Highcliffe Care Centre Limited

Highcliffe Care Centre

Inspection report

Whitchurch Road
Witherwack
Sunderland
Tyne and Wear
SR5 5SX

Tel: 01915160606
Website: www.averyhealthcare.co.uk/care-homes/tynewear/sunderland/highcliffe/

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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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 4 and 7 December 2017 and was unannounced.

Highcliffe Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This home does not provide nursing care. At the time of our inspection there were 53 people living at the home.

A registered manager was in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection the registered manager was absent and we were supported by the deputy manager and the regional manager.

We found the service had breached a number of regulations. The service had not undertaken the necessary checks to ensure staff were suitable to work with vulnerable people. Safety checks of equipment and premises were not routinely carried out. Risks to people were not always identified. People did not always receive their medicines as prescribed. People did not always receive support in maintaining their specific dietary requirements relating to moral or ethical beliefs.

The service failed to maintain suitable records for the management of the service. We also found that the provider did not have effective quality assurance processes to monitor the quality and safety of the service provided and to ensure that people received appropriate care and support.

You can see what action we have told the provider to take at the back of the full version of the report.

The provider had systems in place to ensure people were protected from abuse and harm. Staff had completed safeguarding training. The service ensured appropriately trained staff were deployed to support people. Staff told us they received regular supervisions and appraisals.

People we spoke with were positive about the choice and quality of meals. People were supported to maintain good health and had access to healthcare professionals. People were able to make day to day decisions about where and how they spent their time. Care plans did not always reflect people's current needs.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

The provider had a comprehensive activities program with both individual and group activities. People and relatives told us staff were kind and caring. People and relatives were involved in reviews of their care and support. Staff worked well together and were respectful of each other. People, relatives and staff were complementary about the registered manager and the deputy manager.

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 safe.

The service did not always follow the provider's recruitment and employment policy.

Premises and equipment checks were not routinely carried out.

People did not always receive their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive support in maintaining their specific dietary requirements relating to moral or ethical beliefs.

The service ensured people had access to care, support and treatment in a timely way.

The service used technology to enhance the delivery of effective care and support.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider was not supporting the service to deliver caring outcomes for people.

People told us staff were kind and caring.

Staff were respectful when providing care and support to people.

People were encouraged to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always reflect people's current needs.

People were supported to take part in activities which were important to them.

The provider had a complaints process to deal with people's concerns.

Is the service well-led?

Requires Improvement

The service was not always well- led

The service did not have effective quality assurance processes to monitor the quality and safety of the service provided.

People were given the opportunity to give feedback on the service.

Relatives of people using the service and staff were confident in the management of the service.

Highcliffe Care Centre

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 4 and 7 December 2017 and was unannounced. During this inspection the registered manager was absent and we were supported by the deputy manager and the regional manager.

The inspection team consisted of one adult social care inspector, a specialist advisor in nursing care and an expert-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed other information we held about the service, including any statutory notifications we had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. We also contacted the local authority commissioners for the service and the local authority safeguarding team, the local Healthwatch and the clinical commissioning group (CCG). Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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.

During this inspection we spoke to nine people who lived at Highcliffe Care Centre, six relatives, the regional manager, deputy manager, administrator, three senior care workers and nine care workers, two ancillary staff and two kitchen staff.

We looked at eight people's care records and four staff files including recruitment information. We reviewed medicine records and supervision and training logs as well as records relating to the management of the service.

We carried out an observation using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We undertook general observations of how staff interacted with people as they went about their work. We looked around the home, visited people's bedrooms with their permission and spent time with people in the communal areas.

Requires Improvement

Is the service safe?

Our findings

During our last inspection we found risk assessments didn't always correspond with people's care needs which impacted on people's care such as pressure damage. In addition, appropriate equipment was not always identified and implemented for people.

The service could not give reassurance that all staff employed were suitable to work with vulnerable adults. We found the service did not always follow the provider's recruitment and employment policy. The policy stated, 'No employee can start work until DBS is received along with two employment references.' DBS checks help employers make safer decisions and help to prevent unsuitable people from working with vulnerable adults.

