Osmaston Grange Limited

# Osmaston Grange

**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** |

## Overall summary

Osmaston Grange is situated in Belper in Derbyshire. The service is provided within two separate buildings. The older building is used for residential care for up to 40 older people. The new building accommodates up to 24 people with nursing needs on the upper floor and up to 11 people with dementia on the lower floor. A total number of 80 people can be accommodated at this service. On the day of our inspection a total of 66 people were in receipt of care at Osmaston Grange.

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 found that there was not always enough staff available to meet people's needs and individual preferences.

Systems in place had not identified what staff needed to do when medicines were found to be out of stock. This meant that people were at risk of not being given specific medicines such as pain relief when they needed it.

# Summary of findings

People and their relatives told us that people were safe at Osmaston Grange and were protected from abuse. Staff had a good understanding of how to protect people.

We found safe recruitment practices were in place to protect people using the service from unsuitable staff and training was provided so that staff were able to improve their knowledge and skills to provide care for people.

People and their representatives were involved in issues of consent and for people who lacked mental capacity under the Mental Capacity Act 2005 and Deprivation of Liberty; measures were being put into place to ensure that the appropriate legal requirements were being applied. Staff demonstrated an understanding of the relevant requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. This is a law that protects people's right to consent to care and treatment and to their freedom.

People told us that they received care provided by staff that were kind to them and knew their individual needs well. We saw that people were supported to make decisions about their care and welfare because their risks were identified, managed and reviewed. People were provided with an individual care plan which set out their care needs. We saw people and their families were involved in their care planning and when people were unwell healthcare professionals including community nurses, hearing specialists and doctors were contacted. Staff understood people's support needs.

During the meal time we found that staff supported people according to their needs. People were provided with sufficient food and drink to meet their nutrition and hydration needs.

People told us that they knew how to raise any concerns they had and a complaints policy was in place. We saw complaints were investigated and recorded with actions taken where necessary.

The registered manager communicated with people using the service their visitors and family members. Staff received communications through staff meetings, supervisions and daily contact with the registered manager. A quality assurance system was in place to monitor the care provided at the service although staff told us that they did not always feel supported.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which correspond with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what actions we told the provider to take at the back of the full version of the report.

# Summary of findings

## 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 consistently safe.

Staff were not always available at the times that people needed them.

People's medicines were not always available because staff had not acted when medicines were out of stock.

People were protected from the risk of abuse. Incidents were managed appropriately and people told us they felt safe in the service. When accidents occurred they were treated promptly and advice for treatment was sought from health professionals when required.

**Is the service effective?**

Good 

The service was effective.

People who lacked capacity were protected under the Mental Capacity Act 2005 and staff worked towards meeting the requirements of the Deprivation of Liberty Safeguards.

Staff had received the appropriate training and support to carry out their roles, in order to meet people's needs.

People were supported to eat and drink sufficient amounts to maintain their health. When their health needs changed referrals were made to healthcare professionals and additional support or interventions were used. This protected people from risks in relation to their healthcare.

**Is the service caring?**

Good 

The service was caring.

People told us that staff were caring and helpful, and when they received care and support staff demonstrated that they respected their privacy. People were involved in decisions about their care.

People were supported to maintain relationships important to them. Visitors were told that they could visit when they wanted to and were encouraged to help their relative at meal times.

**Is the service responsive?**

Requires Improvement 

The service was not consistently responsive.

People told us that although staff were supportive when there was not enough staff it was difficult to have their needs met at the times and in the ways they preferred.

People were encouraged to take part in social activities of their choice.

# Summary of findings

People told us that they knew how to raise concerns and records showed that complaints were dealt with appropriately. This meant people were supported to raise concerns and knew they would be acted on.

**Is the service well-led?**

Requires Improvement 

The service was not consistently well led.

The provider had a system in place to monitor the quality of the service although staff told us that they did not always feel supported.

A registered manager was in place at the service. They were clear about their role and the actions they needed to take to develop the service.

# Osmaston Grange

**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 17 December 2014 and 13 January 2015 and was unannounced. The inspection team consisted of two inspectors.

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 also reviewed information we held about this service. This included any notifications. Notifications are changes, events or incidents that providers must tell us about.

We contacted the local authority and the Clinical Commissioning Group (CCG) who fund some people's care at the home. We asked them for information about the quality of service provided.

