Unannounced Care Inspection Report
15 August 2018

Killynure House

Type of Service: Residential Care Home
Address: 26 Church Road, Carryduff, BT8 8DT
Tel No: 028 9504 2960
Inspector: Priscilla Clayton

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home which is registered with RQIA to accommodate a maximum of forty residents with a diagnosis of dementia. A maximum of two placements for day care service users with dementia can also be provided.

3.0 Service details

Organisation/Registered Provider: Belfast HSC Trust **Responsible Individual:** Martin Dillon	**Registered Manager:** Manager (on secondment)
Person in charge at the time of inspection: Renni Jimmy (Senior Care Assistant) until 13.00 hours Julie Grimes, manager from 13.00 hours	**Date manager registered:** Manager (on secondment)
Categories of care: Residential Care (RC) DE – Dementia	**Number of registered places:** Total number comprising 40 RC – DE Two places for day service (DE)

4.0 Inspection summary

An unannounced care inspection took place on 15 August 2018 from 11.20 to 17.15.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

Evidence of good practice was found in relation to the promotion of a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents. There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's internal environment.

Areas requiring improvement included update training in GDPR and addressing the uneven paving within the secure patio area to minimise the risk of fall to residents.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and resident experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Julie Grimes, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action taken following the most recent care inspection.

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent care inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records: the previous inspection report, the returned QIP, notifiable events, and written and verbal communication received since the previous care inspection.

During the inspection the inspector met with the manager, seventeen residents and three staff.

A total of ten questionnaires were provided for distribution to residents and/or their representatives to enable them to share their views with RQIA. A poster was provided for staff detailing how they could complete an electronic questionnaire. No completed questionnaires were returned by residents, residents' representatives or staff within the agreed timescale.

During the inspection a sample of records was examined which included:

- Staff duty rota
- Staff supervision and annual appraisal schedules
- Staff competency and capability assessments
- Staff training schedule and training records
- Three residents' care files
- The home's Statement of Purpose and Resident's Guide
- Minutes of staff meetings
- Complaints and compliments records
- Audit
- Equipment maintenance/cleaning records
- Accident, incident, notifiable event records
- Annual Quality Review report
- Minutes of recent residents' meetings/ representatives' meetings/ other
- Evaluation report from annual quality assurance survey
- Reports of visits by the registered provider
- Legionella risk assessment
- Fire safety risk assessment
- Fire drill records
- Maintenance of fire-fighting equipment, alarm system, emergency lighting, fire doors, etc.
- Individual written agreements
- Input from independent advocacy services
- Programme of activities
- Selected policies and procedures

Areas for improvements identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met. .

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 18 January 2018

The most recent inspection of the home was an unannounced care inspection.

The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last care inspection dated 18 January 2018

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 25.1 **Stated:** First time	The registered person shall ensure that the dependency levels of residents are monitored in order to inform staffing levels, thus ensuring that all residents' needs are met, including residents having a shower/bath. Ref: 6.4	**Met**
	Action taken as confirmed during the inspection: Resident dependency levels were discussed with the senior care assistant who advised that these were carefully monitored by the manager to ensure staffing levels were appropriate to meet the assessed needs of residents accommodated.	

Area for improvement 2 **Ref**: Standard 20.2 **Stated:** First time	The registered person shall ensure that issues raised by staff in regard to communication issues are addressed to ensure that the home delivers services effectively. Ref: 6.7	**Met**
	Action taken as confirmed during the inspection: The senior care assistant advised that meetings with held with staff to discuss and address issues in regard to team communication which was being monitored by the assistant service manager. Staff advised that marked improvement has been made since the previous inspection with the provision of staff training, development of staff handover templates and an "open door" approach operated by the manager.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager advised that the staffing levels for the home were subject to regular review to ensure the assessed needs of the residents were met. The manager advised that permanent staff or bank staff generally work additional hours to cover staff leave when necessary. The registered manager stated that the use of bank staff did not prevent residents from receiving continuity of care. Any turnover of staff was kept to minimum, where possible, and was monitored by the manager. Two staff members reported that staffing issues do arise with the 14.30 – 16.00 shift on Tuesdays and Thursdays when only two staff were on duty instead of the usual three required to provide the arranged activities. Two activity therapists are rostered to lead the therapeutic activity on Monday, Wednesday and Friday each week. The manager explained that the shortfall was being addressed by senior management.

