Cavendish Healthcare (UK) Ltd

St Marys

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 19 June 2015 and was unannounced.

At our previous inspection of 20, 21 November and 22 December 2014, we found a breach of legal requirements regarding having suitable arrangements in place to ensure the service complied with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Also the provider had not taken proper steps to ensure that each person had been protected against the risks of receiving care or treatment that is inappropriate or unsafe. Staff had failed to respond appropriately to an allegation of abuse and how the quality of the service was monitored.

We asked the provider to take action to make improvements. An action plan was received from the provider which stated they would meet the legal requirements. During this inspection we looked to see if these improvements had been completed.

Summary of findings

We found that action had been taken with regard to the above but further improvements on these issues and others found were still required.

St Mary's provides a residential service not nursing for up to 59 people accommodated over two floors. This includes care of people with dementia. On the day of the inspection the service was providing care to 46 people.

A registered manager was not in place, but the manager was applying to become the 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.

The experiences of people who lived at the home were mixed overall. Some people felt safe, while others did not feel there were enough staff, which was a view shared by some relatives.

All staff spoken with confirmed they have received training in recognising and responding to abuse and were knowledgeable about how to make referrals to local safeguarding authority and Care Quality Commission.

Some of the care plans did not provide sufficient guidance for staff to keep people safe and how to care for them. The service did not use a dependency tool to calculate how many staff were required to be on duty and had not permanently identified senior staff to night duty. Instead staff of the same rank were allocated to be in charge on the night shift. Staff had been assigned to work on the dementia unit without having undergone training in dementia or challenging behaviour.

The service had a safe procedure for recruiting staff, however supervision although planned had not been provided for staff. Staff did not receive annual appraisals. This meant that opportunities to plan staff training opportunities and planning their development had not been provided. .

The service had worked with the pharmacy to have an effect procedure for ordering, administrating and auditing medicines.

Staff were not fully aware of which people had been identified as at risk of malnutrition. During our inspection we heard staff inform people that there was no choice of pudding for lunch other than a fruit cocktail. We could not find that the service undertook calculations at the end of the day to assess whether or not people identified as at risk had consumed sufficient amounts of fluid to meet their needs.

There was no planning for supporting people to have regular baths and showers on the dementia unit.

People received funding for one to one care but this was not planned or accurately recorded.

Complaints discussed at a staff meeting were not recorded as a complaint in the provider's log of complaints. Also timescales were not recorded for when complaints had been responded to.

There was evidence of some audits. However, these were sporadic and not did not contain action plans with timescales where shortfalls had been identified.

Staff spoke positively about the manager and deputy at the service and told us that they were supportive.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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?

Requires improvement

Some aspects of the service were not safe.

Staffing levels had not been determined with regard to the specific needs of the people, a ratio of staff to people was being used.

There were no permanent senior designated night staff

Recruitment procedures designed to keep people safe had been correctly followed. Medicines were managed safely and appropriately.

Is the service effective?

Inadequate

Some aspects of the service were not effective.

Staff had not received supervision and staff had been assigned to work in the dementia unit without having training to work with people with a diagnosis of dementia.

The service had completed Mental Capacity Act assessments and completed Deprivation of Liberty Safeguards referrals appropriately.

There was insufficient choice of food available regarding desert, however we aware staff had gone out of their way to find some food that people wanted.

Is the service caring?

Requires improvement

Some aspects of the service were not always caring.

Peoples involvement in their care planning was inconsistent

One person was not able to meet their spiritual needs

People considered staff were caring

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

People's social care and emotional needs were not being properly assessed, planned and delivered.

Not all people's care plans were sufficiently detailed to enable staff to deliver consistent, personalised care that met people's individual needs.

Complaints were not accurately logged and there were no time-scales to inform when complaints would be investigated and concluded.

Is the service well-led?

Requires improvement

Some aspects of the service were not well-led.

Audits did not contain action plans with timescales where shortfalls had been identified.

Summary of findings

Members of staff found the managers approachable and supportive.

On-call arrangements to support staff were not clear to all staff.

St Marys

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 tool place on 19 June 2015. This was an unannounced inspection and the team consisted of two inspectors 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 used a number of different methods to help us understand the experiences of people who used the service. We spoke with eight people who used the service, four relatives, the cook on duty, three members of care staff, two senior care staff the deputy manager and the manager. We looked at six care records. We used 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 looked at five people's care records and other records which related to the management of the service such as training records and policies and procedures.