On examining four recruitment files we found two staff members had started employment prior to the return of their DBS checks, with one staff member's DBS response alerting the service to view the person's certificate. The management team were unable to provide an explanation of why staff had been allowed to commence work before the receipt of a DBS check or without a supporting Adult First Check (this is a check which allows employees to commence work under supervision whilst awaiting a return from DBS). Once aware of our findings the deputy manager took immediate action. Another staff member's file only held one returned reference however they had also commenced their employment at the service. This meant the service had allowed staff to work with vulnerable adults without carrying out appropriate recruitment checks.

This is a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safety checks of equipment and premises were not routinely carried out. We saw monthly checks for fire doors; emergency lighting and lifts had not been carried out since October 2017. The last monthly checks for window restrictors and bath temperatures were conducted on 12 September 2017, with the last monthly check on wheelchairs being on 10 August 2017. The deputy manager advised that a new maintenance person had recently been employed in early November 2017. They told us the service had received support from another service's maintenance person but were unable to find records of the checks carried out during that period. We saw maintenance records were stored in a small cupboard under the stairs with equipment and materials. This meant identified safety measures had not been completed therefore placing people and staff at risk of harm.

We noted a fault was identified on the routine maintenance inspection of the hoist of a bath in December 2016, the same fault was remarked upon in the maintenance inspection dated June 2017. The deputy manager advised that the bathroom was marked out of order and was unable to advise us why the issue had not been resolved. This meant for 27 people living on that suite had access to one bath and one shower.

Accident and incident records reported on the 1 December 2017 identified a person had fallen from their wheelchair and sustained an injury. On 4 December 2017 we observed the wheelchair was in disrepair with a

side panel and footplate missing. We saw the wheelchair was still being used by staff to support the person. There was no record that staff had reported it to the maintenance team. We asked the deputy manager to address the matter. As the last monthly audit of wheelchairs had not been conducted since August 2017 we were unable to establish how long the wheelchair had been faulty.

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

On the first day of our inspection during our initial walk around the building we noted a number of hazards. Combustible material was stored in the stairwell creating a potential fire hazard and people on the first floor, some of whom were living with dementia, had access to a balcony area which had slippy decking. We alerted the team leader to our findings who quickly organised for the stair well to be cleared and balcony area locked with a notice displayed to remind staff to keep the door locked. We also observed bins without an inner bag and a used disposable bedpan on top of a waste bin. The deputy manager told us they conducted daily walk arounds but had no records. On the second day of inspection they had introduced a daily walk around report with actions to take and confirmation that issues had been resolved.

Risks to people had not been assessed and identified consistently. There was not always detailed guidance for staff to follow to mitigate risk and keep people as safe as possible. For example, we saw in one person's care records it reported, "Unable to use nurse call to get assistance." No risk assessment was in place to reduce this risk. We saw from accident and incidents one person had recently fallen from a wheelchair. We noted no risk assessment had been put in place following this incident.
Within one person's care plan it mentioned that the person was unable to use the nurse call to get assistance. No information was available advising staff how best to support the person or the consideration of alternative equipment. When asked staff were unable to tell us how the person called for assistance. Although the service had identified the person's inability to use the nurse call they had not acted upon the information. We discussed this matter with the deputy manager who advised that the issue would be addressed immediately

Medicines were not always managed safely. The service had repeated issues with the ordering and obtaining of people's medicines. On the first day of the inspection three people did not receive their morning medicines until midday as it was not available. The service had requested the medicines from the pharmacy but the items had not been delivered. One person who had recently moved in failed to receive their medicines as they were not on the electronic medicine system. The service sent a staff member to obtain a further prescription and pick up the medicine.

We found gaps in people's medicines administration records (MAR) this was because medicines were not received which meant people did not receive their medicines as prescribed. The deputy manager advised they had arranged a meeting with the electronic medicine systems company and pharmacy to resolve the issue but the pharmacy failed to attend. They advised the problem lay with the pharmacy. We discussed the service adopting safeguards to ensure people receive their medicines when prescribed.

The senior had extensive knowledge of the electronic medicine system. They advised that they were in constant consultation with the software company to remedy any issues identified. However, this had, as yet, not been effective in mitigating the risk of people not receiving their medicines as prescribed.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were sufficient numbers of staff to support people safely. People and relatives told us there were enough staff. The atmosphere was relaxed and calm. One person told us, "Everyone has time for me, even the cleaner's talk to me." Another said, "There is a fair mix I know quite a lot of them. I have a key worker." Throughout both our site visits we saw staff were visible around the home. We observed staff assisting people with mobility and transfers using various aids, including zimmer frames, wheelchairs and hoists. Staff gave clear explanations and were unhurried with their support maintaining people's dignity.