We spoke with ten people using the service, six relatives and friends, and three visiting professionals. We spoke with eight staff including the clinical lead responsible for nursing care, the registered manager and the provider. We reviewed the records of four people with residential and nursing care needs and three staff records. We looked at a range of documents in relation to the management of the service. We used a Short Observational Framework Inspection (SOFI) and made general observations of people during their day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

# Is the service safe?

## Our findings

People who spoke with us told us that staff were 'good at their jobs' and 'supported them' when they needed it. We observed care during the day in different parts of the service and found staff to provide care that was safe. This included observing how people were transferred safely using the hoist and standing aids provided. We saw that call bells were responded to and staff were present in the communal areas.

The provider used a tool that identified people's assessed dependency needs and the numbers of staff needed were based on this. This showed that four or five staff were the recommended minimum staffing levels during the time that the staff rota was devised as this was produced in advance. However, since this time an additional five people had begun to use the service and the staffing rota had not been adjusted accordingly. This meant that the current staffing levels at the time of the inspection was not sufficient. In addition, staff we spoke with told us that staff absences were not always covered although a senior member of staff was available on call when needed. Staff rotas and time sheets showed us there were six occasions between 19 December 2014 and 18 January 2015 when the rota for the residential part of the service had worked below the provider's recommended staffing levels. Half of these occasions had been during the weekends when additional management staff had also not been at the service.

Staff spoken with and the staffing rotas identified that in these instances staff covered additional shifts, and worked for example double shifts. However, they also told us that they could be taken off a shift, for example a late shift so that they were available to work the night shift instead. This had, on occasions resulted in reduced staffing levels on the late shift.

In January 2015 we received information of concern about staffing levels. It was reported that staff numbers were low at weekends and staff sickness was not always being covered. During our inspection staff told us that this increased the likelihood of people having injuries due to falls as they were not available to monitor people's safety, and people were having to wait longer to receive care.

Staff told us that sometimes they did not get a break when they had to work with four or less staff, or if they were the person in charge of the shift. This was because they had additional duties whilst working in this role.

Staff told us that because of shortages it was not always possible to deliver care that met people's individual needs and preferences. Staff told us that they had to rush and this resulted in people missing out on basic care. They told us they became less efficient as they were not able to take their breaks to give them a needed rest. One staff member told us; "When new people are admitted to the service it makes it harder as you have to get to know people first before you can meet their needs properly."

Staff told us that they worked additional shifts when they were able to do so. Agency staff were not used except for nurse cover. The manager told us more staff were being recruited.

We did however observe an occasion when people were kept waiting for assistance to be moved before the mid-day meal as other people's personal hygiene needs were being attended to. Prior to a meal time the senior care worker gave out medicines that needed to be given. We saw that they returned to help take people from the lounge area to the dining area of the service. We observed when the senior assisted at meal time people's medicines were delayed because of this.

We found people's assessed needs were not always met by ensuring that enough staff were available to meet their needs.

One person told us "Staff are usually pretty good but if they work short of staff we all have to wait longer for care." Another person commented about staff making last minute changes because of changes in the staffing levels on the day. They told us this could result in having to wait longer for personal care to be delivered such as waiting in a wheelchair to be moved to another part of the service or of cancelling planned events such as baths. The registered manager told us staff should always explain if a change had to occur and to offer a suitable alternative as soon as possible.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 18 (1) Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service safe?

In the staff files we looked at we found the required safety checks had been completed before new staff worked at the home. This was to ensure staff were of good character and suitable to work with people who used the service.

People who self medicated using inhalers told us that they were monitored by staff so that they could manage their own medicines safely. People told us that they received their medicines on time. We found that the service did not consistently follow safe practice around ordering, checking and obtaining medicines. There was no record of the 'as required' medicines brought forward from the previous month. It was therefore not possible to check the amounts in stock. This meant people could run out of their medicines

Prior to the inspection the local authority received a safeguarding alert about this location. It stated that two people had not received some of their medicines for up to four weeks. These included 'as required' medicines for pain management and to reduce anxiety. They found that people may have experienced discomfort and distress as a result.

We checked medicines and found that staff had not acted when medicines were out of stock. The provider did not have a contingency for this eventuality. There were no written protocols in place for 'as required' medicines. Staff had no guidance on when to give people these medicines. This was discussed with the registered manager and before we left a form was produced for this. This could result in an inconsistent approach from staff and people not getting their medicines when they needed them.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment of people's medicines.

People told us they felt safe and listened to. They told us that they were able to speak to the staff and manager if they had any concerns. One person said, "I'm comfortable here as I have a room that I like and I feel safe here as I can ask for help when I need it." People in their bedrooms told us that they used the call bell system to summon help when they needed to and staff attended to their needs.

Visitors we spoke with told us that they thought their relatives were safe at the service. One relative told us, "Staff are good, I have no concerns." Another visitor told us "Staff are around when [my relative] needs them I see them in the lounge areas or nearby."

