Larchwood Care Homes (South) Limited

Brookes House

Inspection report

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Brentwood
Essex
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on the 25 September 2017 and the 17 and 19 October 2017. Breaches of the legal requirements were found. This was because there was often not enough staff working at night. Staff did not always support people to move in a safe way and some people told us they were not always treated with dignity and respect.

Brookes House provides accommodation and personal care for up to 70 older people. Some people also have dementia related needs.

A registered manager was 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.

We received mixed feedback about staffing levels. Some people told us there were enough staff available, but a number of people and staff told us that there wasn't always enough staff, particularly at night. We saw that the deployment of staff in communal lounge areas was not always appropriate and staff did not always have time to spend with the people they supported.

Before this inspection, we received information of concern and were told that poor manual handling techniques being used. We observed how staff helped people to mobilise who were unable to do this for themselves. We observed a number of unsafe manual handling practices.

The registered manager made sure that staff had regular training, but even though staff had been given training the registered manager did not always make sure that staff were competent to carry out their role safely.

Overall people and their relatives reported high levels of satisfaction. Although this was the case during our inspection, some people were not satisfied and we received several concerns prior to our inspection that people didn't always receiving a caring service. Front line staff were working well to ensure people's day to day care was good, however, the management team had failed to provide a safe, effective, caring, responsive and well led approach to people's care.

Audits and checks were in place and completed regularly. However, these checks had failed to pro-actively address the concerns we had found, specifically in the area of staffing numbers and the competency of staff in relation to manual handling. There was a lack of oversight based on the observations of the care being provided.

People received their medicines correctly and in line with the services policy and procedures. The dining experience for people was positive and people were complimentary about the quality of meals provided to

them. Eating and drinking was an important part of people's daily life and the staff ensured this was a social occasion.

People were supported to have choice and control, and staff supported them in the least restrictive way possible.

Full information about CQC regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

There was not always enough staff to support people safely at night and the deployment of staff in some communal areas were insufficient.

Staff did not always move and position people in a safe way.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were given training, but the registered manager did not always make sure that staff were competent in their role.

The dining experience for people was positive and people were supported to have enough to eat and drink.

The registered manager and staff understood the legal requirements of the Mental Capacity Act 2005 and had made applications to deprive people of their liberty.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people and relatives told us staff were caring, whilst others did not. The management team needed to ensure that a caring service was provided to all people regardless of their needs.

Most staff treated people with dignity and respect, but some people told us that staff did not always talk to them in a polite and respectful manner. This occurred mainly at night.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people told us they could not always have a bath when they wanted to.

People were supported to enjoy and participate in social activities.

There were processes in place to deal with any concerns and complaints appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

The quality assurance system was not robust enough to identify and address the concerns we found. Further improvement was required to make sure that the quality of the service continued to improve.

The registered manager understood that the staffing numbers were too low at night, and had failed to proactively address the issues.

Brookes 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 during the day of the 25 of September 2017, and the 19 October 2017 and the night of the 17 of October 2017. On the 25 September 2017 the inspection team consisted of two inspectors. On the 17 October 2017 the inspection team consisted of four inspectors, and on the 19 October 2017 the inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for older people and people living with dementia. The inspection was unannounced.

This inspection was partly prompted by a number of concerns raised with us which may have had a serious impact on the person (s) using the service. This information indicated potential concerns about the management of risk in the service. While we did not look at the circumstances of the specific incident (s), which may be subject to a criminal investigation, we did look at the associated areas, relating to risk management, manual handling, staffing levels, governance and management oversight. Four inspectors carried out various observations throughout the service both at night and during the day.

Prior to this inspection, we reviewed the information we held about the service including safeguarding alerts and other notifications. This refers specifically to incidents, events and changes the provider and manager are required to notify us about by law. The CQC had been made aware of injuries possibly sustained at the location. These incidents have been brought to the local authority and the police attention who are conducting their own investigations. We will report on the outcome of these investigations once they have been concluded.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with sixteen people who used the service, fifteen members of care staff, six relatives, the registered

manager, and the deputy manager. The regional manager was also present.

We reviewed twelve care plans and twelve staff files. We also looked at the service's arrangements for the management of medicines, complaints and compliments information and quality monitoring and audit information.

Inadequate

Is the service safe?

Our findings

Prior to the inspection, we received information of concern regarding the safety of the administration of medicines, low staffing levels, particularly at night and poor manual handling techniques. We found that people had received their medicines in a safe way, but found staffing number's needed to be increased and staff needed to improve how they supported people to mobilise safely.

