Servicescale Limited

inTouch Home Care

Inspection report

117-121 High Street
Barnet
Hertfordshire
EN5 5UZ

Tel: 02084416868
Website: www.intouchhomecare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

inTouch Home Care is a homecare agency based in Barnet that provides services to people of any age. At the time of this announced inspection, they were providing personal care and support to 63 people living in their own homes.

The service had a registered manager. 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.

At the last inspection in March 2015, we found that the service met the regulations we inspected against. At this comprehensive inspection the provider was not meeting four regulations.

We found that there were not always enough staff with the right skills to meet the needs of everyone using the service. This resulted in some staff being sent to provide care without sufficient training, and of people cancelling planned care visits due to there being no staff available that met their needs and preferences.

Some staff were supplied to provide care to people before appropriate recruitment checks were completed to ensure they were suitable to be employed, which compromised the safety and welfare of people using the service.

The service had not embedded the principles of the Mental Capacity Act 2005 into its practice. Many consent forms were signed by relatives who had no formal authority to consent on people's behalf. There were no mental capacity assessments or best interest decisions highlighting that people did not have capacity to sign their care plan consent forms.

Whilst there was a complaints system, it was not always effective at ensuring concerns and complaints were listened to, documented and learnt from.

Most people and their relatives provided positive feedback about the service and said they would recommend it to friends and family. No-one said they would not recommend the service.

The service provided support for people's health and nutritional needs. There were effective safeguarding and risk management procedures in place that staff understood, and staff received training on supporting people to manage their medicines safely.

The service promoted people's privacy and dignity. People usually received the same staff members, which helped positive and caring relationships to develop. Most staff were provided with good support for their roles and there was an extensive induction process for new staff.

The provider audited the quality of the service and took action to address concerns that were identified through that process or by other means. There were good management systems in place.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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 consistently safe. We found instances where new staff were providing care to people before completing mandatory training and before reference checks of their previous employments were finalised. There were not consistently enough staff with the right skills to meet the needs of everyone using the service.

There were effective safeguarding and risk management procedures in place that staff followed. The service had appropriate medicines and infection control systems in place.

Is the service effective?

Requires Improvement

The service was not consistently effective. Where people lacked capacity to consent to the care services, the service had not documented a capacity assessment and, if necessary, followed a best interests process.

The service provided support for people's health and nutritional needs.

Most staff were provided with good support for their roles and there was an extensive induction process for new staff.

Is the service caring?

Good

The service was caring. People's views were sought and acted upon, and their privacy and dignity was respected and promoted by staff.

People received consistent staffing, which helped positive and caring relationships to develop.

Is the service responsive?

Requires Improvement

The service was not consistently responsive. Whilst there was a complaints system that was monitored, it was not consistently effective at ensuring concerns and complaints were listened to, documented and learnt from.

People's support needs were assessed and agreed with them

and their relatives, and were kept under review.

Is the service well-led?

Good

The service was well-led. There was an enabling culture that was focussed on people as individuals.

The provider audited the quality of aspects of the service, including the views of people using the service, their relatives and staff. There were appropriate and responsive management systems in place.

inTouch Home Care

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 26 July 2016 and was announced. Notice of the inspection was given to ensure that members of the management team would be available at the office to provide us with the necessary information.

Prior to our inspection, we reviewed information we held about the service, including legal notifications and the Provider Information Return that the provider sent us. 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.

The inspection was carried out by one inspector who visited the agency's office, and an expert-by-experience who phoned people using the service and their representatives. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

There were 63 people using the service and 37 care staff at the time of our inspection. During the inspection process, we received feedback from eleven people using the service, ten people's relatives and representatives, six care staff, three office staff, the registered manager and three community healthcare professionals who worked with people using the service.

As part of the inspection we looked at the care files of five people who use the service, personnel files of four staff members, and other records relating to the care delivery and management of the service such as service audits, complaint records and electronic visit records.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe using the service. One person said, "I've never had any problems." A parent of a child receiving care told us, "They make sure he does not bang his head on the wall or touch any wires." We saw that the agency carried out risk assessments that enabled people to take acceptable risks as safely as possible. The risks assessments were monitored, reviewed and adjusted as people's needs changed or on an annual basis at minimum. We saw records of staff sharing safety concerns with the office so that action could be taken. Computer entries for each person highlighted to office staff if there were any specific safety concerns, for example, reporting that equipment was not working or where care staff had identified a health concern for the person they were visiting that may need additional input.

