Care Quality Commission

Lench's Trust
William Lench Court
Inspection report

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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**

Overall summary

The inspection took place on 10 and 11 September 2015 and was announced. The service had not been inspected before.

The service provided domiciliary care to 26 people who lived in their own homes within the provider's housing scheme. At the time of our inspection two people who used the service were in hospital.

There was a registered manager in place. The registered manager we spoke to during the inspection had been in their role for about two months. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Care staff were aware of people's needs and how to keep them safe. Whilst staff knew how to support people, care plans lacked guidance about how to meet people's conditions as they changed. People were at risk if

Summary of findings

receiving inconsistent care or care that failed to address known risks to people to keep them safe from harm. You can see what action we told the provider to take at the back of the full version of the report.

People were supported by the number of staff identified as necessary in their care plans and were usually supported by staff who were familiar to them. People felt staff were considerate and respectful of their wishes and feelings. However several people said that a lack of consistent staffing had prevented some of them from getting to know staff as well as they would like.

The provider was unable to demonstrate their processes to identify and review the numbers of and deployment of staff to meet people's care needs or robust made arrangements to ensure staff attended calls on time.

The provider had conducted the appropriate character checks when new staff joined the service to ensure they were suitable to support the people who used the service. They were unable to demonstrate they always followed up gaps in people's employment histories.

Care staff sought permission before providing care. When required people were supported to take their medication however the provider locked away people's medicines so they could only be accessed by care staff. They had not assessed if people had the mental capacity to manage their own medicines safely or if less restrictive alternatives were available. The provider had not conducted assessments to protect peoples legal rights or identified if other people had authority to make decisions on behalf of people who used the service. You can see what action we told the provider to take at the back of the full version of the report.

Staff had the skills and knowledge to ensure people were supported in line with their care needs and best practice. People who required assistance to eat and drink were supported by staff but records of what people had eaten were not robust. Therefore it was not possible to review if people had eaten enough to keep them well.

People felt concerns would be sorted out quickly by care staff without the need to resort to the provider's formal process. Investigations into formal complaints were conducted when necessary.

The provider had no formal process to engage and conduct reviews with people about their care plans. There was no effective process for staff to express their views of the service or discuss how the care people received could be improved. People had only limited opportunities in how they could influence and develop the service.

Staffing structures did not support care staff to be clear about their roles and responsibilities and what was expected of them. The provider had not ensured there was clear guidance to staff about how they should respond to ad-hoc requests for support outside of people's agreed call times.

The provider did not have robust processes for monitoring and improving the quality of the care people received. The provider had identified several concerns with the quality of the service but had not developed plans to address these in order to keep people safe. You can see what action 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?

The service was not safe. People did not always receive care and support at the times that had been agreed for them to receive timely support with medication or meals.

People were not always protected from harm because the provider had not ensured that risks to people had been identified and the appropriate action taken.

It was not possible to identify if people had been supported to take their medication as prescribed.

Requires improvement

Is the service effective?

The service was not effective. People were at risk of having decisions about their care being made by people who did not have the right to do so.

People were at risk of being supported in ways which restricted their liberties and choices.

People were supported by staff who knew how to support them in line with their wishes and preferences.

Requires improvement

Is the service caring?

The service was not consistently caring. People were at risk of having their confidential information shared with people who were not involved with their care.

Most people were supported by staff who knew them well enough to develop friendly relationships. However some people said a lack of consistent staffing had prevented them from developing relationships with the staff who supported them.

People were supported by staff they wanted in order to maintain their dignity. However the provider had not always taken robust action when people's behaviour risked compromising their dignity.

Requires improvement

Is the service responsive?

The service was not responsive. There was no formal process to review the care people received in order to ensure it met their needs and was provided in line with their wishes.

People received supported when they wanted it because staff responded promptly to ad hoc requests for help. However not all pre-arranged calls were attended on time.

Requires improvement

Summary of findings

Is the service well-led?

