Care Community Limited

King Edwards House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The inspection took place on the 16 and 17 June 2016. The home was last inspected on 14 and 15 January 2016 where we found breaches of regulations and issued a warning notice. Prior to this the home was inspected on 13 May 2015 to check if breaches of regulations had been met which had been found at an inspection in December 2014.

King Edwards House provides accommodation and personal care for up to six people with learning difficulties and mental health needs. At the time of our inspection there were four people living at the home.

King Edwards House did not have a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although staff had the knowledge to protect people from abuse there had been a failure to report incidents of physical abuse between two people using the service, these had not been investigated. In addition we had not been notified about these incidents and another incident where the police had been called.

The environment of the home had not been maintained in a safe manner.

Sufficient numbers of suitably qualified, skilled and experienced persons were not always deployed.

One person's rights had not been protected, they had not had an authorisation made to deprive them of their liberty under the Mental Capacity Act 2005 (MCA).

Despite regular checks on the service provided these had not resulted in improvements to areas identified for action such as guidelines for giving people their medicines and maintenance of equipment and the garden.

People were treated with respect and kindness, their privacy and dignity was respected. They were supported to maintain their independence and keep in contact with relatives. People were enabled to be involved in activities such as trips out of the home when staffing levels allowed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Despite their knowledge of safeguarding people staff had not followed correct procedures when people had suffered physical abuse.

The environment of the home had not been managed or maintained in a safe way.

People were not always supported by sufficient numbers of staff.

People's medicines were not always managed correctly.

People were protected by robust staff recruitment practices.

Is the service effective?

Requires Improvement

The service was not effective.

One person's rights were not protected because the Deprivation of Liberty
Safeguards had not been used.

People were regularly consulted about meal preferences.

People's health needs were met through on-going support and liaison with relevant healthcare professionals.

Staff received support through training although supervision sessions were not consistently planned.

Is the service caring?

Good

The service was caring.

People were treated with respect and kindness.

There was consultation with people about their views on the care and support they received.

People's privacy, dignity and independence was understood,

promoted and respected by staff.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

People did not always receive support that met their needs.

People were enabled to engage in activities when staffing levels allowed.

There were arrangements to respond to any concerns and complaints by people using the service or their representatives.

Is the service well-led?

Inadequate

The service was not well-led.

A registered manager had not been in post since April 2011.

Effective systems had not been operated to ensure the sustained improvement of the service.

King Edwards House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 June 2016 and was unannounced. One inspector carried out the inspection. We spoke with one person using the service, the acting manager, the deputy manager and three members of staff. In addition we reviewed records for four people using the service, toured the premises and checked records relating to the management of the service.

Before the inspection we reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law. We also spoke with the local authority quality team.

Inadequate

Is the service safe?

Our findings

People were at risk of not being protected from abuse because incidents of abuse had not been reported. At our previous inspection of 14 and 15 January 2016 we found an allegation of abuse had not been robustly investigated. An allegation made by a person using the service in November 2015 had not been reported to the acting manager and therefore had not resulted in an investigation or a referral to the local authority with responsibility for safeguarding people. The provider wrote to us in February 2016 about the improvements they were making to ensure allegations and incidents of abuse were properly investigated. At this inspection we found there had been incidents of physical abuse between two people using the service in March, April and May 2016. Records described incidents such as "(the person) was punching the other client", "(the person) got angry and pushed him and then kept hitting him", "lifted wash basket up and hit another service user in the head with it also punched him", "smashed another clients plate and threw it at him". Staff had completed safeguarding training and described the arrangements for reporting any allegations of abuse relating to people using the service. However they had not recognised the importance of reporting the incidents between the two people. The incidents had been recorded but had not been reported to the acting manager. As a result they had not been referred to the local authority. Therefore no external or internal investigation into the incidents had been made.

This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk from an unsafe environment. Some aspects of the environment of King Edwards House had not been maintained safely. On the first day of our inspection we carried out a tour of the premises. The laundry was situated in an outbuilding, the door was propped open with a fire extinguisher and inside a cupboard to store cleaning materials was unlocked and left open. This was contrary to the home's policy on the control of substances hazardous (COSHH) to health which stated "all COSHH products are to be kept outside in laundry room and locked away". Despite the acting manager raising the issue with staff, we found exactly the same situation on the second day of our inspection. We raised the issue with the acting manager a second time and when we checked later the cupboard and laundry were locked.