No concerns were raised regarding staffing levels during discussion with residents. A review of the duty rota confirmed that it accurately reflected the staff working within the home at the time of inspection.

Discussion with staff confirmed that mandatory training, supervision and annual appraisal of staff was regularly provided. Schedules and records of training, staff appraisals and supervision were reviewed during the inspection. Senior care assistants are supervised by the manager on a monthly basis. Care assistants are supervised approximately every two months by a senior care assistant.

The manager advised that staff were recruited in line with Regulation 21 (1) (b), Schedule 2 of The Residential Care Homes Regulations (Northern Ireland) 2005 and that records were retained at the organisation's personnel department.

Arrangements were in place to monitor the registration status of staff with their professional body. Care staff spoken with advised that they were registered with the Northern Ireland Social Care Council (NISCC).

Staff were knowledgeable and had a good understanding of adult safeguarding principles. They were also aware of their obligations in relation to raising concerns about poor practice and whistleblowing. A review of staff training records confirmed that mandatory adult safeguarding training was provided for all staff. The manager advised that the trust had an identified adult safeguarding champion. The manager advised that no current adult safeguarding issues were being screened or investigated.

The manager stated there were risk management procedures in place relating to the safety of individual residents and the home did not accommodate any individuals whose assessed needs could not be met. A review of care records identified residents' care needs and risk assessments were obtained prior to admission.

The policy and procedure on restrictive practice/behaviours which challenge was in keeping with DHSSPS Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) and the Human Rights Act (1998*).* It also reflected current best practice guidance including Deprivation of Liberties Safeguards (DoLS).

The manager advised there were restrictive practices within the home, notably the use of keypad entry systems, lap belt and pressure alarm mats. In the care records examined the restrictions were appropriately assessed, documented, minimised and reviewed with the involvement of the multi-professional team, as required.

Systems were in place to make referrals to the multi-professional team in relation to behaviour management when required. Behaviour management plans were devised by specialist behaviour management teams from the trust and noted to be regularly updated and reviewed as necessary. The manager was aware that should individual restraint be used, that RQIA and appropriate persons/bodies must be informed.

There was an Infection Prevention and Control (IPC) policy and procedure in place which was in line with regional guidelines. Staff training records evidenced that all staff had received training in IPC in line with their roles and responsibilities. Discussion with staff established that they were knowledgeable and had understanding of IPC policies and procedures.

Inspection of the premises confirmed that there were wash hand basins, adequate supplies of liquid soap, alcohol hand gels and disposable towels wherever care was delivered. Personal Protective Equipment (PPE), e.g. disposable gloves and aprons, was available throughout the home. Observation of staff practice identified that staff adhered to IPC procedures.

Good standards of hand hygiene were observed to be promoted within the home among residents and staff. Notices promoting good hand hygiene were displayed throughout the home in both written and pictorial formats.

The manager explained her intention to establish IPC audits within the home and confirmed there had been no outbreak of infection within the last year. Any outbreak would be managed in accordance with trust policy and procedures, reported to the Public Health Agency and RQIA with appropriate records retained.

Notifications of accidents and incidents/events were discussed with the manager who advised that all slips, trips and falls occurring within the home were notified to RQIA. Clarification of notifications to be submitted was explained in accordance with RQIA guidance issued September 2011.

The manager reported that they were aware of the "Falls Prevention Toolkit" and were using this guidance to improve post falls management within the home. Audits of accidents/falls were undertaken on a regular basis and analysed for themes and trends; an action plan was developed to minimise the risk where possible. Referral was made to the trust falls team in line with best practice guidance.

A general inspection of the home was undertaken and the residents' bedrooms were found to be individualised with photographs, memorabilia and personal items. The home was found to be dementia friendly, fresh- smelling, clean and appropriately heated. The manager explained how the home had progressed by way of introduction of the dementia Butterfly Project with the focus on staff attitudes and the environment. Each area within the home, including bedrooms provides greater emphasis on the individual with familiar clever use of small basics, for example; small shop situated within the main hall way, memory boxes mounted outside residents bedrooms, post boxes and 50's music room (largely dedicated to the 1950's music). Management and staff are to be commended in regard to their promotion of this project to improve the care of the residents with dementia.

Inspection of the internal and external environment identified that the home was tidy, safe, suitable for and accessible to residents, staff and visitors. No malodours were detected in the home. One identified area requiring improvement related to the outside secure patio area where paving was noted to be uneven which could result in a trip hazard for residents.