The provider had a plan in place to ensure people would continue to receive care following an emergency. This outlined potential risks and actions to be taken. Each person had a personal emergency evacuation plan (PEEP) which detailed the type of assistance required for a safe evacuation.

The service had systems in place to record all accident and incidents these were reviewed by the registered manager and collated to identify any trends or patterns for further investigation. All the data was collated centrally by the provider and a detailed report produced monthly highlighting lessons learnt. The provider was also collating information centrally regarding safeguarding and complaints. The service had recently reviewed its procedures to ensure serious injuries were notified to the CQC in line with registration requirements. The provider had systems in place to ensure lessons learnt were cascaded across all of its services.

The provider had procedures in place for the logging of safeguarding concerns. Whilst the service logged all concerns and was active in alerting the local authority safeguarding team it did not always fully investigate the matters. Following our discussion with the deputy manager, they had produced documentation to follow and promote action with future safeguarding concerns.

The deputy manager was fully aware of their responsibility to ensure the management of infections and make alerts to the appropriate external agencies regarding concerns that affect people's health and wellbeing.

Requires Improvement

Is the service effective?

Our findings

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The provider had a system in place for monitoring and requesting authorisations to ensure no people were deprived of their liberty without authorisation. Where required mental capacity assessments had been carried out.

Staff we spoke with had an understanding of MCA and DoLS and why it was important to gain consent when providing care and support. Staff were clear about the need to seek consent and to maintain people's independence.

We noted one person had been a vegetarian throughout their life. The care plan stated, "[Person] is no longer aware of their vegetarian status due to their dementia. Staff to act in best interest by only offering veg options." The service failed to explore suitable and ethical alternatives to meat to allow and support the person to remain loyal to their chosen beliefs. We did not see a dietician assessment or best interest decision in relation to the matter.

This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with were positive about the choice and quality of meals. One person said, "It is so good, I didn't eat well at home." Another person told us, "I definitely get enough to eat. They always try and get what I like, the two chefs ask what would you like."

The deputy manager told us mealtimes were slightly staggered to ensure enough staff were available to support people. Staff were attentive and regularly asked people if they needed assistance and if they wanted anything else or another drink. Staff offered people a plated example of what was on offer for lunch. We noted the menu was displayed on the wall outside the dining rooms. The typeface was small and it was difficult to work out the menu for that day. We discussed this with the deputy manager who advised that the menu format was currently getting reviewed.

Staff told us they felt the training provided assisted them in their roles. One staff member told us, "The

training is good here." Another staff member said, "We can always ask for more training if we wanted."

Training included safeguarding, infection control, moving and assisting people, first aid and fire safety. The deputy manager told us, "The training is blended with some classroom based and other eLearning." On the first day of our inspection we observed staff taking part in first aid training. The trainer advised that all new staff completed a six day induction course with a period of shadowing experienced staff.

On examining the training records we noted a number of staff members' had moving and assisting training which had lapsed. The trainer took immediate action, consulted rotas to ensure enough suitably trained staff were available to support people safely and arranged to deliver the training required. The trainer advised that systems had recently been introduced so this matter would not occur in the future. They said, "I monitor and staff are alerted to the requirement to attend training."

The provider ensured staff had sufficient support with regular supervisions and annual appraisal. Staff told us they had regular supervisions with their team leader. One staff member said, "We discuss how work is going."

People were supported to access healthcare professionals. Care records showed people had regular input from a range of health care professionals, such as GPs, speech and language therapists (SALT), and occupational therapists.

The home had spacious corridors with handrails in a different colour so people could easily see them. Clear signage was present on toilets and bathrooms to assist people identify the rooms. Some people had memory boxes containing personal items attached to the wall to help them recognise their room. We noted some people's doors only had their name in very small print which was difficult to read. The deputy manager told us this was a work in progress and key workers were supporting people and their relatives to gather items to display.

The provider had embraced technology and used it to enhance people's reminiscence experience. The regional manager told us the provider was currently looking at purchasing an electronic care record system.