People's comments about staffing levels were variable and some people felt that there were insufficient staff available to meet their needs. Out of the 16 people and three relatives we spoke with; six people and one relative said they felt more staff were needed. Typical comments were, "It's good in the daytime but not always at night; I call for help with the toilet, sometimes I am busting, on two occasions I have had accidents waiting for help." And, "If you ring they will come and say they will be back but it can be a long wait." Another person said, "I avoid using the bell as I know how busy they are." Alternatively other comments were, "Care here is first class, the carers put their heart and soul into it." And, "The care is good and staff on the whole are good."

Seven members of staff told us that staffing levels were not always maintained and would benefit from being increased. Typical comments were, "The staffing is bad, to be honest with you there could be more. They are recruiting but I will probably be leaving soon." And, "Some people need more one to one time and there just isn't always the time;" And "Sometimes at night there are not enough staff. Some staff are just 'names on a rota' and then you have new staff that start and they don't even stay the week."

Staff told us that because of some people's dementia their care and support needs increased at night. One staff member said, "During the day [Name, Name and Name] sleep all day but as soon as night comes, it's a different story. Lots of people here just don't sleep at night."

Before this inspection, concerns were raised that there were not enough staff working at night and that it was common for only two members of staff to be assigned to each floor. We were told that some people needed two members of staff to assist them, and that when two members of staff were assisting one person that other people would have to wait if they needed help. We looked at the last three months rotas and found that during the day staffing levels were generally consistent, however at night there were many occasions when there were only two people working on each floor. One person explained, "They do the best they can with not enough staff. There is not enough during day and night. If someone is taken ill and it takes two people to care for them then there's only one left, you do the maths."

Observations showed that the deployment of staff was not always suitable to meet people's needs and we found that communal lounge areas on the ground floor were frequently left without staff support. For example, one communal lounge was left without staff support for a period of 30 minutes. After this time a staff member came in but just to ask a service user if they could borrow his matches. This person said to the member of staff, "I will lend you my matches, if I can have my medication."

One person had been left in a lounge on their own without access to a call bell. They were unable to

mobilise independently. The nearest call point was on the far side of the lounge. They said, "No, I have no buzzer, for some reason they put it on the far wall. I'd like the thing moved to this side. Usually there is someone going past if I need help, only occasionally you have to wait." Another person said, "The buzzer sometimes seems a long time, I would like a quicker response."

The measures that the registered manager used to determine staff deployment and numbers were not adequate to ensure people's needs were met. Calculations of people's dependency were carried out to determine the deployment and number of staff. However these had not proved effective. These tools had not picked up that people's needs were not being effectively and safely met. It did not take into account the layout of the service or the changing needs of people at night. A number of people and staff told us that staffing numbers were not consistent and that there was not always enough staff to meet people's needs and preferences.

The registered manager explained, "My dependency tool says I have enough staff to meet people's needs, but it doesn't take into consideration the staff that you have. Not every staff member has the correct skills and abilities. It also doesn't take into consideration the environment. I need seven staff to cover the day and at least six at night." Despite the registered manager knowing that the service required more staff, the staffing levels during the three months prior to the inspection was not increased or consistently maintained. On the last day of the inspection the registered manager told staffing numbers had been increased. Following the inspection the regional manager informed us that staffing number had been increased two days earlier.

Accidents and incidents had been recorded and copies were kept in each person's care records and in a master accident file. Each report detailed information about the person who had the accident, where and when it occurred, and what caused it. We noted high number of accidents and incidents had occurred at night. Whilst the registered manager completed a review of the accidents that had occurred, they did not consider that a possible reason for this may be because of the inadequate lack of staffing provision particularly at night. One person told us, "If you wake up and want to go to the toilet the night staff don't hurry. That's how I fell twice getting out of bed in the night."

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

Before this inspection, concerns were reported to us that staff were not helping people to mobilise correctly. We observed how people were supported to mobilise and how staff moved people who were unable to do this for themselves. We observed six unsafe manual handling occurrences. For instance, during the evening inspection we observed two night carer staff help someone from the chair to their frame. A staff member stood either side of this person and pulled them up under their armpits. This is not a recognised technique for supporting people to stand and places them at a risk of injury to their shoulders. We saw staff assist a person in a wheelchair. The person placed both hands on the walker to stand up. The staff member put their arm under the person's armpit to lift them up, and when they sat down this person was seen to be distressed. From our observations and the information that we received prior to the inspection it was clear that unsafe moving and handling practices were routinely used which placed people and staff at risk of potentially serious injury.