There was ongoing recruitment and training of new staff. Office staff showed us how the care-visit booking system worked and that all visits were covered for the next three days. The registered manager told us that new care packages were only accepted if the assessment of the care needed and the working environment indicated that safe staffing could be provided. However, whilst we saw that some care packages were refused, we did not find that there were always sufficient numbers of suitably skilled staff to provide care to people. This reflected some feedback we received such as a relative telling us, "There are times the carer does not turn up. I did talk to the agency and they said there has been an emergency."

We found that two staff members, both working on live-in care packages where they lived in a person's home with them to care for them, had not completed the agency's induction training before starting work in the four months before our inspection. Neither had been signed off as fit to work alone by the registered manager, despite this being the expectation under the provider's policies. Records showed that both staff had been working without a day's break for a number of weeks, which had potential to cause fatigue and so undermine their ability to provide safe care.

One of these staff members had no documented training on file except for four training course certificates from 2015 that were all dated the same day, and which pre-dated their current employment. We found nothing to indicate that they had undertaken any training with the agency. They were recorded as first working alone overnight for three nights with someone who the registered manager told us needed emergency overnight care and for whom there was no care plan as the service ceased after those three nights. Records showed the staff member subsequently worked with two different people who both needed live-in care. The first person had dementia care needs, but there was no record that the staff member had any training on dementia care. Records showed that a family member requested a new staff member within a few days due to care concerns, which was agreed but not actioned for a further thirteen days as at the time there were no staff available to provide that. This put the person receiving care at ongoing risk of unsafe or inappropriate care from a staff member who had no training on how to meet their needs.

A third staff member was recorded as providing care to someone alone a day before their shadowing process was completed. Shadowing is where a new staff member learns from an experienced staff member providing care to people before they work alone. They were not signed off as fit to work alone for another month. However, they provided care, and had a member of staff shadowing them, before they had

completed their induction training.. The fourth staff member was signed off as completing their shadowing process with only five hours' experience, which was contrary to the provider's policy of ten hours for someone with no previous care experience.

These issues demonstrated that there were not enough staff, with the right skills, to provide care to people. Other records confirmed this. We saw a recent email to all staff pointed out limited cover and so encouraged staff to avoid taking short-notice leave. There were records across the previous three months of visits being cancelled due to staff being late, off sick, or no-one being available that the person using the service or their relative wanted. For example, recent records for one person indicated that the second of two allocated care staff did not attend three times in a five-day period.

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

Of the four new care staff files we checked, appropriate references were not in place before three of the staff started working alone in people's homes. The fourth staff member was shadowing experienced staff in people's homes before appropriate references were in place. One of the staff members did not have a second reference in place from a previous care employer, contrary to legal requirements. Many care employer references stated only the dates employed, but there was no subsequent record of phoning the employer to check if there were any concerns about the applicant. By failing to have appropriate references in place before sending new staff to work in people's homes, the provider was not taking reasonable steps to ensure people's safety.

One of these staff members was employed with no records of exploring anomalies in their application. There were no previous training certificates in their file despite declaring extensive care experience. Their current criminal record check failed to declare the previous surname on their passport. An old criminal record check included information on an employer that they had not declared on their application. This meant insufficient steps had been taken to ensure people's safety when receiving care from this staff member.

The above evidence demonstrates a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our visit, we asked the provider to confirm key recruitment checks of all staff members working in people's homes. This reassured us that all staff had criminal record disclosures in place, and that where one further staff member was found to lack a relevant written reference, they were not working until the matter had been addressed.

Staff told us they knew about the different forms of possible abuse and what to do if they suspected abuse. The Service User Guide that was left in people's homes gave them some information on what constituted abuse and what care staff must not do when working with them. There was also information on safeguarding, disciplinary and whistle-blowing procedures in the staff handbook. The provider operated a policy of rechecking staff members' criminal record disclosures on an annual basis, to help ensure that staff remained safe to be sent to provide care to people. Records showed that where appropriate, the agency raised safeguarding alerts and took action to protect people.

Most people and their relatives said that the agency did not need to help with medicines. One relative explained, "They don't give her medication, I put it in a box and they just remind her." However, records and staff feedback showed that staff received extensive training on medicines and that their capability was then regularly assessed in someone's home to ensure that they followed correct procedures. There was a specific

medicines risk assessment within each person's file that was filled in according to need and which stated the person's current medicine prescriptions. Care plans then guided staff on what medicines support they were to provide.

Staff recorded on medicine administration records (MAR) when they provided people with help to take medicines. The MAR that we checked were mostly completed accurately, and we fed back to the registered manager where there were occasional discrepancies. The MARs were also checked by the agency. Records of these checks identified if there were concerns with how staff provided medicines support so that actions could be taken to reduce the risks of medicines errors occurring.