For people with behaviours that challenged others, we saw staff managed these situations in a safe way. They would approach the person calmly and use distraction techniques to reduce the behaviour that distressed them or put themselves or others at risk of harm. People were referred for professional assessment at the earliest opportunity.

We were told that physical restraint was not used and staff told us they would gently guide the person away from a situation. This showed that the least restrictive way was used to reduce behaviour. We saw bedrails were used following an assessment to identify the risks of not having them. Staff had reduced the likelihood of people having falls through the use of bedrails and pressure sensor mats at night, and observations during the day when the people were in the lounge sitting with other people.

Procedures were in place to ensure concerns about people's safety were appropriately reported. Staff we spoke with explained how they would recognise and report abuse. We saw that suspected abuse was reported in accordance with the local safeguarding adult reporting procedures.

Risks to people's safety were assessed, managed and reviewed. Where risks had been identified, management plans were in place to provide staff with the information they needed to keep people safe and reduce the likelihood of harm. For example, one person was at risk of choking and was able to continue to eat meals independently with staff members seated at their table at meal times to help and support them when needed, in order to keep them safe.

Staff responded appropriately when people were at risk. For example, should people who were not always steady on their feet get up and walk unaided in the lounge, we saw that the staff member present would provide them with appropriate support to ensure they were safe.

We saw that when incidents occurred they were reported and investigated appropriately. Staff told us they received handover meetings and changes to people's care records were made to reduce further incidents.

Requires Improvement

# Is the service safe?

When medical emergencies took place staff told us they were able to deal with them and to seek appropriate advice and assistance when required. In the care records we looked at we saw that people's illnesses, accidents or injuries were reviewed in order to reduce the risk of further incidents of a similar nature from occurring again.

Good

# Is the service effective?

## Our findings

People were encouraged to make choices about their care and support. One person told us they liked to sit with someone who they could talk to and that staff made an effort to meet this need. Another person they told us that they had a hearing aid but did not always choose to wear it and staff respected this decision.

We saw that people who were able to were encouraged to keep some of their own medicines this included the use of inhalers. We saw risk assessments were in place to help the decision process for this.

Some people had made decisions about receiving active resuscitation in the event of an emergency. We found that one person's 'do not actively resuscitate' (DNAR) orders did not follow current guidance. This was because it had not been reviewed and updated following their return from hospital and therefore this was not a valid document. Staff spoken with did not fully understand current guidance and this meant there was a risk that consent to care and treatment may not always be sought in line with legislation. The registered manager told us that she would ensure this person's records and others were reviewed by staff.

A new admission form included the checks made for copies of DNAR forms and information about who could act on the person's behalf when the person lacked capacity to do so for themselves. A copy or record of the documentation for people who needed a Lasting Power of Attorney was being requested from relatives. Family representatives confirmed this.

Staff we spoke with were aware of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA sets out how to act to support people who do not have capacity to make specific decisions about everyday things like what to wear or more important decisions like agreeing to medical treatment. DoLS are legal protections for people who need to have their freedom restricted to keep them safe.

The registered manager told us that work continued in the area of mental capacity assessments and reviews around issues of consent to meet people's needs. She told us on a practical every day basis people were offered choices. She also told us the community matron was helping staff at the service with their skills, knowledge and record keeping in areas of consent, best interest assessments, and the Deprivation of Liberty Safeguard (DoLS) assessments. She said that people assessed as being most at risk were in the process of having Mental Capacity Act 2005 (MCA) assessments completed.

People told us that they were supported by a staff team that was able to meet their needs. Visitors told us that staff knew what to do for their relatives. One visitor told us "When my relative is not well staff will contact me and the doctor is asked to see them." Another visitor told us "When [staff member] is on duty they always attend to my relative's needs it's great because they seem to get on well together and it works."

Staff told us they worked with experienced staff when they first started working at the service. Staff received induction training followed by additional training including a nationally recognised qualification in health and social care. This meant they were made aware of expected standards in order to meet people's needs and were kept up to date with best practice guidance. They also received supervision from their line manager which meant they could discuss their learning and development needs.

People told us they were provided with meal choices and regular drinks were offered to them. We observed people to ask for specific drinks which staff made available to them. When there were identified concerns about people's weight, further monitoring took place in order to ensure that people received the care and support they needed. We saw that people who were prescribed food supplements were offered these in between meal times.

