Robelen Enterprises Ltd

Aspire Community Care & Support

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 5 December 2017 and was announced. The provider was given 48 hours' notice as they are a small domiciliary care service and we needed to be sure someone would be in.

The service is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older adults and adults with learning disabilities and people with physical disabilities. At the time of the inspection the service was providing personal care to five people.

This was the first inspection of this location. They registered to provide personal care from this location in March 2017.

There was 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.

Care plans and risk assessments were inconsistent. Although some contained a high level of detail to inform care staff how to meet people's needs and keep them safe, others lacked detail. There was insufficient information available to staff about how to respond to health related emergencies.

Staff were recruited in a way that ensured they were suitable to work in a care setting and were provided with training and support to help them perform in their roles. However, there were not enough staff employed to ensure staff could have days off or to cover staff absences.

People who had capacity to consent to their care had indicated their consent by signing consent forms. However, where people lacked capacity to consent to their care the provider had not followed the principles of the Mental Capacity Act (MCA) 2005. We have made a recommendation about following the principles of the MCA.

The provider had systems in place to monitor the quality of the service and to seek feedback from people, their relatives and staff. Care plans and people's experience of care were reviewed regularly. However, actions had not always been completed following incidents or feedback being received. We have made a recommendation about ensuring the effectiveness of quality assurance systems.

People were protected from the risk of abuse as there were clear processes in place to safeguard people from harm. Relatives told us they were confident their family members were safe with staff. Staff were knowledgeable about the action they should take if they were concerned about abuse.

The provider completed comprehensive needs assessments and planned care to be delivered in a person centred way. Care plans contained details of people's personal history, cultural background and religious

beliefs including details of how care workers should support people in these areas. The provider did not explore people's sexual orientation and the impact this had on their experience of care. We have made a recommendation about ensuring sexual orientation is considered in care assessments.

Care plans contained information about people's routine healthcare needs and details of healthcare professionals involved in people's support.

Relatives told us they were confident staff could support their family members with their healthcare needs. People were supported with their medicines and this was managed in a safe way.

People were supported to eat and drink in line with their preferences.

Relatives told us care workers demonstrated a caring and compassionate attitude. Care workers spoke about the people they supported with kindness and affection.

The provider had clear systems in place to ensure people were supported at the end of their lives in a way that reflected their preferences.

Relatives and staff spoke highly of the registered manager and found the provider was supportive and listened to their feedback. There was a clear values base to the organisation with a credible and realistic business plan in place. The registered manager attended local network meetings to learn and share best practice with other organisations.

We found breaches of three regulations regarding staffing, safe care and treatment and person-centred care. You can see what action we told the provider to take at the back of the full version of this 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?

Requires Improvement

The service was not always safe. There were not enough staff employed to ensure people's needs were met, although staff in place had been recruited in a safe way.

Measures in place to mitigate risk were not always clear.

It was not always clear how the provider had responded to incidents.

People were protected from the risk of abuse and staff were confident in how to raise concerns about abuse.

People's medicines were managed in a safe way.

People were protected by the prevention and control of infection.

Is the service effective?

Good

The service was effective. People who had capacity provided consent to their care. The registered manager refreshed their knowledge of the principles of the Mental Capacity Act 2005 during the inspection.

Staff had received the training and support they needed to perform their roles.

People's needs had been assessed and care planned in a person-centred way.

People were supported to eat and drink in line with their preferences.

The service worked with other services and healthcare professionals involved in people's support.

People were supported to have their routine healthcare needs met.

Is the service caring?

Good

The service was caring. People were treated with respect by compassionate staff who demonstrated a caring attitude towards the people they supported.

People were supported to be involved in making decisions about their care, and their preferences were clearly captured and acted upon.

Staff demonstrated they understood how to support people with dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive. The level of detail in care plans varied, and plans had not been updated when people's needs had changed.

The service had a robust complaints policy and complaints were resolved in line with the policy.

The service had clear systems in place to ensure people received appropriate care at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not always well led. The provider had not completed actions in response to feedback and had not identified issues with the quality of records found on inspection.

Relatives and staff spoke highly of the registered manager.

There was a clear business plan in place for the development of the service based on person centred values.

The registered manager attended local forums to build links with other organisations and shared best practice.

Aspire Community Care & Support

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.

The inspection took place on 5 December 2017 and was announced. The provider was given 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff. We needed to be sure they would be in.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this information and other information we held about the service in the form of notifications submitted to us. A notification is information about important events which the service is required to send us by law. We sought feedback from the local Healthwatch.

The inspection was completed by one inspector.