People and their relatives told us that staff paid attention to cleanliness and preventing infection. One person told us, "It's always clean and tidy." There was also positive feedback about this from a community healthcare professional. People's care plans paid appropriate and individualised attention to supporting with cleanliness and food hygiene matters, for example, with helping someone to check that their food was not out-of-date and that towels and bedding were regularly changed.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us care staff provided encouragement to eat and drink. One person told us they got "more than enough" to eat and drink, and that staff "also tell me about healthy foods. They do tell me if I'm eating unhealthy but they never stop me." This indicated that staff encouraged good nutrition but balanced that with respecting people's decisions.

We found that the service provided appropriate support for people to eat and drink enough. People's care plans included sections for health and nutritional needs and preferences. Where appropriate staff recorded what and how much people had to eat and drink. People were advised and supported by staff to prepare meals. We saw guidance that was emailed to staff for their work with people to make sure they drank enough during hot weather.

People and their relatives told us that the service provided support with maintaining good health where needed. A community healthcare professional told us that the agency acted on any instructions and advice they gave. The registered manager told us that where people were being discharged from hospital, a member of the office staff always assessed their needs before agreeing to the care package, and that there could therefore be a need for additional healthcare input such as from an occupational therapist before the agency would agree to provide care. We saw records confirming, and that staff raised health concerns with the office so that appropriate action could be taken to help the person with their health.

There was good knowledge of specific health matters within the office staff team. We found there to be some complex health procedures that staff were providing to a small amount of people, for example, percutaneous endoscopic gastrostomy (PEG) feeding and catheterisation. Staff had training on carrying out these procedures, but there was no formal process for assessing staff competence embedded into the provider's training policy, to ensure that all relevant staff had the appropriate skills to meet the relevant person's specific health needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

Staff told us they had training on understanding their responsibilities under the MCA. The provider told us that all staff had completed an online test about the principles of the MCA. However, the registered manager told us that the agency had not undertaken capacity assessments of anyone using the service (to see whether they were able to make decisions for themselves) as it was believed that this was the responsibility

of other healthcare professionals. We found two cases where people's relatives had signed consent on behalf of the person when there was no Lasting Power of Attorney in place for the relative to act on behalf of the person. In one of these instances, the person signed on quality visit forms that recorded their feedback about the care, without evidence of the relative being involved.

Therefore, whilst the agency's processes were likely to be in people's best interests, the processes were not following the requirements of the MCA. The agency had not assessed the person's capacity to consent to the decision to receive care from the agency where there was doubt that they could consent to this. When assessed as lacking capacity, they had not documented that a best-interests process had been followed to agree it was in their best interests to receive care at home from this agency.

The above evidence demonstrates a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us that staff asked for their consent to provide care. They said, "They are always asking me, 'do you want to do this or that?'" A relative told us, "They try to persuade him to do things, but he does not listen, they do try their best." Relatives' feedback confirmed that where their family member wanted their involvement in making decisions about the care, the agency involved them.

Most people and their relatives said that staff had the skills and knowledge to provide them with care that met their needs, but one person and two relatives disagreed in respect of replacement staff. The person said, "When my regular care workers are not able to attend due to leave or sick, there should be an appropriate care worker to take over the tasks which does not happen all the time. Then I get an unknown worker who does not know my needs and tasks. This is lacking." A relative stated, "This service has improved beyond recognition but it would be even better if they had more carers that my relative knows to cover when the main carers cannot attend."

Staff feedback was that they received good training. New staff told us of a "week in the office" for classroom-based training. This included practical training such as a day that covered good moving and handling principles and practices. We were told that everyone had to pass each course through a test at the end. Records showed that training took place in the office focussing on no more than three topics per day. Some topics such as helping people to move safely and medicines support each took a whole day. The management team showed us that the training was based on the new national Care Certificate standards, and that further work was taking place to improve training such as with developing a more specific dementia training course to better support staff working with people living with dementia.

New staff told us they worked with an experienced staff member for a short period and were assessed as competent before working alone. However, we found that some new staff did not receive the induction training before working alone in people's homes, which we have considered further under the question Is It Safe?

Staff told us they received regular supervision and appraisal that enhanced their skills and learning. Records confirmed that these processes took place on an ongoing basis.

Good

Is the service caring?

Our findings

People and their relatives told us that staff had a caring approach. One person said, "They are very friendly and caring." A relative told us, "When I've talked to them they are always nice and my mother has never complained about them."

