Amber Care (East Anglia) Ltd

Stewton House

Inspection report

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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

Overall summary

We inspected Stewton House on 11 May 2015 This was an unannounced inspection. Our last inspection took place on 06 January 2014 and the service was compliant. The service provides care and support for up to 48 people. When we undertook our inspection there were 45 people living at the service.

People were of varying ages who lived at the home. Some were able to move around the home with the assistance of staff, whilst others required a wheelchair which they propelled themselves or staff helped to move. Some people were ill and did not want to leave their bedrooms. Some people were in varying stages of dementia and required assistance from staff for most tasks each day.

There was a registered manager in post. 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.

Summary of findings

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves or others. There was one person living at the home that was subject to such a restriction. Staff were not fully aware of how to record people's legal rights such as maintaining a Court of Protection order.

There were insufficient staff to meet people's needs. The provider had not taken into consideration the complex needs of people who used the service and how to deploy staff to meet those needs. People could be put at risk of harm if suitable numbers of staff are not available to meet their needs.

The administration and stock control of medicines was poor. Staff did not ensure during the administration of medicines process that stocks were securely locked away. Staff had not ensured all the necessary medicines were in stock which resulted in people going without their prescribed medicines.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the number of staff available at times and in administration of medicines. You can see what action we told the provider to take at the back of the full report.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives. However, people's individual interests and hobbies were not taken into consideration when planning activities.

People had a choice of meals, snacks and drinks. And meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the internal processes to take if they were concerned about the welfare of an individual, but not what happened with the referral once it was received by statutory agencies.

People had been consulted about the development of the home and quality checks had been completed. Feedback was not given to staff when audits had been completed. Lessons learnt from incidents were not passed on.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were not involved in the planning of their care and had not agreed to their care plans. The information and guidance provided to staff in the care plans was unclear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe. You can see what action we told the provider to take at the back of the full report.

We have made a recommendation about involving people in the planning of their care.

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

The service was not consistently safe.

Checks were made to ensure the home was a safe place to live.

Insufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were not stored and administered safely.

Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights were protected.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Information was given to people to help them understand their conditions.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

People's care was planned but not reviewed on a regular basis with them.

People were not supported to develop their own interests and hobbies.

People felt assured anything would be investigated in a confidential manner.

Staff ensured other health and social care professionals were aware of people's needs when they moved between services.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

People were relaxed in the company of staff and told us staff were approachable.

Summary of findings

Checks were made to review and measure the delivery of care, treatment and support against current guidance. However, lessons to be learnt and details of audits were not passed on.

People's opinions were sought on the services provided and they felt those opinions were valued, as did the staff.

Stewton House

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 11 May 2015 and was unannounced.

The inspection team consisted of three 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 service.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority and the NHS who commissioned services from the provider in order to obtain their view on the quality of care provided by the service.

During our inspection, we spoke with ten people who lived at the service, three relatives, two members of the care staff, three trained nurses, a cook, an administrator and the manager. We also observed how care and support was provided to people.

We looked at seven people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, minutes of meetings for staff and people who used the service, staff rotas, audit reports and training records.

Requires improvement

Is the service safe?

Our findings

People told us there were insufficient staff to meet their needs. They said they could speak with staff members at any time of the day and night, however, they often had to wait. One person said, "The poor girls are run off their feet. Sometimes are worse than others. If there is an emergency or some other reason." Another person said, "Sometimes you have to wait half an hour before they come. They are always short staffed." Another person explained how long they had to wait and said, "You wait a long time if you need someone. I often have to wait for assistance."

Call bells rang throughout the day and were continuous. One call from a sitting room was ringing for over 10 minutes until we brought it to a staff member's attention. They responded immediately but told us in some areas of the home the bells could not be heard. We observed staff walking past rooms when call bells were being rung and on one occasion we called a staff member back as the call bell had been ringing for over three minutes, but it had been ignored. They responded immediately. Staff told us they had to prioritise calls if they were short staffed. If call bells are not answered this could put people at risk of harm.

