Apollo Home Healthcare Limited

Apollo Home Healthcare Limited - East Anglia Office

Inspection report

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Date of inspection visit:
10 April 2019
12 April 2019

Date of publication:
05 August 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Apollo Healthcare Ltd is a domiciliary care agency specialising in providing personal care and assistance for people with complex healthcare needs living in their own homes. The East Anglian office of Apollo was supporting 27 people at the time of this inspection, including eight children, the majority of which was funded by NHS Continuing Health Care for 24/7 care. This support often included appropriately delegated healthcare tasks required to enable people to live in the community safely.

People's experience of using this service and what we found
People using the service gave us mixed feedback regarding the availability and consistency of care staff. The potential negative impact upon people not receiving care, support and clinical interventions when needed was so significant we judged this to be a breach of regulations regarding staffing.

People received their medicines when they should. However, we made a recommendation about their medicines administration systems. Records relating to the planning of end of life care and mental capacity assessments were not based upon best practices. We recommended that the provider reviewed best practice guidance in both these areas.

Feedback regarding the administrative team was mixed with people reporting inconsistent communications. People experienced a service that needed to improve the way complaints were used to drive consistent quality provision. The quality assurance systems were not always sufficiently thorough to identify issues. The effectiveness of communication and organisation of the service therefore required improvements.

The care provided was rated highly by people in that they felt safe and the care received was of good quality. Staff ensured people's safety and acted when necessary to prevent any harm.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. People received a thorough assessment which effectively supported achieving their desired outcomes. Comprehensive training and nurse led support ensured staff were competent to carry out complex health and social care. People were supported to maximise their health and well-being. People with often complex health conditions were supported to access their community.

People described care staff as kind and compassionate. They promoted people's independence and dignity. The provider ensured people's individual characteristics were respected and supported. The provider involved people in decisions about their care and sought feedback regularly on the standard of care provided. People were positive about the registered manager's approachability and support.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
This service was registered with us on 12/04/2018 and this is its first inspection.

Why we inspected
This was a planned inspection based on the service's registration date.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

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Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was completed by one inspector 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.

Service and service type
This service is a domiciliary care agency. It provides personal care and nursing support to adults or children living in their own houses, flats and specialist housing. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the provider or registered manager would be in the office to support the inspection. We also needed consent to speak to people using the service to be gathered.

What we did before inspection
We reviewed information we had received about the service since they registered as a provider. We sought

feedback from the local NHS Continuing health care team and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and 12 relatives about their experience of the care provided. We spoke with six members of care staff and the provider's nominated individual, registered manager, and regional clinical lead. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included three people's care records and medication records. We looked at four staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, including quality assurance records, complaints and incident records, policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with three professionals who regularly work with the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At this inspection this key question was rated as 'requires improvement'. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

● Due to the complexity of the care required, it was usually not appropriate to use generically trained or unfamiliar carers. The provider therefore agreed contingency care plans with both family and commissioners to avoid admission to hospital when regular carers were not available. These plans typically identified seeking trained nurses as cover when required, but also often identified a family member as a last resort. As such these contingency plans had ensured no hospital admissions had been required and no-one was left without care. However, we found the competency of family members to provide complex and in some cases potentially life-saving care was not suitably risk assessed. This could place people at increased risk if the family carers did not have the required expertise to deliver the care.

● We received mixed feedback on the availability of staff. Half of the people we spoke with reported occasional shifts were missed (approximately once a month) and family had to provide care, sometimes without notice. For example, one relative said, "A carer was on annual leave, but the office didn't know when I called to find out where they were." On one occasion when a person was left in the care of a family member the person fell and injured themselves. Relatives also reported having to cover care had negatively affected their own lives, including loss of money and stress. The agency acknowledged that one percent of shifts had been covered by family over the preceding three months.