As part of our observations we saw that people were supported to eat and drink in a way that met their individual needs. There was a kitchenette where staff made regular drinks for people. People were encouraged by staff to eat at a relaxed pace. People told us that the food was plentiful and that the meals were enjoyable. For people supported in their bedrooms staff provided them with the assistance they needed whilst the remaining staff supported people in the dining rooms.

We spoke with visiting relatives of a person with additional dietary support needs. As regular visitors they were satisfied with the care provided, saying "My relative eats everything given to them but we have noticed [they] do not

Good

# Is the service effective?

drink very much. Staff listened to our concerns and the doctor was asked to visit. This is to make sure [our relative] has no swallowing difficulty and if they have appropriate help will be provided."

People's nutritional needs were clearly defined. Where people were at risk of poor hydration or nutrition, food and fluid charts were in place to record the daily input. Staff told us the charts helped them to form a judgement when deciding to seek medical advice.

Family visitors told us how helpful staff were because they contacted health professionals in a timely manner. One visitor told us, "My parent is treated with respect and when they are unwell staff will let me know and the doctor is asked to see them."

When people's health needs changed early referrals were made to other healthcare professionals and additional support or interventions were used. This protected people from risks in relation to their health care. Assessments were included in the care records to monitor changes in a person's health needs. A nutritional score assessment was in place to determine people's dietary needs. People were referred to the speech and language therapists when potential problems with swallowing were identified by staff at the service.

We saw evidence that staff sought advice and intervention from a wide range of external professionals including doctors, chiropodists, the falls prevention team or dieticians. We spoke with a healthcare professional. They told us staff offered to stay with them during the visit to make sure the person was put at their ease before the examination took place. Records showed that advice provided by healthcare professionals was included in the person's care plan and acted upon.

Good

# Is the service caring?

## Our findings

People and their relatives told us that they were satisfied with their care because staff were caring. One person told us, “Staff always remembers to close my door when they give me personal care and this protects my privacy.” When I am in bed I have constant access to the call system and staff remember to place my television controls within my reach. Staff are quite considerate.” Another person told us, “Staff always do their best to help me.”

We observed positive engagements between staff and people using the service. Staff told us how specific people wished to be supported and what they needed to do when supporting particular people. A staff member told us “[One person] cannot wash themselves all over but they can wash certain areas and we respect and encourage that.” We saw one person who went out with their visitor for the day. This helped them to maintain their relationship.

People told us they were offered choices this included being asked what they wanted to wear, where to sit, who they wanted to sit with, meal preferences and when they wanted to go to bed. We saw there were open visiting arrangements. This meant they could see their visitors when they wanted to. There were areas within the service where people could see their visitors in private. People told us it helped to make them feel they had some choice, control and independence within their own environment and day to day lives.

People told us they were involved in their own care. For one person this meant planning when they went out with their family and friends. For another person this was about making a decision about the programme they wanted to watch on the television in their bedroom.

We spoke with a family visitor who told us they were involved in their relative’s care planning. People’s personal history and preferences were included. The care records we saw confirmed our observations. People told us they could access their records if they wanted to. People told us they were listened to and they felt respected. The provider information return told us, ‘We have a responsibility at all times to ascertain and take into account the wishes and feelings of residents. All staff should encourage and help residents to make decisions about their care.’

The provider told us information about advocacy services was available for people who needed the help of an independent person to help them to make decisions about their life. We saw that support for people to access this service was available when needed.

People’s needs for privacy were considered as staff delivered people’s individual care. For example, when staff went to assist a person with personal care they shut the door behind them. They told us this was to ensure the person had privacy during this time. We observed care workers to knock on people’s doors and waited for a reply before they entered. When staff spoke with people they spoke with them in a way that they would understand and at their own pace. People were treated with kindness and compassion. Staff responded to each person in a caring and reassuring way.

Communications between staff about different people’s care could be over heard in a public place within the home. We gave our feed back to the registered manager who told us that they would review where staff received their communication between the shifts so that no one’s confidentiality would be breached.

Requires Improvement

# Is the service responsive?

## Our findings

One person told us if they were short of staff they had to wait longer for help this included being taken to the bathroom, the dining room for meals or to their bedroom. People did not always receive person-centred care. For example before a mealtime people were taken to the bathroom facilities off the lounge area. They were returned to the lounge area where they were expected to wait for another staff member to take them to the dining room. We observed care that looked disjointed and not always personalised to meet people's individual needs when they needed it. On the dementia floor staff told us if people were unable to ask for support, due to communication difficulties, they observed them for changes in their behaviour and used this to determine what support they required.