The service was not well-led. The provider did not have robust processes for monitoring and improving the quality of the care people received.

Staff shared the provider's vision for the service but were not clear of their duties or how to prioritise tasks.

Staff said the service had improved since the new manager had been appointed.

Requires improvement 

William Lench Court

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 10 and 11 September 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to ensure that care records were available for review had we required them. The inspection team consisted of one inspector.

We checked if the provider had sent us any notifications since our last visit. These contain details of events and incidents the provider is required to notify us about by law, including unexpected deaths and injuries occurring to people receiving care. We also reviewed any additional information we held or had received about the service. We used this information to plan what areas we were going to focus on during our inspection.

During our inspection we spoke with seven people in their own homes, the registered manager and chief executive who was also the nominated individual for the service. We spoke with four members of care staff and a GP, social worker and district nurse who were visiting the service to support people in their homes. We looked at records including five people's care plans, three staff files and staff training records to identify if staff had the necessary skills and knowledge to meet people's care needs. We looked at the provider's records for monitoring the quality of the service to see how they responded to issues raised.

After our visit we spoke to the relatives of three people who used the service and a palliative care nurse who had supported people who used the service.

Requires improvement

Is the service safe?

Our findings

People who used the service and the relatives we spoke with all said that they felt care staff were aware of their needs and knew how to keep them safe. A member of staff explained how they supported a person who was sometimes at risk of falling so they would be kept safe when moving. Several members of staff expressed concerns that some people's care plans had not been updated as their conditions changed. We saw that some assessments had been completed in order to identify specific risks to people, but most of the care records we looked at were incomplete and not up to date. For example we saw risk assessments that identified one person was at risk of depression and another for a person who was at risk of self-neglect. The registered manager was unable to find guidance about how staff were to protect people from the harm associated with these specific conditions. Staff who were supporting people were able to advise how they managed known risks and met the individual needs. The lack of current and accurate records about support that was to be provided placed people at risk if staff who knew them were unavailable to deliver care. This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with said they felt the service kept them safe. One person told us, "I am safe in my home." The relative of a person told us, "They keep the front door locked at night and always check where [my relative] is." Staff we spoke with were able to explain how they respected people's views and were confident they could recognise signs of abuse and knew how to raise concerns. Staff understood the importance of keeping people safe and recognised it as an important part of their role.

People confirmed that they were always supported by the number of staff identified as necessary in their care plans. Although most people said they were usually supported by staff who were known to them some people told us they were sometimes attended by staff who were not familiar with their specific care needs. Staff. People told us they were not informed in advance which staff would be supporting them each day. One person told us, "You never know who is going to turn up." Another person said, "I can't always get the same staff. I am always having to explain things." Another person told us, "I always recognise their voice when they knock."

Several people we spoke with told us that staff did not always turn up on time but this did not cause them concern. However some people who had responded to a recent survey conducted by the provider, also stated that they frequently experienced late calls and infrequently had experienced missed calls. One person had raised concerns that this had resulted in receiving their meals and medication later than necessary to keep them well. Records showed that staff call times were regularly inconsistent and it was not always possible to identify in people's care plans what their agreed call times were. This meant there was a risk that people might not get time critical care when they needed it.

Staff told us that they were constantly busy and often chose to delay or miss taking breaks in order to meet people's care needs. Staff said they were responsible for responding to additional ad-hoc requests for support and to calls from people, who lived in the housing scheme, but the people had no formal arrangements in place to be supported by the care service. The registered manager told us this was part of the service offered to all the people who lived in the housing scheme. At the time of our inspection, care staff were also responsible for serving and clearing away food in the provider's restaurant at weekends. We saw that on one occasion, this had resulted in a member of staff forgetting to attend a person's allocated call. The registered manager told us this was a temporary arrangement until the end of September when care staff would no longer be responsible for serving food in the dining room.