Before our inspection, we reviewed all the information we held about the service. This included notifications of incidents the provider had sent to us. We also looked at safeguarding concerns reported to us. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect.

Requires improvement

Is the service safe?

Our findings

At our last inspection of November and December 2014, we found that the provider had failed to take action to ensure people's health and welfare was not put at risk and action taken to protect people from the risk of harm. The provider sent an action plan to us explaining the improvements they were putting in place.

Whilst we found some improvement at this inspection, further action is required.

We spoke to a person who had a serious health condition. We looked at their care plan and found that it did not provide guidance for staff in order to provide care to the person. The care plan only told staff to check on the person every 30 minutes but there was no log of this having been carried out. Staff could not confirm that they were carrying out 30 minute checks and there was no other information with regards to meeting the person's needs. We found that the care plan did not include a current risk assessment in relation to the person's diagnosis. The impact of this situation was that the staff did not have the information required to care for the person which could have left this person at risk harm.

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

People told us they thought there were not enough staff at the service. One person said. "I was lying in bed asleep and woke up to find a lady poking me and I told her to go away. Next morning I told a member of staff and they said that it should not happen and she would look into it." This happened as there were insufficient staff on duty at night. The night staff were not able to monitor people appropriately and were therefore unaware and unable to prevent people from disturbing others. A relative told us. "The staffing could be better in general. Everybody seems so busy."

We spoke with the manager about staffing levels. The manager was not able to explain to us how the staff establishment was calculated with regard to the assessment of people's needs.

Seven people on Constable Unit required support with two care workers for personal care and support with mobilising. Three staff were allocated to this unit at each shift. This included one senior care staff member plus two care staff.

All of the staff spoken with working on this unit said the staffing levels meant there was not enough staff to support people safely and meet their needs. They stated that some seniors supported them but this was not the case with all seniors.

Prior to lunch we asked staff how many In Constable unit required help with their lunch. They were not sure but thought it was two, however we observed that seven people needed assistance.

The impact upon people was that there were not sufficient numbers of staff to meet their needs as required.

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

There were no dedicated senior night staff. It was decided on the night which member of staff would be in charge. The manager told us they were addressing the situation of appointing designated senior staff to night duty. Night staff were trained to administer medication.

People felt safe. One person told us. "The staff are very good and I feel safe." Another person told us about a fall they had recently experienced and how quickly the staff attended to them.

All of the staff spoken with confirmed they have received training in recognising and responding to abuse. We found they were knowledgeable about how to make a referral to local safeguarding authority and CQC. The provider had safeguarding policies and procedures in place. Staff we spoke with told us they would immediately raise any concerns with their manager.

The provider had a safe and robust system in place for the recruitment and selection of new staff.

We looked at five staff files and found proper recruitment processes, which are designed to keep people safe, had been consistently followed. For a new member of staff we saw that the service had taken up references from their last employer and sort confirmation that a DBS (Disclosure and Baring Service) check had been completed. A member of staff confirmed with that when they were employed they had completed an application form, attended an interview and had a job description and contract.

People told us they received their medicines on time and staff them about the medicines, when they asked what they were for. We found medicines were stored securely

Requires improvement

Is the service safe?

and managed safely. We looked at 16 person's Medication Administration Records (MAR) and found there were no gaps in the administration of medicines and the balance of medications agreed with the MAR. We saw that medicine administration was divided up into medicine trolleys for different units and ensure people received their medicines on time. We inspected the Controlled medications which are required to be in separate lockable cabinet and two staff signed to state they have been administered. We found for each person prescribed this medication their medication chart and the controlled drug administration book had been completed correctly. The two senior staff we spoke with told us about their training and support they had received from the supplying pharmacy to assist the service manage medicines safely.

Inadequate

Is the service effective?

Our findings

At our last inspection of November and December 2014, we were concerned that the provider did not have suitable arrangements in place to ensure they complied with the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The provider sent to us an action plan and at this inspection, we saw that the service had addressed the matters raised. Staff had received training, assessments had been carried out and DoLS had been submitted. We discussed a best interest meeting with the deputy manager and saw how the service had worked with an individual and kept their family informed. We also saw the correct documentation had been completed and submitted.