The failure to ensure sufficient numbers of staff nor appropriately risk assess the contingency plan was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider operated a robust and thorough recruitment process to ensure that staff were of appropriate good character to provide care in people's own homes. This included checks with the Disclosure and Barring Service (DBS) and the receipt of references.

● The provider recruited a team of care staff for each person requiring support. These staff would then be individually trained and assessed as competent in all required healthcare tasks such as tracheostomy or specialist feeding device care by an appropriate nurse prior to commencing care.

Using medicines safely

● People were receiving their medicines when they should. The provider audited the medicines administration recording monthly to monitor and respond to any errors found. We noted occasional gaps in medicines administration records (MAR) which the audits had failed to pick up. However, this appeared to primarily be a recording issue rather than administration issue. For example, in one instance the service user had been away and cared for by family; and in another, the family were confident the medicines had been given but not recorded.

● Staff were trained in the administration of medicines and could describe how to do this safely. Their competency to do so was checked regularly by the provider.
● Medicines management systems were not always well organised. For example, both staff and people using the service noted that the MAR were not always delivered in time to start the new month, necessitating staff expanding on the old records, sometimes for several days. The provider advised they had recently identified this issue which they attributed to be due to waiting for information from the prescriber. They had recently revised their practice to ensure sufficient MAR paperwork will always be available.
● Written guidance was in place for each topical medicine. The provider agreed to consider using body maps to provide greater clarity during the administration of topical medicines.
● The provider had a policy for the administration of 'as required' (PRN) medicines, however there were not always separate protocols for each PRN medicine prescribed. PRN protocols are needed to ensure staff have clear guidance on when to support people with medicines that were prescribed to be administered as required. The provider assured us that they would put individual protocols in place quickly.

We recommend they consider best practice guidance for medicines administration and the associated quality assurance tools and act to update their practice accordingly.

Assessing risk, safety monitoring and management
● We found that risks were well managed and mitigated where possible to ensure care and support was delivered safely. Each person receiving a service was assigned an office contact and clinical nurse who completed thorough risk assessments prior to commencing care provision. These covered both the environment and person's individual care needs. Each required healthcare task was suitably risk assessed and appropriate care plans were in place to guide staff.
● All risk assessments were quality checked by both the registered manager and clinical lead prior to the client and/or their family receiving a copy to check and sign. All staff providing care were required to sign to confirm they had read the care plans.
● All office staff and nurses complete external training in completing risk assessments.
● The provider recognised a person's rights to take positive risks and suitably risk assessed to manage these choices appropriately. For example, they enabled a person to have an alcoholic drink via their specialist feeding device.

Systems and processes to safeguard people from the risk of abuse
● People using the service and their relatives unanimously reported they felt safe when in the care of staff provided. One person said, "Yes definitely [safe]… the carers are knowledgeable."
● Policies in relation to safeguarding of adults and children, alongside whistleblowing procedures, were in place and staff continued to receive regular training based upon these.
● Staff demonstrated a good awareness of the types of abuse possible and how to recognise potential signs of abuse. Staff knew to inform the provider or the local authority if they witnessed or had an allegation of abuse reported to them.

Preventing and controlling infection
● Each person's file held personalised information on the prevention of infection. Many people required support from complex equipment and there were clear guidelines on how to keep items clinically clean. Feedback from commissioners noted one instance where a staff member had not felt sufficiently confident to clean a piece of medical equipment as per the care plan, which raised the risk of infection. Whilst the staff member had been trained and assessed as competent, the provider took appropriate actions by withdrawing and retraining them.
● Staff used appropriate personal protective equipment including gloves and aprons. The provider had

recently designated a staff member for each person, to be responsible for ensuring there was always ample stock of equipment and medicines.

Learning lessons when things go wrong

- People could be assured that the service and staff were learning from events because accident and incident records were completed and investigated appropriately by the registered manager.
- Themes were considered, and quality checks were completed by a regional manager.
- Lessons learnt and any changes to practice were disseminated to staff verbally and by email. Where changes were made to people's care plans staff were asked to sign to acknowledge the changes.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At this inspection this key question was rated as 'good'. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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. Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the Deprivation of Liberty Safeguards (DOLS) cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty. We checked whether the service was working within the principles of the MCA.