Staff views on there being sufficient staff available to meet people's needs were mixed. Some staff said there were normally enough on duty but they would appreciate more time to spend with people on activities. They told us that short notice staff absence created staff shortage which was hard to control. Other staff told us they needed more staff. We were told that two nurses were needed during each day shift but sometimes in the afternoon this was reduced to one nurse. We saw the shortfalls on the rota. Staff told us this was a difficult time to only have one nurse as often relatives visited in the evening and wanted to speak with a nurse.

We saw the provider had calculated the hours required depending on the dependency of people living at the home. However, this had not taken into consideration the different times people may need more help than others. The staff rota showed several days when the home had to use agency staff and when other staff had been called in due to staff absences. The manager told us there were vacancies for nurses and care staff and was actively recruiting.

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

People told us they did not always receive their medicines at the same time each day. One person said, "I have medicine morning and evening. It never comes at the same time each day." A failure to take medicines at the times prescribed could make a person unwell as some medicines were required to have specific time periods between dosages.

Medicines were kept in a safe and clean environment. We looked at eight people's medicine administration record sheets (MARS). We found on five MARS that there were gaps in the signature boxes so we did not know if those people had their medicines. We found on three MARS alterations had been made to the original times the doctors had made on the prescription, but there was no explanation why this had occurred. A failure to give medicines as prescribed could result in people's health and wellbeing being at risk.

We observed medicines being administered at lunchtime by two different nurses. During one observation the medicines trolley was left unlocked in an area used by visitors for eight minutes. The nurse did not have sight of the trolley. This could result in unauthorised people having access to medicines. It was discovered on the second observation that medicines had been left on top of the trolley as it had not been given at the correct time. There was no name in the pot. One person's pain relief medicine had run out of stock and there was no alternative medicine. Alternative methods of pain control were offered until a doctor could be contacted. Staff told us they sometimes ran out of stock of medicines if the pharmacy was slow in sending. The ordering of medicines had not been robustly checked. A failure to have the correct stocks in place could result in the people's health and well-being being affected.

Staff who administered medicines had received training. The reference material available was an out of date book from September 2012. The internal medicine audits had failed to highlight problems identified on the external audit completed by the pharmacy supplier in April 2015. This included stock balances, gaps on MARS and reference material. The manager told us she would address this immediately as it was also items we had found during our visit.

Requires improvement

Is the service safe?

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

One person was capable of taking their own medicines and the staff ensured regular assessments were undertaken to see if they were still competent to do so. We saw the person had locked cupboards in their room to store their medicines. We saw the assessment staff had completed to ensure the person was competent.

People told us they felt safe living at the home. One person said "I feel much safer here. I couldn't really look after myself at home." Another person said, "It's not home but it is an extremely good substitute."

Staff were able to explain what constituted abuse and how to report their concerns to the manager. Staff were unaware of what happened to a referral once they had made it and there were no notices on display on how to escalate a concern outside of the company. This could mean that reporting of a concern could be delayed to the correct statutory body if the manager was not available. Staff said they had received training in how to maintain the safety of people who spent time in the service. The training planner confirmed which staff had received training.

The manager had kept us informed when they had made referrals to the local safeguarding team and about other incidents and had updated us through the year of the progress of any investigations. There was nothing currently outstanding. This ensured people were protected against harm coming to them.

To ensure people's safety was maintained a number of risk assessments were completed for each person and people had been supported to take risks. For example, risk assessments were in place for moving and handling, falls, nutrition and pressure ulcers. A person at risk from choking had a risk assessment in place and it was noted the person required different methods to obtain a balanced diet. The person had the capacity to make their own decisions once information was obtained from the speech and language therapist. It was recorded that staff respected the person's decision.

However, although people at risk of falls had a risk assessment in place which ensured they were in an uncluttered environment and how to use walking aids, there were no additional measures in place to protect them. For example, there was no monitoring of falls or measures put in place after a fall to protect the person.

Plans were not in place for each person in the event of an evacuation of the building. Staff were not aware they were required. We did not see any evacuation chairs or slide sheets to evacuate people down the stairs when the lifts were out of action. This could prevent people being evacuated safely from the building when required. The fire maintenance checks on equipment were completed on a weekly basis.

We looked at three staff files which showed security checks had been made prior to their commencement of employment to ensure they were safe to work with people. These included information on their past career history, qualifications and references from other employers and character references. Safety checks had been made with the disclosure and barring service. These measures helped to ensure only suitable staff were employed.

Good

Is the service effective?