However we found that staff training and development was not sufficient to show that people's healthcare conditions were fully understood by staff so their needs were recognised and met consistently.

Two staff recently employed by the service within the last four months had both been placed to work on Constable Unit. This unit is designated within the service to provide care to people with dementia. The staff had not received training in supporting people with dementia. One member of staff had no previous experience of working in the care profession. When asked how they were supported to know how to meet the needs of people with advanced dementia. They told us, "I just follow what the other staff does. We are also caring for people with learning disabilities and I have had no previous experience or training to know how to care for them properly."

Although one person told us they had received induction, we found two further staff files with no evidence of their induction training having been provided.

Training was provided by the deputy manager, including moving and handling. We were not able to see evidence of their accreditation to provide this training and they were unable to provide evidence of refresher.

There had been no staff training provided in meeting the needs of people living with a diagnosis of specific medical condition. The impact upon people was that staff did not have the knowledge to meet their specific needs.

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

We saw that supervision sessions to support staff had been planned but as yet had not been provided.

Discussions with the cook on duty identified that they were not made aware of which people had been identified as at risk of malnutrition. They stated that staff gave nutritional supplements and did not get involved in fortifying foods even though they had received The Malnutrition Universal Screening Tool (MUST) training last year where they learnt how to fortify foods.

We found food and fluid charts did not state what food has been eaten and not always amounts eaten. There were gaps in recording of food and fluid charts of up to five days. Fluid was monitored for people assessed as being at risk of malnutrition and de-hydration but no plan to provide staff with the guidance they needed as to what amounts people should be consuming and neither calculations at the end of the day to assess whether or not these people have consumed sufficient amounts of fluid to meet their needs.

We also found that MUST records had not always been calculated correctly. Where two people had lost weight of 3kg or more they were scored as 'o' incorrectly and there was no record of action taken to protect the person from the risk of malnutrition. For example, referral to a dietician.

One person had experienced continued weight loss since: 25 May 2014 when their weighed was 86.7kg and their current weight was 59.20kg. They had only been referred to dietician in February 2015 when weight had gone down to 66.9kg. The care plan states offer regular snacks but we could find no record of snacks offered. This same person prescribed nutritional supplements. Section to record when these have been consumed left blank of food and fluid chart. Person observed on day of inspection to throw their lunch time supplement drink on the carpet. Not recorded on food and fluid chart as not consumed. This meant that inaccurate record keeping could have an effect upon the well-being of person, as we could not be sure they were having enough to eat and drink.

During our inspection a person asked what was the alternative to fruit salad for pudding. They were told there was not any alternative. We discussed this with the manager and told us there were alternatives and they would address this with staff immediately.

This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Inadequate

Is the service effective?

One person told us the staff had gone out of their way to find them some food they fancied and on the day of our inspection thought the scampi was very good.

One person told us of a specific time they were happy with the care provided. “I was poorly a few days ago and the staff insisted I saw the Doctor.” They explained the Doctor reviewed and made a change to their medicines. They said. “Feeling so much better now and have not looked back.”

People reported they received appropriate healthcare support. One people said, “The GP visits and you can see them.” Care plans showed people were routinely referred to community health professionals such as dieticians, community nurses and doctors The outcome of these visits was documented to assist care staff in meeting peoples’ needs, but what the service then did was not always clearly documented. However one relative did not feel that the service had referred their relative appropriately to see their GP.

Requires improvement

Is the service caring?

Our findings

At our last inspection of November and December 2014, we were concerned about the care provided to people. The provider sent an action plan to us outlining the improvements they were going to put into place.

Although we recognised improvements had been made one person told us they were not being supported to meet their spiritual needs fully. This was because they could not attend a place of worship and they were not visited by a person of that faith. The impact was that the person's needs were not being met with regard to their spiritual preference.

A relative told us about their [relative] who had not they believed had a shave for 3 days. This was not in keeping with their preference as they were use to shaving every day.

People's involvement in their own care including planning and making decisions was inconsistent across the service. People who were able were involved in making decisions about their care and supported to express their views. However people who experienced difficulty in making decisions and expressing their choice or preference were not always supported as well. For example, we saw staff work extremely well with some people but more information and time spent with people with dementia to express their choice at meal times would have provided them with greatly opportunity to express their choice.

A relative said they and their [relative] were not involved in making decisions about care and hence not respecting the person's views or supporting them to make decisions.