Two radiator covers in communal rooms had been damaged exposing parts of the radiator that would have been hot and a risk to people when the heating was in use. In addition cushions, bags and other items had been packed into the area between the back of the washing machine and tumble dryer in the laundry. This area should have been kept clear for ventilation of the machines and so the items may have presented a fire risk. The storage of broken furniture and other items at the rear and side of the home did not follow the home's fire risk assessment. This was also close to where some people smoked. We passed our concerns to a fire safety officer. There was no evidence of any check on the electrical wiring of the building. The acting manager told us a legionella check had been carried out but there was no certificate available to confirm this. There were some maintenance issues in the interior of the home and redecoration was needed in some areas.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

People's needs were not always met by sufficient staffing levels. On the morning of the first day of the inspection there were two support staff working plus the deputy manager. The acting manager was also at the home when we arrived. The acting manager had been organising cover for gaps in the rota. Agency staff had been used recently and one member of agency staff had been used on a regular basis to provide some consistency of support to people. The staff member was due to be recruited to the permanent staff at King Edwards House. A member of staff told us they had been working long hours but this had now stopped. Another member of staff commented "we have struggled". A third member of staff said staffing levels were "not enough, service users are not getting the attention". They felt the use of only one waking staff at night was not enough and there should also be a sleeping member of staff. They also told us staff had been working "too many hours". Another staff member told us staff had "managed" but felt there were not enough staff. Another staff member told us about the long hours they had worked to cover shifts and commented they had been "rushed off their feet". They told us how after they finished a shift one evening they were called back in to support staff dealing with an incident. One person told us "sometimes they don't have cover". The home was being staffed on some days without a member of staff working an afternoon 'mid' shift. Therefore the shifts were worked without the benefit of a third member staff to provide support to people where they may need it such as trips out of the home. Staff told us people's activities were affected by lower staff numbers. There was a smaller window of time for supporting people with activities away from the home. People had to wait for staff to be available to support them to participate in activities. Trips away from the home were an important and major part of how people spent their day providing an opportunity to follow their interests and spend time away from the home. In addition the needs of one person had changed and they needed more support than previously with both their physical and emotional needs.

This was a breach of Regulation 18 of the Health and Social Care Act (2008) Regulated Activities Regulations 2014.

People's medicines were not always managed correctly. Topical creams were stored with oral medicines which was not good practice, when we brought this to the attention of the acting manager they ensured correct storage arrangements were made. One bottle of liquid medicine had not been dated on opening with the risk that it may be used after the expiry date. We discussed this with the acting manager who agreed to look into this. There was an accumulation of people's medicines not returned to the supplying pharmacy. The acting manager explained this was due to a change of supplying pharmacy and staff had not had time to return the medicines. A medicines audit had been completed. However this failed to identify any issues requiring remedial action. One person did not have a protocol and information to guide staff about when to give medicine prescribed on an 'as required' basis to relieve distress.

Risk assessments were in place for people in all of the care files we looked at. These had been regularly reviewed and covered risks such as going out in a vehicle, choking and poor mobility.
People had been protected against the risks associated with portable electrical equipment. A gas safety check had been carried out in May 2015 and so the annual safety check was due A fire risk assessment was in place which had been reviewed on a six monthly basis and was due for review in September 2016. Weekly checks on fire alarms had been carried out. The latest inspection of food hygiene by the local authority had resulted in the highest score possible. The acting manager told us a Legionella check had been carried out but there was no certificate available to confirm this.

At our inspection of 14 and 15 January 2016 we found people were put at risk of being cared for by unsuitable staff because recruitment procedures were not thorough. The provider wrote to us in February

2016 about the improvements they were making to staff recruitment procedures. At this inspection we examined recruitment documents for two members of staff. All the required checks had been carried out for the staff recruited to work at King Edwards House. Disclosure and barring service (DBS) checks had been carried out before staff started work and appropriate risk assessments completed. DBS checks are a way that a provider can make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. Checks had also been made on the applicant's health using a questionnaire. The registered provider had recently updated their policy for staff recruitment. However this did not fully reflect the requirements for checking on previous employment relating to services caring or supporting vulnerable adults or children.