The manager advised that the home's policy, procedures and risk assessments relating to safe and healthy working practices were appropriately maintained and reviewed regularly. For example Control of Substances Hazardous to Health (COSHH), moving and handling and fire safety.

The home had an up to date Legionella risk assessment dated 1 August 2017 and recommendations were being addressed.

The manager advised that equipment in use in the home were well maintained and regularly serviced. A system was in place to regularly check the Northern Ireland Adverse Incidence Centre (NIAIC) alerts and action as necessary. Records were retained.

Discussion with the manager and review of Lifting Operations and Lifting Equipment Regulations (LOLER) records confirmed that safety maintenance records were up to date.

The home had an up to date fire risk assessment in place dated 9 August 2017. Recommendations for improvement had been signed/dated as actioned. It was established that no residents smoked.

Review of staff training records confirmed that staff completed fire safety training twice annually. Fire drills were completed on a regular basis and records reviewed confirmed these were up to date. The records also included the staff who participated and any learning outcomes. Fire safety records identified that fire-fighting equipment, fire alarm systems, emergency lighting and means of escape were checked weekly and/or monthly and were regularly maintained. Individual residents had a completed Personal Emergency Evacuation Plan (PEEP) in place.

Residents and staff spoken with during the inspection made the following comments:

- "At times resident therapeutic activities have to be delayed or postponed due to staff shortfall during the afternoon shift on certain days." (staff)
- "Always staff around to see to things." (resident)
- "I feel safe here the staff see to that." (resident)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's internal environment.

Areas for improvement

One area identified for improvement related to addressing the uneven paving within the external secure patio as this was identified as potential fall risk.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome

Discussion with the manager established that staff in the home responded appropriately to and met the assessed needs of the residents.

There was a records management policy in place which includes the arrangements for the creation, storage, maintenance and disposal of records.

Records were stored safely and securely in line with General Data Protection Regulation (GDPR). Staff update training in regard to GDPR was recommended.

The manager explained that the maintenance of care records was currently under review and that several had been changed over to new folders providing ease of access to information. A review of three care records confirmed that these were person centred and maintained in line with the legislation and standards. Records included an up to date assessment of needs, life history, risk assessments, person centred care plans and daily statement of health and well-being of the resident. Care needs assessment and risk assessments, for example; manual handling, nutrition and falls, were reviewed and updated on a regular basis or as changes occurred.

The care records also reflected the multi-professional input into the residents' health and social care needs and were found to be updated regularly to reflect the changing needs of the individual residents. Residents and/or their representatives were encouraged and enabled to be involved in the assessment, care planning and review process, where appropriate. Care records reviewed were observed to be signed by the resident and/or their representative. An individual agreement setting out the terms of residency was in place and appropriately signed.

Discussion with staff confirmed that a person centred approach underpinned practice. Staff were able to describe in detail how the needs, choices and preferences of individual residents were met within the home. For example, residents were involved in the development of their person centre care plans and participated in the planning of activities and outings.

A varied and nutritious diet is provided which meets the individual and recorded dietary needs and preferences of the residents. Three weekly rotating seasonal menus were in place. Review of the menus evidenced that these were varied and nutritious.

The serving of the mid- day meal within the dining room was observed. This was undertaken by staff in a respectful unhurried manner. Dining room tables were nicely set with table cloths in place, range of condiments, drinks and napkins provided. Residents were supervised and assisted by staff as required. Meals were nicely presented with adequate portions of food served. Special diets were served as required. A pleasant ambience prevailed throughout this important social occasion with residents and staff quietly conversing. Residents who spoke with the inspector following the meal confirmed that choice was offered and that meals were always very good.

Systems are in place to regularly record residents' weights and any significant changes in weight are responded appropriately. There are arrangements in place to refer residents to dietitians and speech and language therapists (SALT) as required.

The home had received the highest rating of 5 in food hygiene standards from Environmental Health on 5 December 2017. This is to be commended.

The kitchen was observed to be clean tidy and organised with all equipment reported to be in good working order. Records of food delivery and fridge temperatures were recorded as required. Records of food served each day were recorded.

The manager advised there was no residents presently requiring wound care and confirmed that any wound care or other nursing needs would be referred to and managed by community nursing services. Referrals were made to the multi-professional team to areas any concerns identified in a timely manner.