- People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. One family member told us, "They include [the person] in decision making… they respect [the person's] mental capacity." Another said staff "[supported choice] through play, allowing [the person] to make choices about what they want to do."
- We saw generic mental capacity care plans had been completed. These records guided staff as to which decisions people were likely to be able to make and how decisions should be made were they unable to do so themselves. However, the provider did always complete decision-specific mental capacity or best interest assessments which should be used to give staff guidance on specific issues.
- Records showed they had involved relatives and other professionals where necessary to make decisions in a person's best interests. Where children were being cared for, this included information about decisions the child could make and when the people with parental responsibility needed to be involved. The provider had not always sought proof or recorded when a person was legally authorised to make decisions on behalf of the person receiving care.
- Staff had a good understanding of the MCA and could describe how to support people to understand their choices and make decisions whenever possible. Staff were also aware of people's right to take risks. One staff member told us, "I would encourage [people] to not take risk but, at the end of the day, if they can make the decision, I shouldn't stop them." Staff described consulting the care plans or the delegated person when the person being cared for was deemed to lack the mental capacity to make a particular decision.

We recommend the provider consider best practice guidance in their recording of mental capacity issues and revise their practice accordingly.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People told us that their assessments and care plans were devised with their input and that they reflected their desired goals and preferences. We saw that the care plans included clear details of tasks and the person's preferred methods of support.
● The provider ensured that people's level of need was appropriately assessed initially, and the competency of the care staff matched their need. The nurse allocated would visit frequently in the initial stages to check the service was meeting the person's needs and ensure all staff introduced to the person's package were competent to complete the care required. Care plans and risk assessments were scheduled to be reviewed every six months or sooner if changes were identified. We noted that in one case revisions to care plans and risk assessments following a significant change in circumstance had been completed. However, an administration error meant the family nor care staff had been aware of the updated versions for several months. This had not impacted on the person however the provider acknowledged the risks had been raised. They immediately revised their practice to ensure updates were always quickly accessible.

Staff support: induction, training, skills and experience
● The provider had a comprehensive induction and training programme. New staff completed the Care Certificate, an industry recognised national training programme for staff working in health and social care; and spent time shadowing experienced staff. Staff had regular checks and refresher training on their key skills and competencies.
● Where people needed support with healthcare tasks the provider's nurses would ensure each member of staff providing care for the person was individually trained and assessed as competent to complete the task.
● We had positive feedback from people about the effectiveness of the training. One relative told us, "When we first started we had visits from the managers and the staff did a meet and greet beforehand to see how to work with [the family member]." Another relative said, "I have witnessed the training and [the provider's nurse] trains to a high standard."

Supporting people to eat and drink enough to maintain a balanced diet
● Staff understood people's needs and preferences in relation to food and hydration. People told us they were supported to maintain a healthy diet and were offered choice.
● When required, staff were appropriately trained to provide nutrition and medicines via artificial feeding devices.
● For people at risk of malnutrition, there were separate risk assessments and documentation to ensure adequate intake.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The provider and its nurses worked closely with allied health professionals and commissioners to support often complex and changing health conditions. We saw records that included liaising with occupational therapist, physio therapists, respiratory nurses, tissue viability nurses, dieticians and doctors. The provider sought monthly updates from the GP to ensure medicines prescribed remained unchanged.
● The provider often attended multi-disciplinary meetings to support a change in circumstances such as when a discharge from hospital was planned.
● Detailed care plans were in place to manage and monitor healthcare needs. For example, risks such as developing pressure ulcers were managed through techniques including regular repositioning, pressure relieving equipment and prescribed creams.
● All the people we spoke to told us staff were quick to alert the appropriate person to any medical concerns.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At this inspection this key question was rated as 'good'. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- All the people we spoke with described the care staff as kind and compassionate. One relative told us, "The care workers are absolutely outstanding, they are wonderful and understanding of our circumstances." Another described the staff as, "Gentle and kind."
- The provider ensured people's preferences were recorded and responded to. One relative described the use of the provider's 'All about me' document which supported staff to know the person's preferences. The provider usually met people's preferences such as care staff gender.
- Where appropriate, the provider ensured staff had specialist skills and aids for communication such as sign language to enable people to express their wishes.