People's money was stored securely and there were appropriate systems in place to manage how their money was spent and protect people from financial abuse. Risk assessments had been completed where people were at risk of potential financial abuse. We checked the recorded balance of one person's money against the amount held and this tallied.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found there were no assessments of people's capacity to consent to decisions about their care and support. However people were involved in decisions about how they spent their day and aspects of how the service was provided. One person had an authorisation in place to deprive them of their liberty. We checked the conditions of the authorisation in place and these were being complied with. Another person had an application made for authorisation to deprive them of their liberty and this was awaiting approval. One person had been identified as requiring an authorisation but these had not been applied for and a relevant assessment of their mental capacity had not yet been completed. Therefore their rights were not protected. A fourth person did not have their liberty restricted.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed staff had received training in the MCA although one member of staff could not recall receiving this training.

People using the service were supported by staff who had received training and support for their role. Staff had received training in subjects such as handling medicines, fire safety and first aid. Staff new to the roles of caring for and supporting people were undertaking the Care Certificate -. They had also received training specific to the needs of people using the service such as epilepsy, diabetes and positive behaviour management. One member of staff told us they received enough training but felt less experienced staff would benefit from more. Another member of staff told us they did not get enough support although acknowledged the supervision sessions they received were helpful. There was an inconsistent approach to holding staff supervision sessions, these are where staff have regular individual meetings with a manager or senior staff. Some staff had not had supervision sessions since October and November 2015 although others had their most recent sessions in March 2016. One member of staff told us they had a supervision session "last month". There was no information readily available about when staff supervision sessions and annual appraisals were due.

People were regularly consulted about meal preferences. Minutes of individual meetings with people showed how people were asked for their meal choices. People were offered breakfast at a time suitable for

their individual daily routine. One person who did not eat red meat told us they were happy with the meals provided for them. We observed lunch being served to people on the second day of our inspection visit. There were only enough chairs for two people to eat at the dining table. One was a plastic garden chair the other a lounge chair made up to the correct height with cushions. Staff had improvised this arrangement due to the lack of dining chairs which had been damaged. One person sat on a sofa where they were supported by staff to eat their meal. A quiet atmosphere was not achieved with staff engaging in a loud conversation with a visitor. The acting manager told us the expectation was for staff to sit at the table and eat meals with people. The lack of suitable furniture did not allow this. Menus offered a cooked snack at lunchtime and a cooked meal in the evening although on Sunday the cooked meal was at lunchtime.

People's healthcare needs were met through regular healthcare appointments. People attended their GP surgeries, dentists and hospital appointments. People had health action plans and hospital assessments. These were written in an individualised style and a statement indicated that they may form part of each person's 'person centred plan'. These described how people would be best supported to maintain contact with health services or in the event of admission to hospital. We saw evidence of people attending health care appointments in the form of letters about hospital appointments and letters regarding referrals to health care professionals.

Good

Is the service caring?

Our findings

People were treated in a caring way by staff and spoken with in a respectful manner. When staff interacted with people they took time to explain actions and checked for preferences. Staff were respectful and caring in their interactions with people. Support plans included information about people's preferred choice of name for staff to address them correctly. A communication passport was in place for one person as an aid for staff to understand the person's methods of communication. This included information for staff on how to interpret verbal and non-verbal communication and how best to support them in a number of areas such as when they were angry or distressed and broader information such as likes and dislikes.

People were involved in decisions about how they spent their day and aspects of how the service was provided. Minutes of individual meetings with people demonstrated how they were able to express their views. Individual meetings had been found to be the most suitable way to gather people's views about the service provided. Records showed the most recent meetings had been held in June 2016. Discussions were held around subjects such as social activities, menus, what people were looking forward to, appointments and complaints. People's responses were recorded. One person had been appointed an advocate in the past although had recently chosen to discontinue their use of the service. Information was available in the home about advocacy services.

Staff gave us examples of how they would respect people's privacy and dignity when providing care and support. When supporting someone with personal care they would ensure doors were closed and people were covered appropriately. One member of staff described their awareness of how some people preferred only to receive personal care from staff of the same gender and how these preferences were known and respected.