Requires Improvement

Is the service caring?

Our findings

Although we found aspects of the service to be caring we are not able to give a rating of good as the provider was not supporting the service to deliver caring outcomes for people.

People told us they were happy living at Highcliffe Care Centre. One person told us, "Yes, I am very very happy and settled in when I first came straight away." Another person said, "I like living here."

We observed staff knocking and seeking permission before entering people's bedrooms. One person told us, "The carers are kindness itself, some more than kind they become friends." A relative said, "They knock on the door when they come in." They described an occasion when their relative was unwell and how the staff member comforted the person by sitting and holding their hand.

Staff were sensitive to people's needs. We observed one person repeatedly asked the cost of the meal at lunchtime. The staff member each time reassured the person saying, "No cost today [person]" and "We are all paid up." The staff member's reassurances put the person at ease and they happily ate their meal. On another occasion we saw one staff member offering a person a choice of a hot or cold drink, showing them both and explaining what each was. They could see that the person was having difficulty in making a decision. The staff member asked, "Should I leave both?' this was met with a smiling response from the person.

We observed staff throughout the day calling into bedrooms and the lounges asking if people needed anything, letting them know what activities were on or just staying for a chat. People were encouraged to make choices about their day to day lives. People told us they decided when to get up, what to wear and what to do during the day. One person said, "Yes, I can go to bed, get up when wish, I just get what I want to wear out of the wardrobe."

People and relatives confirmed they were involved in planning their care. One relative told us, "It is excellent, they review every six months and [my relative] is there at the review." Another relative said, "There is a care plan and they do a review." One person said, "We chat about what is written down."

Where people had no family or personal representative we saw the home provided information about advocacy services. Information was displayed in the foyer area, outlining the support available and detailing the local advocacy service. The deputy manager told us they had obtained the services of an Independent Mental Capacity Advocate (IMCA) to support a person.

People told us they could bring their own furniture and belongings, and bedrooms were personalised and individual to each person. The service ensured people's personal information was held securely. The team leader showed how people's medicine records were password protected and so could only be accessed by authorised staff.

Requires Improvement

Is the service responsive?

Our findings

Care records were divided into individual care plans and included areas such as eating/drinking, breathing/circulation, personal hygiene and sleeping. Care plans we viewed held conflicting information and did not consistently reflect people's changing needs. For example, in one part of a person's care records it referred to the person needing pureed foods and eating independently whereas the SALT assessment reported the person required supervision at mealtimes with a fork mashable diet. Another person's mental health care plan identified confusion, disorientation, wandering and verbal aggression. The care plan did not detail how staff were to support the person to meet their needs or how to promote their mental health and well-being. Another person's care plan stated that the person could be anxious and tearful. It reported, "[Person] responds to distractions and reassurances one to one over a cup of tea." No guidance was available to assist staff in how to reassure the person.

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

We spoke to the deputy manager and regional manager about our concerns regarding the care plans. The regional manager advised that the service was aware of the issue and had begun a process of resolving the matter which included monitoring the quality of the care plans and the development of a template for staff to follow. The deputy manager showed us a template of a care plan they had produced to support staff and to improve the quality of report writing within the care plans. The process had just been introduced and therefore we were unable to see its benefits.

Although care plans were not always accurate and complete, staff demonstrated extensive knowledge and understanding of people's needs.

The provider had a comprehensive activities program that covered the physical, psychological and social needs of people. The service had two dedicated well-being and activities coordinators. Both spoke passionately about their role and the part they play in people's well-being. The service had liaised with local nurseries and schools and supported interaction between the generations with the creation of a reading group. It also utilised volunteers from the local Age UK to support people on activities.

The service offered a range of activities including pet therapy, excursions, reminiscence, gardening, knit and natter, singing for the brain and exercise classes. During our inspection we observed an entertainer singing in the lounge, people and staff were clapping and singing along. One person told us, "I went to the Metro Centre last week and I have been to Clays Garden Centre." Another person said, "Yes, there was a concert the other day with local children dancing and singing."

The well-being and activities coordinators told us about individual activities people enjoyed. For example one person liked to help staff with the tea trolley and how another person has their own planted area. They also told us how the service had used virtual reality (VR) technology as a new format to explore reminiscence. This allowed people to explore specialist reminiscence activities in a safe supported

environment. They advised that the software producer was in the process of mapping local areas familiar with people. They told us people who had used the equipment had expressed positive comments.