The manager advised that she was currently reviewing the range of audits undertaken. Currently there were arrangements in place to monitor, audit and review the effectiveness and quality of care delivered to residents at appropriate intervals. Audits of fire safety, medications, catering/kitchen audits were in place. Further evidence of audit was contained within the reports of the visits by the registered provider and the annual quality review report. The manager advised that it was her intention to develop additional audits in order to ensure continuous quality improvement of the service. Development will be reviewed at the next care inspection of the home.

The manager advised that a resident satisfaction survey was currently underway and when questionnaires were returned these would be analysed and where necessary an action plan developed to address low response scores. Details of the survey would be presented within the home's annual quality report for 2018/19.

The manager advised that systems were in place to ensure effective communication with residents, their representatives and other key stakeholders. These included pre-admission information, multi-professional team reviews, residents' meetings, staff meetings and staff shift handovers. Minutes of staff meetings and resident meetings were reviewed during the inspection. Minutes of staff meeting minutes dated 27 July 2018 and 5 June 2018 were reviewed and found to be recorded in accordance with good practice. Minutes of residents meeting dated 28 July 2018 and 8 June 2018 reflected residents in attendance and a wide range of topics including environmental issues, food, outings and activities. The manager advised that she had arranged a resident representatives meeting for 5 September 2018 at 18.30 hours to provide opportunity to introduce herself as the new temporary manager and seek their views, comments and suggestions on the service provided.

Observation of practice evidenced that staff were able to communicate effectively with residents. Discussion with the manager and staff confirmed that management operated an "open door" policy in regard to communication within the home.

There were also systems in place to ensure openness and transparency of communication, for example, the registered provider monthly visits and RQIA inspection reports.

A review of care records, along with accident and incident reports, confirmed that referral to other healthcare professionals was timely and responsive to the needs of the residents.

Residents and staff spoken with during the inspection made the following comments:

- "Yes care is effective with all we need including good training, staffing, good team working and support to do the job." (staff)
- "Great home, care excellent." (resident)

No issues or concerns were raised or indicated by residents or staff.

Areas of good practice

There were examples of good practice in relation to care records, audits and reviews, communication between residents, staff and other interested parties.

Areas for improvement

One area identified related to the provision of staff update training in GDPR

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

A range of policies and procedures was in place which supported the delivery of compassionate care. Staff confirmed that they had ready access to all policies and procedures.

The manager advised that staff in the home promoted a culture and ethos that supported the values of dignity and respect, independence, rights, equality and diversity, choice and consent of residents.

The manager and residents advised that consent was sought in relation to care and treatment. Discussion and observation of care practice and social interactions demonstrated that residents were treated with dignity and respect. Staff described their awareness of promoting residents' rights, independence, dignity and confidentiality were protected.

Discussion with staff and residents confirmed that residents' spiritual and cultural needs, were met within the home. Action was taken to manage any pain and discomfort in a timely and appropriate manner. This was further evidenced by the review of care records, for example, care plans were in place for the identification and management of pain, falls, infection, nutrition, where appropriate. The manager advised that pain management and systematic review included the use of a pain assessment tool/chart (PAINAD) which was based on observed behaviours of residents with dementia. Charts were reflected within care records.

Residents were provided with information, in a format that they could understand which enabled them to make informed decisions regarding their life, care and treatment; menus and the activity programme, for example, were written in a pictorial format.

Discussion with staff and residents confirmed that residents' needs were recognised and responded to in a prompt and courteous manner by staff; residents' were listened to, valued and communicated with in an appropriate manner and their views and opinions were taken into account in all matters affecting them. For example; residents were encouraged and supported to actively participate in the annual reviews of their care. Other systems of communication included, residents' meetings, care reviews and visits undertaken by the registered provider.

Discussion with staff, residents, observation of practice and review of care records confirmed that residents were enabled and supported to engage and participate in meaningful activities by two activity therapists who work in the home each Monday, Wednesday and Friday. Care staff provides this support on Tuesdays and Thursdays. Arrangements were in place for residents to maintain links with their friends, families and wider community

Residents and staff spoken with during the inspection made the following comments:

- "My friends and family can come and visit at any time." (resident)
- "I can choose what I like to do. I go to bed and get up when I want." (resident)
- "All our residents are treated with respect." (staff)
- "Residents are always consulted about their care and I would recommend this home to my family." (staff)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing residents and taking account of the views of residents.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

The registered manager's post is vacant and Julie Grimes is the new seconded manager of the home since 2 July 2018. She is a registered nurse currently undertaking a QCF level 5 in residential care and has a long experience of working within dementia care units.

