investigated promptly.	Substantially Compliant	Yellow	31/03/2020
Regulation 34(2)(e)	The registered provider shall ensure that any	Substantially Compliant	Yellow	31/03/2020

	measures required for improvement in response to a complaint are put in place.			
Regulation 05(1)(a)	The person in charge shall ensure that a comprehensive assessment, by an appropriate health care professional, of the health, personal and social care needs of each resident is carried out prior to admission to the designated centre.	Not Compliant	Orange	28/02/2020
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	15/01/2020
Regulation 07(2)	The person in charge shall ensure that staff receive training in the management of behaviour that is challenging including de-escalation and intervention techniques.	Not Compliant	Orange	31/03/2020
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures	Substantially Compliant	Yellow	31/01/2020

	including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.			
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 abuse.	Not Compliant	Orange	17/01/2020
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.	Not Compliant	Orange	31/03/2020