Overall, most people's information in relation to risk was up to date. Risk assessments had been carried out when people had bed rails in place. However, one risk assessment was not as up to date as it should have been. The person had recently dislocated their shoulder but despite a fracture care plan being added the information contained inadequate guidance for staff to follow. For example, the care plan lacked detailed

information about how to support the person with their activities of daily living. There was no additional information for staff to know how to move and transfer this person in a safe way. There was no detail providing with staff with guidance about how they would need support them to eat or dress with restricted mobility. The care plan simply stated to support this person in a very gentle and careful manner. We found that some staff were aware of the person's injury but were not confident about how to support them in a safe way.

Safety checks were in place which looked at ways to reduce harm to people living at the service. The registered manager had completed a fire risk assessment, but a number of areas for improvement were still outstanding. For example, all bedroom doors needed to be replaced due to excessive gaps. Air vents needed to be installed into the lift motor room, and fire doors needed to be updated. We observed staff wedging open fire doors. We also found a trip hazard in the lift. We spoke with the registered manager and they assured us they would take swift and robust action to address these issues.

These failings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before this inspection, the provider had notified us of a problem obtaining medicines for people. We reviewed all the information related to the omission of medicines and found that the provider had followed their usual procedures for the ordering of medicines and sent requests to the pharmacy at the appropriate time. Following the completion of an investigation into this issue, it was established that people were not put at any significant risk. People's prescribed medicines had been delivered in blister packs and were administered as prescribed.

At our previous inspection in November 2016, we found that the recording of administration of some emollient and topical creams was not being completed to a sufficient standard. At this inspection, we found that the recording had improved.

Staff had received the necessary training in medicine administration and competency checks had been completed. Medicines were safely stored and administered from a lockable trolley and were returned and disposed of in a safe way. When we undertook an inspection to the service at night, we found a medication trolley which had been left unlocked. We immediately spoke to the member of staff about this. Sometime later we found that the same trolley had been left unlocked again. We recommend that the service provides further training to staff, based on current best practice, in relation to the safe storage of medication.

The décor in some areas of the home was tired and some of the doors had chipped paintwork, but a number of people, told us they liked living at the service. We spoke with registered manager and they told us that there were plans to improve the décor and redecorate some aspects of the environment.

We recommend that the registered manager consult with people to ascertain their preferences around the decoration of the environment and include best practice around creating dementia friendly environments.

People were kept safe from the risk of harm and potential abuse from staff who had received appropriate training. Staff knew how to recognise and report any suspicions of abuse. Typical comments from staff were, "I would go to my manager and report it straight away or go to CQC." Staff knew how to whistle blow and told us without exception that they would have no hesitation in contacting the CQC if they had concerns that people were not being cared for in a safe way.

Systems and processes were in place for the safe recruitment of suitable staff. Information inspected on the

recruitment files for four members of staff showed they had completed an application form, provided a full employment history and eligibility to work in the United Kingdom was checked. The registered manager had also undertaken a Disclosure and Baring Service Check (DBS) on all staff before they had started work. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal records and whether they are barred from working with people who use health and social care services.

Requires Improvement

Is the service effective?

Our findings

Staff told us they had regular training and were encouraged to complete nationally recognised qualifications. However, after staff had been trained the registered manager had not checked to make sure that staff were competent to carry out their role in relation to manual handling and dignity and respect. For example, we observed a staff member supporting a person to walk to the dining room using a frame. The person was being supported to use the frame using an incorrect technique. They lifted the frame up in the air pointing it forward before bringing it back down on the floor. This meant that this person was unsupported by frame and potentially off balance. When we spoke with the registered manager they said, "We are planning to do more observations but at the moment observations are done informally."

We recommend that the service finds out more about training staff, based on current best practice, in relation to moving and handling and ensures staff are competent to carry out this task.

Newly employed staff received a comprehensive induction which included an 'in-house' orientation and the care certificate. With the exception of one staff member, they spoke positively about the registered manager and told us they were well supported. Staff confirmed that they received regular supervision and appraisals. Records we reviewed confirmed this.

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. 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.

People can only be deprived of their liberty so that they can 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. Where people were deprived of their liberty, the provider had made appropriate applications to the Local Authority for DoLS assessments to be considered for approval.