Our findings

People told us they liked the staff and they were confident staff would give them good care. One person said, "I'm always pleased to get back after I've been away." Another person said, "They are all kind girls." One person told us they had recently attended the hospital to see how effective their treatment was and staff had arranged for a family member to also attend.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example, there were several sitting rooms available for use and staff respected people's wishes of where they wished to be.

People told us staff tried to obtain the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when a person had problems with maintaining their diet the dietician had been called. This was recorded in the care plan. However, staff were not aware of all the relevant evidence based guidance to ensure the person's feeding methods were adhered too. The manager told us further training had been booked. We saw confirmation of this from the training company.

We observed staff writing about discussions with other health and social care professionals in people's care plans. Staff also received a verbal handover of each person's needs each shift change so they could continue to monitor people's care.

One staff member told us about the introductory training process they had undertaken. They told us they had a good introductory process, including basic training, shadowing a staff member and being allocated a mentor for 12 weeks.

Staff said they had completed training in topics such as basic food hygiene and manual handling. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments. Some staff had completed training in particular topics such as specialist feeding methods. This ensured the staff had the relevant training to meet people's specific needs at this time. The nurses had been trained in specific tasks such as how to take blood and insert a catheter. The manager was aware which topics staff required to complete and we saw the training planner and statistics for 2015. This highlighted training required annually, and in two, three and five year periods. A staff member who had been promoted had been encouraged to undertake an external training course to ensure they were competent in their new role.

Care staff we spoke with told us they had received supervision. There was no supervision of trained nurses. However, staff told us they could speak with the manager and regional manager at any time to discuss concerns. They said there was sometimes a delay in receiving a response but they eventually had queries answered.

Staff were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. The training planner confirmed some staff had received training on dignity and rights of people and more was booked for later in the year.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw in the care plans we looked at there was a mental capacity assessment in each one. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Records showed one person had chosen to ignore medical advice; while this may be harmful to their health staff respected their ability to make this decision.

The Mental Capacity Act 2005 (MCA) legislation provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make decisions themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The safeguards legislation sets out an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

There was one person who was subject to a DoLS authorisation. The documents in the person's care plan showed the steps which had been taken to ensure the

Good

Is the service effective?

correct decisions were being made to deprive that person of their liberty. However, there was one person who was subject to an order from the Court of Protection. There were no details in the care plan of how this decision had been reached and what staff needed to do to fulfil the court order. This could result in the person being deprived of what they needed.

People told us that the food was good and often too much. One person said, “There’s always a choice of two meals, and if you don’t want that they’ll give you something else.” Another person said, “I don’t like mashed potatoes so they always leave some whole for me.” People told us they were weighed monthly. One person told us that a loss of weight had been recorded but said, “I’m trying to increase my food intake.” The person had their own food chart which she encouraged staff to complete.

Jugs of water and juice were set out in the sitting rooms and we saw people being offered hot drinks throughout the day. There was a coffee machine for anyone’s use. We observed the lunchtime meal in the dining room. We saw the meals were presented well and there was a choice of food. People were offered sherry before the meal. For those who required assistance to eat their meals some were in the dining room but others in their own bedrooms. Staff were patient and gave people the time they needed to eat. People told us they were asked about meals by the cook and in questionnaires.

Staff we talked with knew which people were on special diets, those with food allergies and those who needed support with eating and drinking. Staff had recorded people’s dietary needs in the care plans such as a problem a person was having controlling their weight and when a person required a softer diet. We saw staff had asked for the assistance of dieticians in sorting out people’s dietary needs. Staff told us each person’s dietary needs were assessed on admission and reviewed as each person settled into the home environment. This was confirmed in the care plans.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and kind. One person said, “The staff are so caring. There isn’t a nasty one.” Another person told us, “I like all the staff here.” People told us staff had given them the confidence to do various tasks and voice their opinions by their caring and gentle encouragement. For example, people had a daily bath or bathed in the evening. Another person told us they were quiet but now felt able to speak up about their food choices.

All the staff approached people in a kindly, non-patronising manner. They showed empathy with each person’s situation. They were patient with people when they were attending to their needs. For example, when someone wished to move out of the sun in the conservatory, staff patiently set up another chair close by and moved all the person’s personal belongings to that area. They ensured they were comfortable before leaving them.