People and their relatives told us that care staff supported people's privacy and dignity. Relatives' comments included, "She knocks before she comes in" and "When we come round they make sure she is covered and presentable. She is always well dressed." We saw that confidentiality, dignity and respect guidelines were contained in the staff handbook. Staff told us of ways in which they were respectful to people, for example, "don't talk down to people" and having patience.

Care staff engaged well with people. One person told us, "I can talk about anything with them. We can talk about politics or what happened in the news." A relative said, "Every time I come round they are always chatting away."

People and most relatives told us they usually received the same care staff, unless staff were on holiday. A relative of someone receiving weekly visits said, "Recently we have had the same carer for the last three months." Another relative told us, "Before the agency would regularly send different carers, which caused great distress. The service has improved over the last year or so and we are now happy with the care." Staff told us of being allocated to visit the same people on a consistent basis, and records showed that the same staff usually visited people. This helped positive and caring relationships to develop.

People told us that they were introduced to new staff before having care provided. Most relatives and all care staff agreed that this was the case.

People and their relatives told us that staff listened to them and acted on requests. One relative said, "I talked with a replacement one yesterday, he listened and did everything I asked." Another relative told us, "We tell them what we can and can't do and if they don't listen, we tell the agency and they will never come back again."

People told us that staff encouraged them to be independent where appropriate. One person told us, "They encourage me to do things first and help me when I get stuck."

We noted that the provider's Service User Guide prominently informed people that alternative versions, such as in Braille and other languages, were available on request. It gave a number of advocacy options should anyone need support with having their views heard. It provided a lot of helpful information on the service, for example, what people could expect of care and office staff, and what was beyond the remit of the service. There was also information on protecting people's personal information, and how the service provides non-discriminatory practice.

The staff handbook provided much information on the potential needs and preferences of different cultural

and religious groups. The agency had an equality and diversity policy that staff had received training on. People's personal information including race, religion, disability and beliefs were clearly identified in their care plans, which helped staff to meet those needs.

Requires Improvement

Is the service responsive?

Our findings

Most people and their relatives told us that they knew how to make a complaint if needed, but that they had not needed to complain about anything. One relative said, "There was a problem, we reported it and it has been handled efficiently." This reflected most feedback we received about how any complaints had been handled.

There was a complaints policy that was advertised to people through the service guide given to them. However, we noted that the provider's website did not give any information on the complaints process.

Complaints records showed that one relative's recent complaint had been effectively addressed and action was taken to minimise the risk of reoccurrence. However, contrary to the provider's policy, the response letter did not include details of what could be done if the relative felt the matter had not been satisfactorily addressed such as providing our contact details.

There was a record of a relative handing a list of concerns to an office staff member in a meeting at the start of the year. Some of the concerns were discussed at that meeting. However, the concerns were not then documented as an informal complaint, a formal response was not sent, and the matter was not logged as a complaint on the provider's complaints monitoring form. This was all in contrast to the provider's complaints policy. A recent staff member's workplace assessment form had a brief record of a complaint from the same relative on the back of it. However, this was not documented for the person using the service on the provider's computer system or on the complaint monitoring form. A formal complaint subsequently made reference to some of the previous concerns, indicating that these concerns were not effectively dealt with at the time.

There was another instance when the provider's complaints policy was not followed. There was a record of a complaint on the provider's computer system a couple of months before the inspection about a relative's concerns in respect of a staff member and a medicines error. However, there was no follow-up action recorded there. There was no reference to the complaint within the provider's computerised complaints folder or on the provider's complaints monitoring form.

The above evidence demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us that staff understood and supported people to address their individual needs. One person said, "Everything I need them to do they will do it. They are very good." A relative told us, "They can answer most questions about her care." Most feedback also confirmed that staff stayed the full length of time they were scheduled for. Staff confirmed that they were informed of what people's individual needs were through care plans in people's homes, so that they could provide responsive care and support.

Before anyone started receiving a service, or usually within 24 hours in an emergency, senior staff visited the person to carry out an assessment visit. During this visit they checked the person's needs and preferences

along with any risk factors, including against any instruction from a funding authority, so as to produce a care plan aimed at meeting expectations. We saw that care plans provided staff with sufficient guidance on how to support people with their needs and preferences.

People and their relatives told us there were meetings with the agency to check that their needs were being met. One person said, "Someone is always coming around asking me questions about carers and asking me if I like or dislike something." A relative told us, "The supervisor comes and looks at the book, and talks to Dad and see what has been done. The assessment is about every six months." Records showed that quality visits took place every six months and formal reviews of risk assessments and care plans were at least annually unless needed earlier, for example, when someone moved to a new address. This helped ensure consistent care delivery.