The registered manager told us that staffing levels had been identified by the previous manager based on people's care needs. Although the provider had recently increased staffing levels they were unable to identify or show they had monitored if these levels were sufficient to meet people's current care needs and the ad-hoc requests for support that they received. Despite this increase in staffing levels people told us and records showed that they often had to wait to receive support. There were additional agency staff available to work when necessary. The registered manager told us that they had recently arranged for specific agency staff to undergo an induction so they were familiar with the people who used the service and their care needs when they were required to work at the service.

The staffing arrangements and deployment of staff failed to ensure that there were available in sufficient numbers to

Requires improvement

Is the service safe?

meet people s needs. This meant that people were at risk of not receiving care in a timely manner. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff who had recently joined the services told us they had undergone a thorough recruitment and induction process and felt supported in learning their new role. We looked at the records of three members of staff who had recently joined the service and saw that the provider had conducted appropriate character checks. This helped ensure that staff were suitable to support the people who used the service. We asked the registered manager about a gap in the employment history of one member of staff and although they said they had discussed this with the applicant at interview, they had not kept a record of the discussion. They were unable to demonstrate they had followed up this gap in information.

People who required assistance to take their medication said they were happy with how they were supported by staff. People told us they received their medication as prescribed. A person told us, "If I've any queries [about my medicine] I always ask the staff to check what I've made up. They know what I have them for." Staff had received training in the management of medicines and were able to explain the specific support people needed in order to administer their medication safely. Because staff did not always support people at their specified call times this meant that some people were at risk of not being supported to take their medication at the prescribed times.

The provider had installed lockable cabinets in some people's homes for the storage of medicines. Care staff held all the keys for these cabinets to ensure people did not access their medication inappropriately. People's care records contained inconsistent information about people's medications. We saw that staff recorded when they supported people to take their medicines however we saw that people's care records had not always been updated when people's medication changed. Therefore the provider could not identify if people were receiving their medication as prescribed.

Requires improvement

Is the service effective?

Our findings

We noted that the provider locked away people's medicines in their homes so they could only be accessed by care staff. The provider had not assessed if the people had the capacity to manage their own medicines safely or if less restrictive alternatives were available. People who used this service had their liberty restricted because they were not freely able to access their medication if they wished. Where people were thought to lack mental capacity to make decisions about their lifestyle, the MCA requires providers to submit applications to a 'supervisory body' for authority to restrict people's liberty. The registered manager told us they were unaware of this requirement. People were at risk of not being supported in a way that supported their legal rights. These issues were a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with said they were generally happy with the care they received. Two people told us that their health had improved since they started to use the service. One person told us, "Staff are gentle and knowledgeable."

All the people we spoke with told us that care staff sought their permission before providing care and constantly asked if they were being supported in line with their wishes. The relatives of three people we spoke with confirmed this. The registered manager and staff we spoke with were knowledgeable of some aspects of the requirements of the Mental Capacity Act 2005 (MCA). The provider had not conducted assessments when people were thought to lack mental capacity. They had not taken action to identify if other people who had made decisions on behalf of people who used the service had the legal right to do so. The provider was unable to demonstrate they had a procedure for when people were thought to lack mental capacity so that decisions, about how their care would be provided, were made in their best interests and in accordance with current legislation.

Staff had the skills and knowledge to ensure people were supported in line with their care needs and best practice. A person who used the service told us, "They know when to leave me alone and when to intervene." Another person told us that when new staff had started working at the service, they had been shown how to meet their specific care needs by other care staff who were experienced in supporting the person. All the staff we spoke with were able to tell us how they met the care needs of the people they supported, what they liked and their preferences. The registered manager however was unaware of some people's specific conditions and how they should be supported. They said that this was because care records were not up to date when they undertook the role and known risks had not been documented or shared with the registered manager.