People were observed being offered choices throughout the day and these included decisions about their day-to-day care needs. People told us that they could choose what time they got up in the morning and the time they retired to bed each day, what items of clothing they wished to wear, where they ate their meals and whether or not they participated in social activities.

People were positive about the meals provided. Typical comments included; "The food is quite nice," "it's fine, I enjoyed it," and "Beautiful." The dining experience of people was positive. We saw that people were not hurried and for those that wanted to remain at the table they were able to do so. Staff encouraged people to eat at their own pace and demonstrated a good understanding of people's eating and drinking

requirements.

People were supported to make daily choices from the menu provided and received food in sufficient quantities. Where people required assistance and support to eat and drink this was provided in a sensitive and dignified manner. People were routinely offered a 'second helping' and people were asked if they had finished their meal before the plate or bowl was removed.

People told us that their healthcare needs were well managed. Relatives confirmed that they were kept informed of their family members healthcare needs and the outcome of appointments. People's care records showed that their healthcare needs were clearly recorded.

District nurses told us that people's healthcare needs were met but that they had concerns regarding staffing levels. One nurse said, "When the staffing levels are good and the usual staff are around we have no issues. On other days the staff seem to be very stretched and it can be difficult to find competent staff."

Requires Improvement

Is the service caring?

Our findings

Comments about caring nature of staff were mixed. Some people and their relatives reported very high levels of satisfaction, but this experience was not shared by everyone who lived at the service. Five people told us that that they had not always experienced a caring service and we received information prior to our inspection that people may not have always been cared for in a kind and compassionate way. Whilst some care staff were working to ensure people's day to day experience of care was good the management team had failed to provide a safe, effective, responsive and well led approach to people's care.

Some people and their relatives told us they were satisfied and happy with the care and support they received. One person told us, "Some staff are very friendly and helpful, they talk to you." Another person said, "They do a wonderful job given how short-staffed they are." A relative said, "It is absolutely brilliant and there is always someone I can go and talk to. I've got nothing but praise." Another person said, "They are very kind, I have not had any problems with staff."

We observed that staff interactions with people were positive and the atmosphere within the service was calm. We saw that some staff had developed meaningful relationships with people. For example, in one of the lounges a person was crying and a member of staff knelt, stroked their arm and distracted them with the suggestion of a cup of tea. Time and kindness was shown. We saw another staff member assisting someone with their hearing aid and this was done in caring way. A relative said, "It is absolutely brilliant and there is always someone I can go and talk to. I've got nothing but praise."

We saw staff asking people how they wanted to spend their time. A staff member knocked on someone's bedroom door and said, "Hello, are you still in bed, it is lunchtime now, are you hungry, do you want to get up."

Staff were able to verbally give good examples of what dignity meant to them, for example, knocking on doors, keeping the door and curtains closed during personal care and providing explanations to people about the care and support to be provided. We saw staff respected people's privacy and dignity. Staff knocked on people's doors before entering used the term of address favoured by the individual. Another person said, "The care here is first class, the staff put their heart and soul into it, they show respect and lean down and talk to you, they have empathy."

People were supported to maintain relationships with others and staff told us that people's friends and family were welcome at all times. Relatives confirmed that there were no restrictions when they visited and that they were always made to feel welcome.

Requires Improvement

Is the service responsive?

Our findings

We found that some of the systems in place did not always encourage staff to provide people with personalised care. For example, we found a number of bathing routine charts. The registered manager explained that not all staff had always wanted to help people to have a bath or shower and that they had tried to incentivise staff to encourage them to give people more baths. Whilst we acknowledge that incentivising staff is positive, this practice was not indicative of staff allowing people to exercise their personal choice and control over when they wanted to take a bath or shower. One person said, "Bath, I would have liked one this morning but did not feel up to it, I get two a week. I ask and they normally fit me in, but I would like one every day."

We received mixed feedback from people about the amount of control they had over when they went to bed and when they got up. The majority of people told us that staff were flexible to their needs. One person said, "I can stay in bed if I want to, I have never been made to get up. If there is a good program on, I can stay up and watch it. Sometimes I go to bed at 21:30, I just tell the staff." However another person told us, "They don't like it when you stay up, they try to get you to bed by nine. I don't want to go I am not a child."