One person confirmed staff were polite and would knock on the door before entering their room.
Staff also told us how they would promote people's independence in particular encouraging people to carry out tasks for themselves. One staff member described how staff encouraged a person to make their own drinks as opposed to staff making these for them. Another person cooked meals for themselves at times with support from staff.

People were able to maintain contact with family members through visits at the care home or visiting family including overnight stays where appropriate. A record of family events such as birthdays was kept to allow people to mark these if they chose to, these were discussed at individual meetings.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive support that met their needs. People had support plans for staff to follow. These included 'pen pictures' consisting of a summary of important information about the person. Support plans were written in a personalised way and detailed records showed how people had been involved in reviewing their care plans. They included a record of issues important for each person including information about a person's preferences and how they enjoyed spending their time. Support plans had been kept under review with additional checks of some care plans undertaken through the monthly inspection visit by the acting manager. Monthly reports were completed about each person giving an overview of their current needs, support given, social activities and any accidents or incidents. Staff described the importance of personalised care and in particular giving people options and respecting their wishes. However we found one person's support plan did not provide guidance to staff for the support they were receiving. One person was being assisted to eat a meal although their support plan stated "I will need staff to be present with me whilst having my meal"; the person sat on a sofa to eat their meal despite the support plan stating "I will sit at the table at mealtimes". There were no specific guidelines for staff to follow to assist the person with eating their meal in the way we witnessed. The person also required weekly weight monitoring but records showed they had not been weighed since 2 April 2016. There were no suitable scales available at King Edwards House for the person to sit on. One member of staff did not feel the person received personalised care. They told us they were not suited for living at King Edwards House and would be better supported at another of the provider's homes where staff had the right knowledge and skills. Two other people had plans for them to be weighed weekly. However records showed they had not always been weighed on a weekly basis or if they had not been weighed there was no record of a reason for this. Another person had been weighed weekly until 28 May 2016, they had been losing weight. Records also showed they had been refusing meals and dietary supplements at times. The person had a support plan and risk assessment in place including an action to refer to their GP if weight loss continued. Although the acting manager told us the person's GP was aware of the issues there was no reason recorded as to why the monitoring of their weight had stopped.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were supported to take part in activities and interests when staffing levels allowed. One person attended a college twice a week and spoke positively about this. There were also trips out with one person going out alone to local shops and a café. However staff told us another person had recently refused to take part in some activities away from the home. A barbecue had recently been held in the garden. Activities attended were recorded in people's support plans.

There were arrangements in place to listen to and respond to any concerns or complaints. Information explaining how to make a complaint was available for people using the service in their support plan folders and on display in the entrance of the care home where forms for recording complaints were available. We checked on any recent complaints. One written complaint had been received from a person using the service in April 2016. Records showed this had been appropriately responded to.

Inadequate

Is the service well-led?

Our findings

At the time of our inspection King Edwards House did not have a registered manager. The previous registered manager left in April 2011. A previous manager had submitted an application for manager registration with CQC but had left before the registration process had been completed. The last acting manager had recently resigned from their post and had withdrawn their application for manager registration. The previous deputy manager of another service operated by the registered provider had been promoted to acting manager of King Edwards House. A registered manager is a person who has registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

At our inspection of December 2014 we found Deprivation of Liberty Safeguards (DoLS) had been put in place for two people using the service in 2014. The DoLS protect people in care homes from inappropriate or unnecessary restrictions on their freedom. However we had not been notified about the outcomes of the two applications made by the home. CQC monitors important events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers.

At the time of our inspection visit in May 2015 we had not received the missing notifications identified at our December 2014 inspection. The provider wrote to us and told us "Management are clear of their responsibility under regulation and requirement of notification. This will be monitored through audit on provider visits". Following this inspection we received the required notifications. However at our inspection of 14 and 15 January 2016 we found information that a person had made an allegation of abuse in November 2015. The acting manager was unaware of the allegation until we uncovered this at our inspection. We had not been notified of this allegation. The provider wrote to us in February 2016 about the improvements they were making to ensure we received notifications. At this inspection we found incidents of abuse involving people using the service had not been reported to us. In addition we were not notified about an incident reported to the police.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At our inspection of 14 and 15 January 2016 we found people did not have the benefit of using a service which was effectively monitored, evaluated and improved. We issued a warning notice for the breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A monthly inspection visit was completed by the acting manager or a deputy manager from another care home and these were known as "provider visits". There was no other person with management responsibility who carried out these visits. The visits covered a range of areas including inspection of the premises, activities provided, menus and interviews with people using the service and staff. Reports included matters arising from visits and action to be taken with deadlines for completion. These visits had failed to address the shortfalls identified at our inspection, some of which were continuing shortfalls. We had not found significant improvements since our inspection in December 2014 and breaches of regulations had

continued.