During the inspection we spoke with two relatives of people who received a service. We attempted to speak with people who used the service directly, but they did not agree to speak with us. We spoke with three members of staff which included the registered manager and two care workers. We reviewed three people's care records, including needs assessments, care plans and risk assessments and records of care delivered. We reviewed five staff files including recruitment, supervision and training records. We reviewed meeting minutes and various documents and policies relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Relatives and staff told us they were concerned that the provider did not have sufficient staff employed to meet people's needs. Records showed that the provider aimed to match each person with a pool of three or four named care workers. However, records showed people were only supported by one or two named care workers. Records showed that one care worker had worked every day in October without a single day off. Relatives told us they were concerned there as a risk of service breakdown if their regular care workers were unwell or went on holiday. One relative said, "If two care workers are on holiday as the same time it's tough, the cover won't be there." A care worker told us, "I'm drained. I've been working seven days a week and it's killing me. I've asked for a day off but [registered manager] can't get cover. I do cover if someone else is off. I don't like to say no because if I say no someone else is going to miss out."

This was discussed with the registered manager who acknowledged the capacity of care workers was stretched. They told us they were recruiting more care workers so they had enough staff to cover packages of care. However, at the point of inspection there were insufficient staff to cover packages in the event of both planned and unplanned care worker absence. This meant there was a risk that people would not receive care if their care worker was absent.

The above issues are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments were completed as part of the needs assessment and care planning process. Some of the risk assessments contained a high level of detail with clear instructions for care workers to follow to mitigate risk. For example, one person's risk assessment for supporting them to complete transfers clearly described how to position and use equipment to support the person to mobilise safely.

However, other risk assessments lacked the specific detail required to ensure staff provided safe care. For example, where people required a hoist to transfer there were no details of the sling size or type, or the person's position within the sling. In addition, one person had epilepsy and experienced frequent seizures. Their epilepsy risk assessment stated, "Care worker to read and follow care plan and risk assessment. Minimise noise around [person]. Avoid ironing in the same room as [person]. Care worker should be observant at all times for signs of a seizure about to come on. Care workers to follow the seizure protocol if [person] starts having a seizure. Note: seizure may go into status if she is fighting an infection. Prescribed medication is administered by [relative]." The registered manager confirmed the seizure protocols referred to were not within the care file and told us that the risk of seizures was mitigated by the person's relative always being present. This was not sufficient and there were no clear guidelines about how the person presented during seizures and what support care workers should provide. This meant the risks had not been appropriately mitigated against.

There was insufficient information to guide staff in how to respond to health related risks and emergencies. For example, where people had diabetes there was no information within care files to support care workers to identify and respond appropriately to a diabetes related health emergency. One person had asthma, but

their risk assessment in relation to this stated, "Care worker to read and follow care plan and risk assessment. Avoid bleach. Assist [person] to use their inhaler if you notice they are having an asthma attack. [Person's] asthma is well controlled with a pump." There was no information describing how the person presented when they were having an asthma attack to ensure they received support to use their inhaler in an appropriate way. This meant there was a risk that people's healthcare needs were not always met, as there was insufficient information about how to respond to healthcare related emergencies in people's care plans and risk assessments.

The above issues with the lack of detail in risk assessments are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed the provider operated a robust recruitment process. The provider completed pre-interview assessments and records showed staff completed a values based interview which was assessed and scored by the registered manager before making a recruitment decision. The provider collected employment references and character references to ensure staff were of a suitable character to work in a care setting. Records showed the provider carried out checks on staff identity and right to work in the UK. Before they started working in the service staff completed checks on their criminal histories. Where people had historic convictions the provider had robust systems in place to ensure they were not a risk to people receiving care. This meant staff were recruited in a safe way.

Relatives told us they thought people were safe with their care workers. One relative said, "I'm confident that the staff know how to keep [my relative] safe." Staff were confident in describing how they would respond to allegations of abuse. One care worker said, "If I notice something [allegation of abuse] I will 100% inform my manager. If they don't act I raise it and I go to the police if I need. Normally I'd inform my manager or my supervisor if I had any concerns. If someone is being abused I'll raise it far above my manager."

Incident forms were reviewed. These showed staff took appropriate action in response to events to ensure that people were safe. However, where follow up action was required records did not show this had been completed. For example, one incident form showed that the person's mobility care plan and risk assessment needed to be updated following a fall. However, their risk assessment had not been updated. This was discussed with the registered manager who told us they had scheduled a meeting with the person and their family to complete a full review of the care plan and risk assessment. However, this meant there was a risk that staff did not have the most up to date risk management information available to them as the risk assessment had not been updated. Records showed there had not been any incidents that were also allegations of abuse.