A programme of social activities was planned each week and this was on display. Everybody with the exception of one person said they were satisfied with the activities on offer. One relative said, "The staff are good and activities. They sing songs and play bowls." One person told us they wanted to be assisted to go out and access the community more. They said, "Staff are rushed and they tell me that they are short staffed. More staff would be helpful and give able bodied people like me a chance to get out and go to the town, if I had the chance."

We were told that the choice of activities was flexible and this could be changed to accommodate people's choice and preferences. People confirmed that they had a choice as to whether or not they participated in social activities. One person said, "Last week, four men came into entertain us, playing violins and such. That was very interesting, and of course we have bingo." A relative said, "Essex County Council Theatre Group came and worked with the residents and made up this song. It is going to be performed on 23 October. It is something really positive for the home and the residents are enjoying this."

Care plans were regularly reviewed and evaluated and people's needs were assessed before they moved in. Following an initial assessment, care plans were developed detailing the care needs and support, actions and responsibilities of staff. Each person's care record contained a social profile, whereby information had been collected with the person and their family and gave details about the person's life history spiritual needs and previous lifestyle choices. Information contained details of people's individual daily needs such as mobility, personal hygiene, nutrition and health needs.

People were aware of the complaints policy but had not made a complaint. We noted the registered manager had received a number of compliments about the service. One person told us, "I have never needed to make a complaint, I like living here." When complaints had been made action had been taken to address the area of concern.

Requires Improvement

Is the service well-led?

Our findings

A number of audits and checks were in place which had been completed regularly and there were structured mechanisms for reporting to the senior managers within the wider organisation. However, these checks had failed to address the concerns we had found. Specifically, in the area of staffing numbers and the competency of staff in relation to manual handling. There was a lack of oversight based on observations of the care being provided.

We also found that where there had been cultural issues in the service, such as, staff not always treating people with dignity and respect. Not enough had been done by the manager to address this and ensure people were receiving a good service. For example, the registered manager failed to recognise the staffing issues in the service and the assessments they used had not robustly addressed the issue. Although we were assured that staffing levels had been increased by the last day of our inspection, had it not been for our visit, we could not be assured that this would have changed for people.

At our last comprehensive inspection, on the 1 and 2 November 2016 there were breaches of regulation due to inadequate staffing levels. We carried out a focussed inspection on the 18 May 2017 and found that improvements had been made. However despite previous assurances made that staffing levels would be maintained, the provider had failed to do so.

The operational manager, registered manager and a number of staff told us that the service had experienced a number of staffing difficulties. It became clear that two competing staff groups had developed a divide and the registered manager told us they spent a lot of time managing these strong group dynamics. One relative explained, "I don't listen to gossip, but it used to be a bit like 'us' and 'them' with some staff and management. If staff try and moan at me I tell them they are speaking to the wrong person. I don't listen to it and I don't get involved."

Some management processes encouraged task focused care because the registered manager incentivised staff with rewards for doing tasks rather than incentivising staff to care for people in a person centred way. For example, the registered manager promoted a competition between staff members to earn a gift for completing certain care tasks. The registered manager explained to us that staff could be reluctant to complete these care tasks so they had introduced an incentive scheme. This created a further continuation of some poor staff behaviours and was not to the benefit of the people.

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

Some handwritten information in some people's care plans, which also included a current investigation into an on-going complaint, was illegible. We recommend that the registered manager reviews the information being recorded and ensures that handwritten information is legible enough for people to understand it.

Services that provide health and social care to people are required to inform the Care Quality Commission

(CQC), of important events that happen in the service. The registered manager did not always report accurately to CQC about events that had happened. Before the inspection the registered manager had notified us that the heating system in one of the bedrooms had broken down. Upon further investigation, we found there were other serious concerns surrounding this incident which we should have been informed of. Whilst the registered manager had notified us of the heating system breaking down, they had not been completely open regarding the additional aspects of this incident.

Regular meetings were held with people who used the service, their relatives and staff. Minutes of recent meetings showed that where concerns had been raised, these had been discussed.

Relatives and staff had positive comments about the management of the service. Staff were clear about the registered manager's and provider's expectations of them and staff told us they were well supported. Comments from relatives included, "The manager here is very friendly and approachable."

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 12 HSCA RA Regulations 2014 Safe care and treatment The care and treatment of service users must be appropriate, meet their needs, and reflect their preferences. Ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

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 17 HSCA RA Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance with the requirements.

The enforcement action we took:

Issue positive condition

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this regulation.

The enforcement action we took:

Issue Positive Conditions