At this inspection we checked the provider visits since our inspection in January 2016. A report of a visit carried out the day before our inspection had been produced along with a record of a visit dated 29 March 2016. The acting manager told us another visit had taken place in May 2016 although no record of this could be found we were later told a handwritten record of the visit had been found at another of the provider's care homes. Although we requested a copy of this it was not sent to us.

The report of the visit in March 2016 recorded actions from an inspection of the premises, "items from the side of house needs clearing and put into tip". This was still the situation we found at our inspection. We reported the issue to a fire safety officer in view of the potential fire risk. In addition another action stated "medication cupboard to be cleared of clutter". We found this situation was unresolved with an accumulation of items including medicines requiring return to the supplying pharmacist. Actions recorded from a check on medicines found protocols were not in place for people prescribed medicines on an 'as required' basis. The action stated "PRN protocols need to be in place ASAP". At our inspection we found this issue had not been resolved with no protocols in place for people prescribed to take medicines in this way. Provider visits had not been carried out on a regular basis and when they did there had been a failure to identify shortfalls in the service provided, some of which were continuing shortfalls. An audit tool was used for checking arrangements for storing, recording and giving people their medicines. The most recent audit checks were dated 14 and 16 June 2016. However they did not reflect the situation relating to the storage of medicines. The audit completed using the tool indicated medicine storage was clean and tidy, this was not the case with the cupboard containing an accumulation of items noted in the 'provider visit' check in March 2016. Use by or opened on dates to indicate when a medicine would expire were not on a bottle of liquid medicine.Use by or opened on dates to indicate when a medicine would expire were not on a bottle of liquid medicine. The audit indicated this was the case. The acting manager realised the ineffectiveness of the audit and told us it would be replaced with another audit tool. Despite improvements to staff recruitment processes, other areas such as protecting people from abuse and making notifications to the CQC had not improved. In addition we found the safety of the environment of the home, staffing and the support given to people needed improvement. There had also been no progress with applying for lawful authority to deprive a person of their liberty. We had not found significant improvements since our inspections in December 2014 and January 2016.

Satisfaction surveys had been sent to people using the service, their representatives and staff. Responses were generally positive but there were some comments relating to improvements people wanted with the service provided such as having their room redecorated and wanting more activities. A relative of a person using the service made comments about the rear garden. There were "cigarette butts everywhere" and "the lawn needs more regular cutting". There was no documentation of actions identified from feedback received. We found the back garden was in an untidy state with a number of items of broken furniture and piles of cigarette ends in places. The lawn had not been cut for some considerable time because a lawn mower was not available making use of the garden difficult.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The acting manager described the main challenge as covering current staff shortages at King Edwards House and recruiting new staff. The current ratings for the home were on display on the registered provider's website but not in the home. We brought this to the attention of the acting manager who arranged for the ratings to be displayed by the second day of our inspection visit.
Although the acting manager told us staff meetings were held, no record of these could be found during our

inspection visit.

Staff we spoke with about the management of King Edwards House were positive about the work of the acting manager. One member of staff told us "a lot more could be done about furniture and fittings".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Commission of incidents of abuse and an incident reported to the Police which occurred whilst services were being provided in the carrying on of a regulated activity.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care did not always meet their needs.

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services were not protected against the risks associated with premises which had not been managed or maintained safely.

The enforcement action we took:

Impose a condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People's care did not always meet their needs.

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had not operated effective systems to ensure the monitoring and improvement of services.

The enforcement action we took:

Impose a condition.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care

Sufficient numbers of suitably qualified, skilled and experienced persons were not deployed.

The enforcement action we took:

Impose a condition