The provider had a comprehensive safeguarding policy which contained details of the different types of abuse people receiving a service might be vulnerable to and what actions staff should take in response to concerns. This included different levels of responsibility and the responsibility of the registered manager to take action was clearly defined. Although there were contact details for safeguarding within the provider organisation, the sections of the policy for the external contacts including the local safeguarding team contact details had not been completed. This meant there was a risk that staff would not have the details they needed to escalate concerns if the registered manager was unavailable to do it themselves.

Records showed most people were supported by family members to take their medicines. Care plans were clear about who was responsible for supporting people to take medicines. Records showed that staff supported people with topical medicines and clear records had been maintained. There were instructions for care staff about the purpose of medicines and how to administer them. Care workers completed medicines administration records which were checked by supervisory and management staff on a monthly

basis. The records were complete and contained no errors. This meant medicines were managed in a safe way.

Staff told us they were provided with personal protective equipment in order to ensure people were protected by the prevention and control of infection. Care workers told us they could collect gloves, aprons and overshoes from the office, or that the registered manager would bring supplies to people's homes when completing monitoring visits. Records showed staff completed training in infection control and prevention. Assessments showed that no one receiving a service had particular risks in relation to infection control.

Good

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decision 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 interest 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. For people living in the community deprivations of liberty must be authorised by the Court of Protection. We checked whether the service was working within the principles of the MCA.

People who had capacity to consent to their care had indicated this through signing consent forms within the care files. In two of the care files viewed the people were deemed to lack capacity to consent to their care and treatment due to their condition. The consent forms within their files had been signed by relatives. A relative can only consent on a person's behalf if they have been appointed by the person under a Lasting Power of Attorney, or if they have been appointed as a Deputy by the Court of Protection. We asked the registered manager if relatives could consent on behalf of people over the age of 16. They said, "Yes, I think they can." This was not correct, as the MCA applies and relatives should be involved in a best interests decision making process. In order for a relative to consent they must be a legally appointed decision maker. The registered manager immediately refreshed his knowledge of the MCA. The registered manager acknowledged these relatives were not authorised to consent on their family member's behalf but had been involved in a best interests decision making process about how to provide care to their family members.

We recommend the service seeks and follows best practice guidance from a reputable source on ensuring it adheres to the principles of the MCA.

Relatives told us they and their family members were involved in the needs assessment process. One relative said, "My relative was here when they [provider] came. We talked it through together." Records showed the provider completed a comprehensive needs assessment which considered people's needs in terms of their health, mobility, communications and all aspects of their care. The assessment included collecting information about people's lifestyle and personal history to ensure their preferences were reflected in the resulting care plan.

Assessments included information from relevant healthcare professionals. For example, where people required nursing input to manage their health conditions this was clearly captured. The assessment process captured people's preferences for their planned care. For example, one person's care plan specified they preferred to have a wash rather than a shower due to their health condition. Another person's care plan reflected their preference to follow a specific routine in the mornings. This meant the provider had ensured people's needs and choices were assessed in line with current guidance for person-centred care.

Staff told us they received training to support them to perform their roles. Records showed staff completed a classroom based induction training course and online training in specific areas relevant to their roles. Staff had to achieve a minimum of 50% in the assessed online training. However, records showed that although staff had enrolled to re-take training where they had failed to achieve the required standard, they had not completed this at the point of inspection. The registered manager made contact with staff during the inspection to encourage them to complete their training. Records showed staff completed training in safeguarding adults, medicines administration, the role of the care worker, nutrition and hydration, moving and handling, food hygiene, infection control, equality and diversity and person centred care.

Some people had complex support needs which required staff to complete specialist training in order to meet their needs. Records showed the service had sought to provide this training to the relevant staff. For example, one staff member had completed training in a specialised technique for administering nutritional supplements. Records showed staff discussed training in their supervision meetings and were encouraged to complete training or identify any areas where they wished to receive further training. Staff received supervision each month with the registered manager where they received feedback on their performance. Staff told us they found supervision useful and supportive. This meant staff had the knowledge and skills required to perform their roles.

Care plans showed staff had a limited role in supporting people to eat and drink as this was usually supported by family members who prepared meals and completed shopping for people where they were not able to do this for themselves. The role of care workers in meal preparation was clearly recorded in care plans, and included ensuring that people made choices from meal options available to them. A care worker confirmed this was how they supported people. They said, "[Person] makes lots of choices. I'll ask her what she wants for breakfast, offer a choice, shredded wheat or toast, orange juice or tea. She'll tell me, 'I want tea.'"