The service had a complaints procedure and process in place which was visible throughout the home. Complaints were fully investigated with outcomes recorded. The provider also gathered data from all its services for analysis to consider areas for improvement. People and relatives told us they knew how to raise a complaint. One person said, "Yes, if I had to complain I would."

Where people wished end of life information was available to support staff to make sure people's wishes were met. Emergency health care plans (EHCP) were also present. EHCP contain information to help communication in an emergency for the individual, to ensure timely access to the right treatment and specialists.

Requires Improvement

Is the service well-led?

Our findings

The provider had a range of quality assurance audits in place with a rolling frequency including food safety, health and safety and medicines management. However we found during our inspection that the provider's monitoring of the quality of the service was not always effective. For example it had failed to identify the issues with recruitment, risk assessments and safety checks of equipment and premises. Whilst the service had made efforts to discuss the situation of late medicines with the Pharmacy the issue had been a problem for a number of months since the electronic medicines system had been introduced and it still remained to have an impact on people.

The service failed to maintain secure and accurate record keeping in regard to the management of the service, including equipment and premises.

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

Highcliffe Care Centre had a registered manager in post, however they were not at work on the days we visited. We were supported by the deputy manager and regional manager.

The deputy manager was extremely passionate about providing great care and support to people living at Highcliffe Care Centre. Whilst only in post a short period he had identified areas for improvement and set about finding solutions. For example, a care plan template and a manager's walk around document. Staff we spoke with were complimentary about his style of support. One staff member said, "I know if I go to [deputy manager] with a problem they will sort it straight away." Another said, "[Deputy manager] is brilliant we work really well together, they listen."

People and relatives we spoke with were positive about the management of the service. One person said, "(Deputy manager) is always around. It a nice atmosphere when he is around, he is always laughing."

The deputy manager previously managed the service for a three month period. He was awarded Avery Healthcare's Managing Director's award which is given in recognition of staff who have gone above and beyond the normal call of duty.

The service had an established management structure. The deputy manager was supported by a strong team leader who had extensive healthcare knowledge. The deputy manager told us, "I am supported by the regional manager and I can just pick up the phone to another manager and they would help me." Unit managers held daily meetings; items discussed included admissions/discharges, planning for people's appointments and activities.

We observed staff worked well together and were respectful of each other. Staff told us they felt supported and were able to go to colleagues and senior staff should they have a worry or concern. One staff member said, "We support each other and are well supported by the manager."

Staff had opportunities to provide feedback about how to improve the service and people's care. Staff told us they were able to speak to the management at any time. The deputy manager told us a staff survey was conducted annually across all the provider's services and was positive.

People had regular opportunities to discuss their care and support. A service user questionnaire was conducted in July 2017. 49 questionnaires were sent out with only seven returned. The conclusion was overall positive with people happy with the service. Resident and relatives meetings were also held to capture people's views. The deputy manager told us, "My door is always open to people come in for a chat."

The service used a 'resident of the day' scheme when all documentation relating to that person was reviewed. The person also received a visit from a member of staff from each department including housekeeping, kitchen and activities. Enquiries were made to ensure the person was happy with all aspects of the service.

The provider produced a seasonal magazine with stories from throughout its services. The service utilised an online service which supported organisations to produce reminiscence newspapers. It created a weekly newsletter called 'Weekly Sparkle' it had articles covering, 'The way we were', 'On this day' and 'Over to you,' and included activities. Visitors were encouraged to use the newsletter as a conversation tool during their visit.

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 11 HSCA RA Regulations 2014 Need for consent People did not always receive support in maintaining their specific dietary requirements relating to moral or ethical beliefs. Where a person lacks mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risks that had been identified in relation to their care needs. 12(2)(b) People were not protected from the risks of unsafe equipment through proactive monitoring and safety checks 12(2)(e) People did not always receive their medicines as prescribed. 12(2)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to assess and monitor the service. The service failed to maintain secure and

	accurate record keeping in regard to the management of the service, including equipment and premises. 17(2)(a) 17(2)(d)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The service had not undertaken the necessary checks to ensure staff were suitable to work with vulnerable people. 19(2)