Staff knew the people they were caring for and supporting. They were enthusiastic about working at the home. They told us about people’s likes and dislikes. For example, when a person was distressed about a problem a member of staff was patient and showed empathy with them and the relative who was involved. They did not leave them until the situation had been resolved to the satisfaction of the person.

Staff responded quickly when people said they had physical pain or discomfort. When someone said they felt unwell, staff gently asked questions and the person was taken to one side and given some medication. Staff told us what steps they would take to protect people’s dignity and provide them with choose. This involved knocking on bedroom doors and asking their views on topics of interest and the running of the home.

People told us that staff treated them with dignity and their privacy was protected. One person said, “They are absolutely marvellous. Far superior than I thought it would be.” We saw staff asked permission of people before they commenced a task. Such as, replacing a slipper on someone’s foot who was sitting in a wheelchair. When people were asked if they wanted a drink, staff waited for a reply before serving them. However, there was very little interaction between staff and people who used the service. Most contact was task orientated, such as, helping with personal hygiene, helping to use a toilet or giving medicines. People told us staff did not always have time to sit and chat. One person said, “The only time staff chat with me is when they are giving me care.”

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes.

People had access to several sitting room areas, a dining room, quiet areas in corridors and large expanses of grounds and gardens. We observed staff asking people where they would like to be, if they required assistance to move about the building. Staff ensured each person was comfortable, had a call bell to hand and had all they required for a while. Some people liked to walk in the grounds with relatives and we saw staff encouraging them.

The relatives felt involved and fully informed about the care of their family members. One relative said, “I’ve looked at many homes in and around the area and Stewton House is the best of the bunch.” Relatives told us there was no restriction on visiting and they were welcomed by staff.

Requires improvement

Is the service responsive?

Our findings

People told us staff had talked with them about their specific needs, but this was in the form of conversation rather than a formal meeting. One person said, "I feel that if I put something forward things won't be done." The people we spoke with had not seen their care plans and did not remember contributing to it. However, they said they were aware staff kept notes on them as they had seen them writing in them. Staff did ask them each day how they felt. A relative told us they had initially seen their family member's care plan but was unaware whether it had been reviewed. This means that people were not totally included in the planning of their care.

People's wishes were recorded in their care plans so staff understood what each person liked to do each day and night. One person told us they liked to walk around the gardens and said, "I go every day, when the weather is fine. It's my breath of fresh air." Another person told us they liked to remain in their room. They said, "It's where I want to be. The staff are kind and visit me each day but I don't like to mix."

The care plans contained a document entitled "All About Me". This when completed would give staff a rounded picture of a person's likes and dislikes and the support they required. However, only three had been completed in the care plans reviewed. Other sections of the care plans included plans about the person's health and well-being. All had been reviewed at least monthly, except one, which had not had a review since December 2014.

We saw behavioural care plans for people whose behaviour was challenging to others. The care plans described the actions staff would need to take to discourage the behaviour, maintain the safety of the person and others. There was a monitoring record in place for when the person's behaviour required close supervision.

There were some instances in the care plans where they did not reflect changes in a person's condition or did not give a level of detail to ensure staff were responding effectively to a person's need. For example, a person with a urinary catheter was having repeated infections and required other treatment and antibiotics. We were informed the treatment had been increased to twice a day but the care plan only stated once a day. One section of a person's care plan stated they been found on the floor the previous day but there was no record of how staff had responded and what, if any, treatment had been required.

Staff had recorded in care plans when they were unsure if treatments for people were being effective. They had called for assistance from such specialist as the tissue viability nurse, who checked the condition of people's skin and wound care. This was recorded in care plans. Input by professionals such as the family doctor and physiotherapist were recorded when they had been asked for advice about on-going or new treatments. The records of one person stated they were making good progress and the treatment was effective. Health and social care professionals we spoke with before and during the visit told us they had every confidence in the ability of staff to ensure effective treatments and care was maintained. One person said, "I would put my mother here."

Wound care plans lacked detail, such as frequency dressings required to be changed and the type of wound dressing. Some assessments were not accurate. For example, one record stated a person had a grade 3 wound but on the day we were told it had healed and barrier cream had been applied to the area. Another part of the care plan stated a wound dressing was being used. A failure to accurately record people's needs and responses could result in them not receiving the care to assist their health and well-being.