Supporting people to express their views and be involved in making decisions about their care

- Everyone we spoke with described staff as enabling people to make decisions for themselves whenever possible. One relative of a person with limited verbal communication described how staff built an understanding of the person's communication. They said, "The carers interact with [the person] and build up a bond…. [the person] vocalises how they like things to be done."
- Staff described how they always asked people what help they wished for and offered choice. People told us they were always asked for consent and staff explained what they were doing.

Respecting and promoting people's privacy, dignity and independence

- All the people we spoke with described staff ensuring the privacy and dignity of the person being cared for. One relative said, "If they do personal care, they make sure curtains are closed and doors are shut, they do one part of the body first and explain what is going on."
- The provider was proactive in enabling people's independence. One relative described, "[staff were] working on giving back some independence, the [staff] assist with physio and encourage [the person] to do it."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At this inspection this key question was rated as 'requires improvement'. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns

- Complaints were not used to consistently drive up and maintain the quality of care provided. We had mixed feedback from service users regarding responses to complaints or concerns. Everyone we spoke with felt comfortable raising a concern or making a complaint. However, three people we spoke with were unhappy with the responses to concerns. Two relatives told us making complaints improved the issue initially, but the same issues often recurred with time. One told us, "I have made complaint after complaint, it improves for a short time and then drops again."
- Most of the complaints people reported to us were in relation to lack of consistency of care staff, short notice missed shifts (often due to sickness or staff leave) and poor communications.
- We saw in the provider's annual survey in August 2018, 88% of people using the service who responded to the survey, reported they had had to make a complaint.
- We saw that the provider had had six formal complaints in the three months preceding this inspection and these had been dealt with appropriately within a reasonable timescale.

End of life care and support

- The provider was not providing any end of life care at the time of this inspection however reported it offered tailored end of life care support as required.
- The provider was not accredited with a nationally recognised 'end of life care' training programme although staff received online training in end of life care when required.
- Many people receiving care from the provider had life limiting conditions. However, the provider had not approached them or recorded their wishes in the event of a deterioration requiring end of life care. Advanced care plans could provide both the dying, their families and the staff reassurance that the person's wishes would be respected.