People were able to express their views for their preferences of bed times or rising times. People were offered baths during the week but one person told us the time of the day was decided by staff to fit in with their routine and baths could get cancelled by staff at short notice. However, they saw this as a 'one off.' Staff told us that when they were short of staff they took shortcuts to meet people's general needs this included people having to accept a wash and not a planned bath. This showed people had a lack of control over their lives. The registered manager told us this was not acceptable and would expect the person to be offered their bath at the earliest opportunity or the following day.

For people in bedrooms a radio, television or magazines were provided to entertain them. They told us that if the service was short of staff they found fewer visits were made and they would have to wait longer for a support.

People had a care record where their needs were assessed and a plan for the delivery of care was included. People's care needs were reviewed and evaluated at regular intervals. We saw that when a person had regular falls a referral was made to the falls prevention clinic for further assessments and the care records up dated with any actions needed. We spoke with families who told us they were involved in the process They told us staff would keep them informed when their relative's needs changed.

Notices were displayed within the home informing people of forthcoming entertainment events. On the evening of our inspection a film was arranged. People and their visitors told us that families and friends visited and were made to feel welcome by staff. A visitor told us that there were a variety of activities that took place. Staff told us when entertainment took place at the home if a person did not want to participate or they found the experience stressful staff would take them to somewhere that they found peaceful.

Staff told us activities were based on people's preferences. For example talking and reminiscing with each other and with staff, arts and crafts and group activities. We saw a record of the activities were included in people's daily notes. We saw photographs around the service where people were encouraged and supported to join in activities.

People were able to have their meals in their bedrooms and the appropriate equipment was provided to allow them to do so. Reasonable adjustments were made to make sure people received the support and equipment to keep them independent.

One person described staff as 'excellent' and said there were no exceptions. The person told us they had no complaints at all about the service. One relative told us that they had been given a copy of the provider's complaints procedure and would feel comfortable in making a complaint if they needed to do so.

A concerns and complaints policy was provided for people and their family representatives to use. It was clearly displayed in communal areas. The complaints procedure included the actions and timescales in investigating complaints and informing people of the outcome of their complaints. The registered manager told us people and their relatives usually raised issues with them verbally as they occurred and they were able to resolve these with them. We saw complaints were acted on and people were satisfied with the outcomes of these.

Requires Improvement

# Is the service well-led?

## Our findings

People spoke positively about the manager and staff at the service. They told us that they were approachable. A registered manager was in post supported by a clear management structure at the service. The registered manager was supported by a clinical specialist who provided specialist knowledge for particular areas of care.

People were encouraged to put forward their suggestions about the service. During March 2014 an annual survey had identified that people had asked for activities to take place at more regular intervals and this was now being done. People had also raised that they wanted to know who was providing their care on each shift. A communication board was introduced to show this. Visitors were seen throughout the day speaking with the senior staff members in charge of the shift. At the start of each shift staff received information to keep them up to date on any issues that could impact on people's care and welfare. Staff meetings were held to inform staff about care issues that they needed to know about.

Regular staff supervisions took place every eight weeks. This was an opportunity for staff to discuss any issues or learning and development needs with their manager. However, staff told us that they did not always feel supported as there were times when they were asked to work without sufficient staff to provide people's care. They told us this situation was made worse when the person in charge of the shift was asked to find the cover required. Staff told us this was time consuming and took the person in charge away from their other duties on the shift.

Senior care workers had three monthly competency reviews by each other. A senior care worker was responsible for the auditing of medicines. This information was collated by the manager and the senior manager advised on actions to be taken to reduce the risk of errors happening again that would impact on people's care needs.

The provider had a system in place to investigate and to respond to complaints and concerns. We saw safeguarding events were promptly acted on by the registered manager of the home.

We found that when complaints were raised they were acted on. Staff used this as an opportunity to learn and develop practice and procedures. For example, in August when the two people had not had one of their medicines for four weeks a more responsive system for checking, chasing and notifying other agencies was introduced. One such change included a new system where a communications medicines book was introduced to show the actions taken. The registered manager told us this should prevent the likelihood of this type of incident happening again.

Providers are required by law to notify us of certain events in the service. Records we looked at showed that we had received the required notifications in a timely manner.

The registered provider told us they carried out regular unannounced visits and audits that lasted over two days. As part of the audit they carried out staff surveys where staff were provided with anonymity and were given an opportunity to receive replies to any concerns raised. They told us that no concerns had been raised with them.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>**The provider had not ensured the proper and safe management of medicines.**<br><br>**Regulation 12 (2) (g) HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>**The provider had not ensured that sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet people's needs.**<br><br>**Regulation 18 (1) HSCA 2008 (Regulated Activities) Regulations 2014 Staffing** |