Records showed the service received feedback and updates from other services involved in supporting people, for example, nutritionists and district nurses. This information was contained within the care files and ensured that care workers were working together with other professionals involved in people's care. The assessment process included a section where the history of multi-disciplinary involvement in the person's care was included. This ensured that the provider worked with other organisations as their input was clearly recorded.

People receiving a service lived with a range of long term and complex health conditions. Records showed the provider collected information about people's healthcare needs during the assessment process. Relatives told us they were confident staff knew how to identify if people were unwell and would escalate any concerns about people's health appropriately. One relative told us, "They know when she is poorly, they always tell me if she's not her usual self." During the inspection we observed the registered manager making telephone calls to coordinate a visiting healthcare worker with the care worker's visit. Although there was limited information about how to respond to health related emergencies, there was clear information about people's routine healthcare needs. Records showed staff escalated concerns about people's health and the provider supported people to access healthcare services.

Good

Is the service caring?

Our findings

Relatives told us they thought regular care workers treated their family members with kindness and respect. One relative said, "I'm happy with the care worker. She's doing very well, she's perfect and my relative has got to know her well." They continued, "They respect it's our home."

Care workers spoke about the people they supported with kindness and affection. One care worker told us, "My customers are like my family. I've been working with them for a long time. I want them to have a good life. I want them to have as good a life as me. I see them every day, I'm invested in them." Care workers described the steps they took to ensure that people felt respected. One care worker said, "I am working in their house, I always ask permission before I do anything."

Care workers demonstrated they understood the importance of providing emotional support to people. One care worker described how they responded when the person they supported was upset. They said, "I'll give her a little cuddle, that makes everyone feel better. I'd sit down with her and get her to tell me what's wrong, what's bothering her. Try and find out what has happened to make her upset."

Care plans contained detailed information about people's communication needs and preferences. This helped give staff the information they needed to build rapport with people in order to establish positive relationships with them. This was supported by the way the provider introduced care workers to the people they supported. Relatives confirmed that staff members visited people and completed shadowing before being allocated to work with people on a permanent basis. Care plans stated where people had a preference for care workers of a specific gender and where people had stated a preference records showed this was respected. People had been asked about their preferences for the style of interaction they preferred to facilitate matching with care workers personalities.

Care plans also contained information about people's background and personal history. For example, there were details about where people grew up and went to school, as well as their employment history and other activities they currently engaged with. There was information about people's interests, for example, one person's care plan contained information about what music and films they liked to facilitate care workers' conversations with people.

People's religious beliefs were captured in their care plans, along with any specific cultural needs that care workers needed to be aware of. For example, one care plan contained details of how the person liked to celebrate and recognise religious festivals. Another care plan provided information about how the person liked to dress when attending their place of worship.

People's significant relationships were included in care plans, including friendships and partners as well as members of their household. There was clear contact information and information for care workers about how to support people to maintain their relationships.

Although care plan assessments included information about significant relationships, and separately asked

people about how their sexual health needs were met, there was no information about people's sexual orientation within the care files. This was discussed with the registered manager who told us, "We have not come across any customer who has expressed any needs in relation to their sexuality." However, as sexual orientation and sexuality were not included in the assessment, people may not have realised it was appropriate to disclose this information.

We recommend the service seeks and follows best practice guidance from a reputable source on ensuring that people of all sexual orientations are supported equally.

Requires Improvement

Is the service responsive?

Our findings

Relatives told us care workers knew their family members well and provided care that was in line with their needs and preferences. One relative told us, "The carers know how to help her." Another relative told us, "They are working to get it [care] exactly how she likes it."

The level of detail about how to provide care to people varied. Some care plans were highly personalised with detail about how people wished to receive care. For example, one care plan provided detail on the person's preferred routine, products and which aspects of care tasks they should be encouraged to complete independently. However, other care plans lacked detail on the precise nature of support to be provided, informing staff to "assist" with care tasks without detail about what type of "assistance" was needed.

Care workers told us the combination of the information in care plans, feedback from family members and their own experience meant they had the information required to ensure people's needs and preferences were met. However, they acknowledged that the information in the care plan alone would not be sufficient. One care worker said, "There was good information in the care plan. It's not enough that you could just walk in and do it though. You'd have to shadow and ask questions to get it fully right."

The registered manager met with people and their relatives regularly to review their care packages. A relative told us, "It's easy to make changes. Sometimes if we have an appointment they have to come early, and they are very supportive." Records showed that people and their relatives gave feedback about how the package was working and requested amendments or changes to their plans. However, care documentation had not been updated to reflect the change in need. This, combined with the variable level of detail meant there was a risk that people did not always receive care that reflected their needs and preferences. The registered manager told us they were looking into ways of developing their documentation templates to ensure a greater level of detail was captured, but this was not in place at the point of inspection.