The relative explained to us that they had discussed with the service about their [relative] moving rooms within the service. They also discussed that although they would move they could continue to access all parts of the service to which they were assured. They considered this was extremely important so that their relative could continue to benefit from the activities provided. However, they informed us that their relative was moved without any further consultation and also to another part of the service (upstairs) and this option had not been explained or discussed.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014

People were very complimentary about the attitude of staff who they said were kind and caring. One person told us about a problem they had experienced and they said. "The care was exemplary."

Another person said, "Staff were friendly and they engage in conversation as well as carrying out care." People said that staff respected their choices, for example one person said. "I prefer to stay in my room and staff respect this choice."

One person told us of a specific time they were happy with the care provided. "I was poorly a few days ago and the staff insisted I saw the Doctor." They explained the Doctor reviewed and made a change to their medicines. They said. "Feeling so much better now and have not looked back."

People we spoke with said their privacy and dignity was respected. People said when staff were providing personal care, doors were closed and curtains drawn. We observed that this was routine during our observations on the day of the inspection. One person told us. "There are lounges within the home where I meet my family and the staff work hard to keep them clean, I think that shows they care."

Our use of the Short Observational Framework for Inspection (SOFI) tool found most interactions between staff and people were positive. Staff were calm, patient, used non-verbal communication to help explain. We found staff asked people their choice around daily living, such as if they wanted to go outside. People told us the staff asked them what they wanted to wear when supporting them to dress when getting up.

We spoke with staff about people's preferences and needs. Staff were able to tell us about the people they were caring for, any recent incidents involving them and what they liked and disliked.

Requires improvement

Is the service responsive?

Our findings

A member of staff informed us. "The bathing here is not very good and it is the only home not to have a bath list, I think that some of them never have a bath." They further explained that they could not find information in the care plan as to whether a person preferred a bath or a shower. We saw that one bathroom was not in use for bathing and was being used as a store room for a bedframe. It was explained to us that the service was purchasing new furniture and this was a temporary measure until it was permanently removed. People told us that they were not given the choice of having a bath or shower it had been assumed that their choice was a shower.

Two staff we spoke with told us that there is no planning for supporting people with access to regular baths and showers on the dementia unit.

Four people's care plans recorded they required support with baths but did not contain evidence of people's choice of bath or shower or when this support was to be provided. We could not find in any of the four people's records when they last had support with a bath or shower. We discussed this with the manager at feedback. The manager confirmed there is no system in place for planning support with bathing/showering. This meant that people's choice was not respect.

The provider receives funding from the LA to support two people for 15 hours per week, with one to one support. How this planned and provided was not mentioned within both people's care plans and so was not evident how the planning to ensure this support is provided was unknown.

We spoke to a staff member who had responsibility to provide this one to one support and we observed they had not spent time with the person during the morning and only provided support at lunch time to eat their meal. The staff member could not confirm any planning for the hours allocated for this one to one support other than support at meal times and confirmed no care plan guidance had been provided.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's records provided evidence that a needs assessed prior to admission to the service was carried out. This information was then used to complete more detailed assessments to complete a care plan. However, we were unable to see that the care plans were reviewed on a regular basis with people and their relatives. We therefore could not be assured that people were involved in relevant decisions about their care, treatment and support. Some staff did appear to be knowledgeable about the people in their care, which lessened the impact of this raised concern and staff would respond to people's needs. Due to the lack of staffing particularly upon the unit where dementia care was provided, this would delay responsive and prompt care being provided. Also while staff dealt with the immediate needs of people due to the lack of staff we could not be assured that care needs were assessed recorded and care plans updated. The impact of this is that it put people at risk of inconsistent care and not being fully person centred.

People told us they had access to suitable activities. For example, one person said "There is always something going on in the lounge." The service had employed an activities co-ordinator and people spoke highly of the activities and inter-actions.

Daily handovers took place so that staff could update the next staff on shift about people's needs and if any changes in their care had been identified. Staff we spoke with told us the handover was a good source of information for keeping up to date with changes and information they required.