Staff told us they received training, such as dementia awareness, as people's care needs changed and were confident they had the appropriate skills to meet peoples' care needs. However one member of staff told us that they did not always receive training timely. The provider could not confirm what training staff had undertaken as these records were kept by an external training

provider. They were unable to tell us when members of staff were due to undertake refresher training in order to maintain their skills and knowledge.

The provider had recently introduced an initiative to ensure that an experienced member of staff would be a designated supervisor for each shift. These members of staff had not however received any training or guidance on how to develop their supervisory knowledge or apply it effectively. Staff told us and records confirmed that they had not received regular supervisions in order to develop their knowledge of the service and professional skills. The registered manager showed us that they were introducing a programme of supervisions for staff but we noted that these were still infrequent and not all supervisions had been allocated a specific date.

Some people required assistance by staff to eat and drink enough to keep them well. Most people told us that they made their own meals but were regularly offered drinks when staff visited. Staff we spoke with could explain what people liked to eat and they told us how, in the past, they had prompted people who lacked mental capacity to eat sufficient quantities. We visited seven people in their own homes and noted they all had access to drinks and things they liked to eat within reach.

Records of people's nutritional support were not robust. We saw that staff had recorded what the person had eaten when they were known to be at risk of malnutrition. They had not however, recorded how much the person had

Requires improvement

Is the service effective?

eaten. Records for another person identified that they were at risk of malnutrition. However the registered manager was unable to find a plan about how staff were to respond to this.

People told us that they had access to other health care professionals when necessary to maintain their health. One person told us how a member of staff helped them to attend a local health clinic. During our visit a health care professional, who was visiting a person who used the service, told us they felt their instructions for how care staff were to support the person were well known and carried out appropriately.

Requires improvement

Is the service caring?

Our findings

All the people we spoke with said that staff were caring and were happy to be supported by the service. People told us staff were considerate and respectful of their wishes and feelings. One person told us, "[Carer's name] is very helpful." Another person told us, "The staff really helped me settle in."

People who used the service told us they had developed positive relationships with the staff who supported them and spoke about them with affection. A person who used the service told us, "There is a smile on their face when they come in." People who used the service told us that staff were sympathetic to their needs and that staff respected their choices and delivered care in line with their wishes. People told us that staff would change their call times if they wanted to stay in bed or would respond promptly to any additional requests for support.

Staff we spoke with could explain people's specific needs and how they liked to be supported. During our inspection we saw staff supporting people to attend a hairdresser and discuss what hair styles they would like. People were clearly enjoying this interaction with the members of staff. However several people we spoke to and the feedback from the recent provider's survey indicated, that a lack of consistent staffing had prevented some people from developing relationships with care staff. Most people said this was now improving.

People who used the service told us that care staff regularly asked if they were happy with their care and made to feel comfortable to express their opinions. People we spoke with said they felt involved with how their care was delivered because care staff regularly asked their views when supporting them. However the provider had no process to ensure they formally engaged with people so their care plans would reflect any changes in their care needs and how they wanted to be supported . Although care staff were aware of how people liked to be supported, there was no information and guidance which would enabled new staff to support people in line with their most recent preferences.

The service promoted people's privacy and dignity. All the people we spoke with told us they were supported by staff of their choosing so they retained their dignity when receiving personal care. Staff told us they supported a person whose behaviour could compromise their dignity and what actions they took to ensure their dignity was maintain. We noted however that there was no care plan in place to help ensure staff would consistently supported the person to maintain their dignity.

During our inspection we noted that the care staff shared an office with members of the provider's staff who were not involved in providing personal care to people who used the service. We noted on several occasions that staff discussed people's care needs within hearing distance of these non care staff and documents relating to people's' care plans were left unsecured in the office. This did not respect people's right to confidentiality.

Requires improvement

Is the service responsive?