We recommend the provider seeks advice from a reputable source regarding advanced care planning and training for end of life care; and act to update their practice accordingly.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- The assessments contained personalised goals. The provider was gradually implementing 'All about me' documentation, tailored to fit adults or children as appropriate. These would ensure care staff had a clearer picture of the personality and story of the people they cared for. These would also enable information to be passed to others if a change of situation such as hospitalisation occurred.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The provider showed documents were tailored to support different communication needs including 'easy-to-read' and 'child-friendly' versions.
- Individualised communication care plans were in place, including use of sign language and non-verbal communication methods.
- The provider recently introduced communication logs in each home to ensure accurate transfer of information. They aimed to contact people monthly via agreed communication methods to check the care was meeting people's needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- The provider ensured detailed risk assessments and care plans were in place to enable people with complex medical needs to access their community safely. This included ensuring correct equipment, medicines and care was available. Where required, it included methods of psychological support for people with mental health issues to promote people's activity in the local community. The provider gave an example of supporting people to go on holiday, including providing staffing and risk assessing the holiday environment. Other examples included support to attend horse racing or to go to the local pub.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At this inspection this key question was rated 'requires improvement'. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service needed to develop further to achieve consistently good outcomes for people. We received mixed feedback from people using the service and their relatives about the effectiveness of communication and organisation of the provider's office staff. Half of the people we spoke with reported difficulties getting a response from the office or out of hours support. Common issues included problems with rotas of staff which were not always complete, accurate or sent in time and poor responses to staff absences. People told us issues raised with office staff were not always dealt with quickly or appropriately.
- We found the provider was not consistently identifying and acting on issues and concerns. The provider's own annual survey, in August 2018, noted only 58% of people using the service who responded agreed they were 'able to contact the office to discuss their care,' and that only 35% agreed 'when they contact the office they felt listened to.' The provider reported they were aware of this issue and were actively working to improve administrative performance and communication. This included recently agreeing with people receiving care their preferred method for monthly contact, to check the quality and effectiveness of the care provided.
- Apollo reports they base their ethos on the 'The 6Cs' nursing principles devised by the NHS – 'care, compassion, courage, communication, commitment and competence'. They advised they had loyalty and performance rewards schemes for staff aimed at promoting these values.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider held quarterly quality surveys with different stakeholders (people using the service, allied professionals, care and office staff) enabling feedback on the service provided. We found that some issues raised in the service user survey in 2018 remained areas of concern, for example poor communications.
- We found that the provider had not always promoted an open and honest approach about the standard of service provided. The provider was however planning to establish stakeholder working groups to develop and address issues arising from the surveys. This would then lead to a bi-annual newsletter for staff, people using the service and other professionals to communicate service developments, survey results and social events. They were also planning to enable feedback on their website.
- The office and on-call staff maintained a communications log to ensure issues or concerns were dealt with or handed over appropriately. Feedback from people using the service was mixed as to the effectiveness of this system.

● Staff performance was supported with regular supervisions and appraisals. This included regularly gaining direct feedback from people using the service through spot checks and supervisions held in people's homes.
● The provider actively worked to ensure their service was accessible to all such as child friendly paperwork. They ensured staff were provided with training to support specific characteristics such communication through different forms of sign language.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The provider had established a comprehensive schedule of quality audits. However, we found these were not always identifying issues or consistently improving the service to people. For example, gaps in medicines administration records and recurrent issues with insufficient care staff leading to missed shifts. This meant management could not be assured quality was being maintained. The lack of end of life care planning and documentation, alongside issues with mental capacity decision making had not been identified as needing development.
● The provider maintained a risk register nationally. They held governance and risk management meetings bimonthly nationally at which identified issues, themes and complaints were discussed.
● Most of the people we spoke with would recommend the provider to others due to the quality of care provided.
● Feedback regarding the registered manager from staff and people using the service was positive, being described as, "Approachable" and, "Supportive." One staff member commented, "[The registered manager] does look after staff and is very appreciative. [The registered manager] sends thank you cards when you help them out."

Continuous learning and improving care
● The provider held bimonthly clinical lead workshops nationally with guest speakers to promote best practice.
● The provider had a service development plan. This included work to develop incident workshops for care staff to promote lessons learnt and increased career development support for staff such as completing additional health and social care national vocational qualifications (NVQ).

Working in partnership with others
● Apollo had built strong relationships with commissioners and allied healthcare professionals to support the provision of complex health and social care for people living in their own community.
● The provider has become accredited to the NHS secure email system to enable confidential information to be shared effectively and enable timely responses.
● The provider had recently taken over several support packages from an alternative provider who had withdrawn from the region. This had included transferring the care staff to ensure continuity of care for the people involved. The competency of these staff was assured initially by the previous provider but was then scheduled to be reviewed by Apollo within 12 weeks.
● The provider promoted community engagement through supporting charitable activities for their chosen local charity of the year. This has included sponsored swims and coffee mornings with staff and people using the service encouraged to participate.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Sufficient numbers of suitably qualified and competent staff were not deployed in order to achieve compliance. The risk of not deploying appropriate staff and relying on contingency plans was not suitably risk assessed. Regulation 18 (1)