People told us they received their visits on time. One person said, about staff turning up on time, "More or less she does, unless stuck in traffic. I don't mind as you can't really help that. I get a call so I know what's happening." Relatives told us that staff were usually punctual. Their comments included, "Sometimes they can be late but it's never longer than 10 minutes." Staff told us of receiving realistic visit schedules.

The provider had an electronic system whereby staff log in and out using the service's designated mobile phones to scan a device in the care file in the person's home. We saw that this allowed office staff to monitor that people received anticipated visits, and be alerted if anyone had not turned up after 15 minutes. Office staff told us that this alert also occurred when they were working outside office hours via the on-call service. Records showed that this process was effective at following up on visits not occurring as planned. For example, another staff member provided cover one day to a number of people recently when a staff member took unexpected leave.

We saw records of office staff responding to people's requests and concerns. Where a relative had phoned to ask for the visit time to be increased, we saw that this had been arranged. Where someone had expressed concern that breakfast and lunch visits were becoming too close together, subsequent visits rectified this. Where people needed to be ready earlier than usual to attend day centres, this was enabled.

Good

Is the service well-led?

Our findings

Most people and their relatives had no concerns about how the service was operated. They told us that they could contact the office when needed and that office staff were responsive. Relatives' comments included, "We talk regularly" and "I talk to them all and we are on a first name basis."

People and their relatives told us of being asked for their views on service quality, mainly through questionnaires. Relatives' comments included, "They do a questionnaire for her but she can't fill it out on her own. So I fill it in with her." The results of the last set of questionnaires, dated February 2016, were positive. For example, 17 of the 19 responses rated the care received as between good and excellent. The agency also made phone calls to people to check on service satisfaction.

The agency had started sending out newsletters to people using the service and staff this year. These provided updates on the service, health advice, and staff training dates.

Most care staff told us of feeling supported by office staff and managers. They felt office staff were approachable and dealt with any concerns raised. Their comments included, "Management is always helpful and very understanding" and "It's a very good company to work for." They reported that the management team asked them about the service provided and took their views into account. We were shown the analysis of questionnaires received from staff. There were only four replies, all of whom stated they would recommend the service to others and whose feedback was positive about the employer.

The management team reported that they felt that the staff team held the right values. We were shown records of staff being supported to understand service expectations where minor concerns arose, and that disciplinary processes were followed where appropriate.

The agency made good use of electronic data to ensure that quality targets were met. Records showed that people received care reviews and quality monitoring visits regularly, and that staff supervisions and work-place capability assessments were appropriately undertaken. We were shown how the care package software was used to make sure these and other processes were kept up-to-date.

We saw that senior staff undertook regular audits of the extent to which the agency was following some of the provider's policies. The most recent audit identified specific shortfalls including around care plans. Records and feedback showed that the shortfalls were being addressed.

There were audits of people's care delivery records that checked matters such as legible care entries being in place for each visit, that times of visits were recorded, and that health matters had been addressed. There were also weekly audits of the electronic staff signing-in and out records at people's homes.

We saw that regular office staff meetings occurred. These included consideration of any changes to people's care packages, oversight of staff recruitment and training, staffing capacity in geographical areas, any concerns arising from people using the service and staff, and ensuring audit targets were being met.

We noted that the provider was registered with the Information Commissioner in respect of securely controlling personal data on its computer systems.

Following our inspection visit, the provider sent us an interim action plan outlining in detail the actions they were taking to address concerns we raised at the end of the inspection visit. This included that they would not start any new packages of care for a short period whilst ensuring that all concerns were addressed. They also provided the full information that we formally requested after the visit to help ensure the safety of people using the service. These responses helped to assure us that the service was well-led.

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 11 HSCA RA Regulations 2014 Need for consent The registered person failed to ensure that care of service users was only provided with the consent of the relevant person, or where the service user was unable to give such consent because they lacked capacity to do so, in accordance with The Mental Capacity Act 2005. Regulation 11(1)(3)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered person failed to operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. Regulation 16(2)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to ensure that the following were available before employing anyone to provide care: • Satisfactory evidence of conduct in previous care employment; • Satisfactory documentary evidence of any qualification relevant to the duties for which the person is employed or appointed to perform.

Regulation 19(3)(a) S3 parts 4 and 6.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to ensure that sufficient numbers of suitably skilled persons were deployed in order to meet the Fundamental Standards. Regulation 18(1)