The manager has settled in very well into her new post and is currently reviewing the systems and processes of daily management within the home. Review and revision of the statement of purpose and resident guide to reflect the new management arrangements is a work in progress. A copy of both documents is to be submitted to RQIA when revision is completed.

The manager outlined the management arrangements and governance systems in place within the home and stated that the needs of residents were met in accordance with the home's statement of purpose and the categories of care for which the home was registered with RQIA.

A range of policies and procedures was in place to guide and inform staff. Policies were centrally indexed and retained in a manner which was easily accessible by staff. The registered manager stated that policies and procedures were systematically reviewed every three years or more frequently as changes occurred.

There was a complaints policy and procedure in place which was in accordance with the legislation and Department of Health (DoH) guidance on complaints handling. Residents and/or their representatives were made aware of how to make a complaint by way of the Resident's Guide and information on display in the home. Discussion with staff confirmed that they were knowledgeable about how to respond to complaints. The manager explained that staff had received training on complaints management.

Review of the complaints records confirmed that arrangements were in place to effectively manage complaints from residents, their representatives or any other interested party. Records of complaints included details of any investigation undertaken, all communication with complainants, the outcome of the complaint and the complainant's level of satisfaction. Arrangements were in place to share information about complaints and compliments with staff.

Discussion with the manager and review of complaints records evidenced that no complaints had been received since the previous care inspection undertaken on 18 January 2018.
The home retains compliments received, for example, thank you letters and cards and there are systems in place to share these with staff.

There was a system to ensure safety bulletins; serious adverse incident alerts and staffing alerts were appropriately reviewed and actioned.

Discussion with the manager confirmed that information in regard to current best practice guidelines was made available to staff, for example; Northern Ireland Social Care Council (NISCC), National Institute of Clinical Excellence (NICE) and DOH guidelines. Staff were provided with mandatory training and additional training opportunities relevant to any specific needs of the residents for example; bespoke dementia awareness, communication skills, oral hygiene, skin care and customer care.

A visit by the registered provider was undertaken as required under Regulation 29 of The Residential Care Homes Regulations (Northern Ireland) 2005; a report was produced and made available for residents, their representatives, staff, RQIA and any other interested parties to read.

There was a clear organisational structure and all staff were aware of their roles, responsibility and accountability. This was outlined in the home's Statement of Purpose and Residents Guide. The manager stated that the registered provider was kept informed regarding the day to day running of the home by way of monthly monitoring visits undertaken and management meetings.

The manager reported that the management and control of operations within the home was in accordance with the regulatory framework. Inspection of the premises confirmed that the RQIA certificate of registration was displayed.

Discussion with staff confirmed that there were good working relationships within the home and that management were responsive to suggestions and/or concerns raised. There were open and transparent methods of working and effective working relationships with internal and external stakeholders.

Residents and staff spoken with during the inspection made the following comments:

- "There is very good team working here now." (staff)
- "We are kept fully informed and feel supported by the manager." (staff)
- "Good manager always around to see that things are done." (resident)
- "I know how and who to speak to if I had a complaint." (resident)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Julie Grimes, manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the DHSSPS Residential Care Homes Minimum Standards, August 2011.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 27.5 **Stated:** First time **To be completed by:** 1 December 2018	The registered person shall ensure that the uneven paving within the external secure patio area is made good in order to minimise the risk of fall. Ref: 6.4
	Response by registered person detailing the actions taken: A meeting has been arranged with estate services management for Friday 5th October 2018 in order to scope the work and cost required to rectify the uneven paving within the external secure patio area of Killynure House. Costings are to be submitted for senior management to secure funds to bring this area up to the required specification that is safe for residents.
Area for improvement 2 **Ref**: Standard 23.4 **Stated:** First time **To be completed by:** 1 November 2018	The registered person shall ensure staff update training in GDPR is provided. Ref: 6.5
	Response by registered person detailing the actions taken: To date some staff have attended the GDPR training and evidence of this has been recorded on the mandatory training matrix and staff training file. Bespoke GDPR training has been arranged for the 13th and 21st of November 2018 for remaining staff to receive this training. The manager will faciliate the remaining staff to attend.

Please ensure this document is completed in full and returned via Web Portal

The Regulation and Quality Improvement Authority

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