The above issues are a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a robust complaints policy and procedure which included expected timescale for response and how to escalate concerns if the complainant was not happy with the initial response. Relatives told us the provider was responsive to feedback although none of them had made a formal complaint. One relative told us, "We're working to get it right. They are listening to me and exploring ways of getting it right." Records showed one complaint had been made and this had been responded to appropriately and to the complainant's satisfaction. This meant the provider responded to people's complaints and feedback and used them to improve their experience of care.

At the time of the inspection none of the people receiving a service had been identified as being in the last stages of their life. The needs assessment included a section where end of life care wishes could be explored, however, in the files reviewed people had said they were not ready to consider this at the time of

the assessment. The provider had a comprehensive policy and procedure about supporting people at the end of their lives. This was based on the best practice guidance identified by the National End of Life Programme and provided clear guidance and structure for staff on how to explore people's preferences and ensure they were supported to live their last stages of life as they wished to. This meant the provider had systems in place to ensure people were supported at the end of their lives to have a comfortable and pain free death.

Requires Improvement

Is the service well-led?

Our findings

Relatives and care workers told us the registered manager was hardworking and supportive. One relative said, "I feel he is trying his best. He is trying to cover every aspect of my relative's care." Another relative told us, "[Registered manager] is good. He comes to see us regularly." A care worker told us, "I think [registered manager] is doing a good job." A second care worker told us, "I think [registered manager] is doing well. He's trying hard. I can drop by the office any time I want. There will be a cup of coffee on the go and time to have a chat."

The provider had previously been part of a franchise agreement with a different organisation. They had left this agreement in 2016 and established themselves as an independent company. As part of this process they had developed a clear business plan. The values of supporting people to live as independently as possible with the same opportunities as everyone else were embedded in the business plan and approach of the provider to care planning and support. The business plan had clear and measurable goals for the development of the service. There were goals for the training of management staff, as well as recruitment of staff and expansion of the number of people supported. The goals were set to ensure that the provider did not grow too quickly in a way that would risk deterioration in the capacity of the provider to ensure quality services.

The registered manager held monthly staff meetings which were attended by all the staff working for the provider. Records showed these were used to discuss current work, training, recruitment and ideas for the development of the service. Following staff meetings the provider had set up two drop in groups for people who used the service to attend outside of their usual care visits. This provided people with social engagement opportunities as care workers had identified that people's opportunities were limited in the community. The provider had supported people to attend a summer barbeque and was planning a Christmas party to celebrate their achievements over the last year. Care workers told us they felt their ideas were valued and acted upon. One care worker said, "I've been to every staff meeting. I don't like to miss them. I think [management team] listen to us. If I need to speak to them they respond. The registered manager respects my opinion 100%." The provider operated a rewards and recognition scheme for staff, including an employee of the month award which was featured on their website.

Two meetings a year were expanded meetings where people who used the service and their relatives were also invited to attend. Staff supported people to attend if they wished. Records showed these meetings were used to discuss development opportunities for the service and social activities that people wanted to be provided. The provider was developing plans to offer a range of different activities outside of their regulated activities.

The registered manager attended a local network meeting for registered managers facilitated by Skills for Care. This gave them the opportunity to network with other providers and learn from best practice examples shared through the forum.

The provider had completed surveys to collect feedback from people and staff. The registered manager told

us they had reviewed this feedback and it had not warranted an action plan as it had been positive. They reflected that the nature of the survey had not generated feedback that they could use to improve the quality of the service. We reviewed the surveys completed and noted that while most of the responses were positive, there were a small number of negative responses that warranted further exploration. The registered manager told us they would incorporate this feedback into their next survey which was not due until March 2018. The registered manager told us the return rate for these surveys had been low and they were also responding to feedback collected through their review process.

The provider's quality assurance approach was based on a combination of face to face reviews and telephone feedback collection. Records showed the provider was collecting feedback from people and their relatives at six weekly intervals. However, although actions were noted as being required in the feedback collected, these had not always been completed. This meant there was a risk that quality assurance systems did not always lead to an improvement in the quality of the service. The provider had not identified the issues with the inconsistencies in care plans and risk assessments found during the inspection.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring quality assurance systems are effective in improving people's experience of care.

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
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans lacked detail on the exact nature of support to be provided and had not been updated when people's needs had changed. Regulation 9(1)(b)(3)(b)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments lacked detail about how to mitigate risk. Regulation 12(1)(2)(b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not have enough staff to ensure people's needs were met. Regulation 18(1)