Three complaints were logged for the last year. All related to problems with the laundering of clothing, missing clothes and clothing that does not belong to the person found in other people's rooms. Also clothing ruined due to lack of care. Complaints discussed at staff meeting from one relative was not recorded as complaint in the provider's log of complaints. Timescales had not been recorded for when complaints had been responded to. One person thought that the service listened to them and would respond promptly if they made a complaint. A relative informed us that the response to any issues raised depended upon the staff on duty at the time. This was meant the service was inconsistent and we could not be confident that complaints were recorded and hence acted upon. A relative informed us that the service did not easily welcome them to feedback upon their experiences about the care their relative had received. Their concern was that they may not take their views on board fully and change or develop their practice to improve.

Requires improvement

Is the service well-led?

Our findings

At our last inspection of November and December 2014, we found that there was a lack of action taken by the provider to monitor the quality and safety of the service. This had placed people who used the service at risk of receiving inappropriate and unsafe care.

Following our inspection the provider sent to us an action plan. However, this did not describe how the provider would plan to put improvements into place.

Whilst we found some improvement at this inspection 19 June 2015, we found that further work was required to ensure the provider was meeting the legal requirements.

There was not a consistent approach to quality assurance to ensure effective development and improvement of the service. There was a lack of managerial oversight of the service as a whole and the manager was unable at this time to demonstrate, how they identified where improvements were needed or applied learning across the service. Whilst accidents and incidents had been recorded there was inconsistent analysis of incidents and action taken to protect people from harm. For example, people who had experienced a high number of falls had not been referred to the falls prevention team for specialist support and advice. This put people at risk of receiving inappropriate and unsafe care.

There were insufficient quality assurance and audit processes. For example, the care plan audits did not appear consistent as to when or how carried them out, however we did see evidence that care plans were reviewed appropriately as a result of an event. This showed us that quality assurance systems at the service were not robust and required improvement to ensure risks were identified and quickly rectified.

Whilst the provider had made some improvements to the quality of the service since our last inspection, further work was needed to ensure this was consistent and improvement sustained. There was evidence of some quality and safety audits. However, these were sporadic and it was not evident who carried out the audits as no name or designation of person had been recorded on the audit record. The manager told us a manager from another home carried out audits of the service. This meant it was not evident how the provider was planning to take action in response to concerns or how they planned for continuous improvement of the service.

Resident and staff meetings were not regular; we saw that two had been recorded in the past year. Hence there was a limited opportunity for staff and people to feedback on the quality of the service. We saw there was a suggestions box in the reception area of the service. However nothing had been logged to evidence how the provider had responded to these.

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

People, relatives and staff had varying views about the leadership of the service. Some people were unsure of who was the manager and thought the deputy manager was in fact the manager. Staff considered at times the management were re-active rather than pro-active and there was inconsistency depending upon who was in charge which in turn lead to confusion as to exactly what they should be doing. Some staff said the culture of the service was open and they found the manager and deputy supportive and approachable. Whilst others said there was a lack of senior staff support for staff working on the dementia care unit. Staff considered that the way the service was managed did not always anticipate risks and have strategies to minimise them for ensure the smooth running of the service in particular in the dementia unit. No doubt this was also due to inexperienced staff being placed on the unit or staff that had not completed training in dementia awareness. Hence although some staff felt supported they were not clear in their roles or responsibilities which was further highlighted by the night staff not knowing until they were on duty who was going to be in charge of the shift.

Documentation which related to the management of the service required improvement. For example the training matrix was not up to date and did not contain accurately the training that had been provided.

The manager told us they had plans in place to continue to review and update peoples' care records. We were aware that the service had changed documentation to improve communication and the documents were stored securely.

The manager told us they and the deputy manager were available to support staff when they were not on duty as

Requires improvement

Is the service well-led?

they provided an on-call system to support staff at the service. However we could not find a rota and therefore could not be assured that this support was always available.

People we spoke with said there was a good atmosphere in the service and staff felt that the environment on the dementia unit had improved. One person told us. “They are a good care team, get on well together.” From our observations people seemed relaxed and had a good rapport with staff.

The staff and management of the service were consistent in what they thought the service was improving since our last inspection. For example, all thought having regular staff on duty was an asset.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person Centred Care. The care and treatment of people who use services did not meet their needs and reflect their preferences. Regulation 9 (1) (a) (b) & (c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment The care and treatment was not provided in a safe way for services users. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs. The nutritional and hydration needs of service users must be met. Regulation 14 (2) (b)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. Regulation 18 (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staff Sufficient numbers of suitably qualified, competent and experienced persons must be deployed in order to meet the requirements of this part of the act. Regulation 18 (1)