Our findings

People who used the service told us that their care needs were being met and that the staff would respond appropriately if their needs and views changed. One person told us, "I can buzz staff anytime and they will come." Another person told us that staff would attend their calls earlier if requested. The relative of a person who used the service told us that staff would make additional calls to the person for reassurance when they were unable to attend themselves. A person told us when they were concerned their call buzzer was not working that, "I didn't feel happy about it and it was changed." All the people we spoke with told us that staff would also undertake ad-hoc duties as required. These included taking people to a hairdresser and attending to answer door bells when people were unable to mobilise.

People told us they were supported by staff they liked and who knew their preferences. Staff we spoke to were able to tell us how people preferred to be supported and how they supported them in accordance with their wishes. A member of staff explained how they would sometimes use a wheelchair to help a person mobilise when their condition changed. The person they supported told us that staff promptly recognised when they were having a, "bad day," and would respond appropriately.

People told us that they were regularly asked by care staff if they were receiving care in line with their wishes. We noted that the provider was currently in the process of conducting a survey of people's views about the service. The registered manager advised that arrangements for analysis and responding to comments received were not yet in place.

The registered manager told us that call times for the people who used the service were linked to meal times e.g. breakfast, lunch, tea and supper but it was not clear from the records we looked at what time had been planned for people to receive their support. Records showed that care staff did not regularly attend arranged calls at the same time each day. On occasion these times varied by over an hour each day. When staff had failed to record they had attended a person's planned call, the registered manager could not confirm if the call had taken place or not. Therefore the provider could not identify if people were receiving support in line with their care needs.

Staff did not have access to up to date information to support them to provide care in response to people's wishes. The registered manager told us and we saw that most care records were incomplete. This made it difficult to identify how staff were to provide care which would be in keeping with people's lifestyle choices and their expressed preferences. There were however summaries of people's care plans in their homes which did contain some personal information for staff. These however were also not regularly updated or reviewed with the people who used the service.

People we spoke with were aware of the provider's complaints process and told us that they received copies when they joined the service. All the people we spoke with felt that concerns would be sorted out quickly by care staff, without the need to resort to the formal process or involving the registered manager. We saw that investigations into two formal complaints were robust. People had been supported by family members to express their views and had received a formal response and apology, when appropriate, from the provider. We saw evidence that the provider had learnt from concerns raised in order to improve the service. In one case this had resulted in more staff being on duty.

Requires improvement

Is the service well-led?

Our findings

The provider did not have robust processes for monitoring and improving the quality of the care people received. There were no processes in place to review the care people received or identify if people were receiving care in line with their needs. Records sampled were not updated and they has not been filed and stored in date order so they could be reviewed effectively. We could not readily identify that information staff required to deliver care in accordance with people's needs and wishes was available. The registered manager was unable to explain how some people's specific conditions were managed because they had not been able to find the necessary information in their care records.

Although the registered manager had started to review people's care plans they had not developed a process to ensure they would be done promptly and that they would be regularly reviewed. The chief executive and registered manger had identified several concerns with the quality of the service but had not developed any plans to address these concerns. There was no information provided about what actions had been taken in order to keep people safe. We saw that when an action plan had been developed last year by the provider but it had not been completed. Actions taken had not been assessed for their effectiveness and uncompleted tasks had not been reviewed or rescheduled.

Incidents such as accidents and falls were reported to the provider's health and safety representative for analysis and review. This was to identify any adverse trends and where people were at risk from repeat events. The registered manager however told us they did not receive any feedback from this analysis and was unable to identify people who may be at increased risk of harm or experiencing missed or late calls. They were unable to identify what actions they may be required to take, if necessary, to improve the service and prevent similar incidences from reoccurring. The failure to assess, monitor and improve the service and mitigate any known risks was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people we spoke with were happy to be supported by the service and expressed no concerns with how it was managed. A health professional who was supporting a person who used the service told us, "The service is very good, one of the better ones." Staff told us they enjoyed working at the service but could be busy at times. Staff felt it had improved since the new registered manger was in post. However we saw adverse comments from people who had responded to the provider's recent quality questionnaire. Four respondents stated they were unhappy with not being informed when staff were going to be late.

The provider had a clear vision for the service which the registered manager shared. The registered manager told us, "My vision is to make the service professional in how we act, look and talk." We saw this was displayed on noticeboards around the public areas of the provider's housing scheme.

People told us they were encouraged to express their views about the service when care staff supported them and we saw that the provider had sought their views in a recent survey. Most people told us they had not met the new registered manger or been involved in any formal review of their care plans. People did not know if their care plans reflected their preferences or were due to be reviewed. The provider had no formal process to conduct reviews with people which meant that people were limited in how they could influence and be involved in developing the service.

Staff we spoke with told us the registered manager was friendly and supportive if they raised concerns. However the provider's formal process to enable staff to share their views of the service was not robust. Staff told us and records showed, that there was no robust process to hold individual supervisions with staff, in order to identify how they could best improve the care people received. The registered manager told us they were currently arranging supervision meetings but we saw these were infrequent and some dates had not been specifically identified. When a planned supervision did not take place it had not always been rescheduled.

We noted the provider had held some staff meetings but these were also infrequent. The registered manager was unable to show us the planned dates of any future meetings. Several members of staff told us they had views they wanted to share with the registered manager but were awaiting the opportunities to do so.

The failure to seek and action feedback from people using the service, staff and other relevant people to assist in continuous evaluation and improvement of the service was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

Is the service well-led?

The registered manager had worked for several years in a non-care role at the service. They took on the additional responsibility for the provider's care service about two months prior to our inspection when the previous registered manager left the service. There was no evidence that the provider had ensured the registered manager had been supported to gain an understanding of people's care needs and develop robust plans to identify, monitor and review the actions which would be required.

The chief executive of the organisation told us that the registered manager was initially being supported to develop the care team and would then embark on a programme of reviewing people's care needs. But there were no plans in place to reflect this or evidence that tasks had been prioritised in order to keep people safe from the risk of harm. Evidence of a previous action plan that was incomplete had not been addressed by the provider .

The registered manager understood some of their responsibilities. This included informing the Care Quality Commission of specific events the provider is required, by law, to notify us about and working with other agencies to keep people safe.

Staffing structures did not support care staff to be clear about their roles and responsibilities and what was expected of them. The registered manager had introduced a system to ensure that one member of staff would act as a supervisor on each shift. However there was no formal guidance for staff about what the role entailed or support to conduct their supervisory tasks in addition to normal care tasks.

The provider had not ensured there was clear guidance to staff about how they should respond to ad-hoc requests for support outside of people's agreed call times. We noted that staff were regularly required to respond to unplanned requests for support from the people who used the service and those people who also lived in the provider's housing scheme.

Staff were also responsible for other duties around the housing scheme but lacked leadership on how these were to be managed along with their required care tasks. The tasks that staff referred to included serving and clearing food in the provider's dining room as well occasional reception dutiesWe saw that staff were called on to escort visitors to people's homes. Staff told us that they often attended calls late because they were engaged in some additional duties and were unclear on how they should prioritise their responsibilities. Staff had not been provided with guidance or instruction about prioritising work, tasks and duties.

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
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's rights and freedom to make decisions were not consistently upheld or protected in line with legislation. Policies and procedures for obtaining consent to care did not reflect current legislation and guidance. Regulation 11 (1)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure they had robust systems to assess, monitor and improve the quality and safety of the service. Regulation 17 (2) (a). The provider did not ensure they had robust systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17 (2) (b). The provider did not ensure they had robust systems to maintain securely an accurate, complete and contemporaneous record in respect of each service users, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (2) (c). The provider did not seek out and act on feedback from relevant persons for the purpose of continually evaluating and improving the service. Regulation 17(2)(e)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that sufficient numbers of suitably qualified, competent, skilled and experienced staff were employed to in order to make sure that they could meet people's care needs. Regulation 18 (1)