People told us there was always an opportunity to join in group events but that they did not take part as there was nothing that suited their needs. People told us there were a lot of bingo sessions which were confirmed in the care plans. One person said, "I prefer to stay in my room and only attend Holy Communion." Another person told us they used to knit but that had now stopped. We pointed this out to staff who were unaware this was the case and immediately made some suggestions to the person.

There was an activities planner on display in the main entrance. There were pictures of events which had taken place inside and outside the home. These included parties and visits out. The care plans stated the type of interests people liked to do and their family relationships. There was no evidence that one to one activity took place with

Requires improvement

Is the service responsive?

individuals or how people would like to spend their days now and if they had any specific interests or hobbies. This did not take into consideration the individual needs of people.

People told us they were happy to make a complaint if necessary but did not know what the process was to make a complaint. Only one relative had made a formal complaint directly to the manager. The relative had not received any feedback. We saw the complaints procedure on display. The manager informed us they had contact with an organisation which could translate this in different languages.

The complaints log detailed two formal complaints the manager had dealt with since our last visit. Each one recorded the details of the investigation and the outcomes for the complainant. One had not yet been completed but the other recorded the satisfaction of the person. Lessons learnt from each case had been passed to staff at their meetings. Staff confirmed these messages had been passed on. We saw this in the minutes of staff meetings in February 2015 and. April 2015.

We recommend that the service seek advice from a reputable source, about how to engage people in the care planning process.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post. People told us they were well looked after and could express their views to the manager and felt their opinions were valued in the running of the home. One person said, "I think she appears to lack confidence but is very supportive." Another person told us the manager was caring and would often come and sit and talk with them.

There was sufficient evidence to show the home manager had completed audits to test the quality of the service. Where actions were required these had been clearly identified and signed when completed. Audits included infection control, medicines and health and safety. However, few of the audits showed when lessons learnt from action required had been passed on to staff. Staff told us they did not receive feedback about audits. Accidents and incidents were analysed monthly but not feedback to staff. This means staff were unaware whether poor practice required to be corrected or procedures altered because of an incident, which could put them and others at risk of harm.

Apart from questionnaires for people who lived at the home and relatives there were occasional meetings, as a method of obtaining opinions from people about the quality of the service. People who used the service and relatives told us they were not aware of any other methods of obtaining their opinions. However, they said the manager was available at any time and they felt confident in going to her for advice and support. We saw the minutes of the last meeting in November 2014 which gave details of a number of topics such as activities and menus.

Staff told us they enjoyed working at the home as the care was good and they liked the people they cared for and the other staff. One person said, "I love it here." All the staff we spoke with said they would be happy for a family member to be cared for at the home. They said ever one worked as a team and there was no friction between groups of staff. A staff member said, "I feel really supported by the carers here." Another staff member said, "On the whole we are a friendly team and get on well together."

We observed the afternoon handover and staff discussed the effectiveness of treatments. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten. However, the handover only took into consideration the last 24 hours. Staff told us it was difficult to catch up on people's needs prior to this. One staff member said, "It's hard. It can be difficult if you come back after a run of days off. You are really stressed by the end of the shift."

Staff said they would challenge their colleagues if they observed any poor practice. One staff member said, "Any one of us would tackle a staff member and report them if we thought they were not caring correctly." They were aware of the whistleblowing process and how to report incidents. We observed the manager tackling problems throughout the day and walking around to ensure staff were observing people and tending to their needs. Staff told us the manager was in the home on a daily basis and on call at weekends. They said they could go to the manager and area manager (who had an office in the home), at any time for advice.

Staff told us staff meetings were held occasionally. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of staff meetings for April 2015 and May 2015. Each meeting had a variety of topics which staff had discussed, such as, allocation of duties, sickness and care plans. Apart from a general staff meeting, each department held meetings for their staff and discussed issues pertinent to them. For example the kitchen staff talked about reviewing the menus. This ensured staff were kept up to date with events.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken. In a couple of cases there was a lack of evidence supplied to us. This had been challenged by CQC so we were then assured suitable action had been taken.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People's needs were not always being met because there were insufficient staff to manage their needs at different times during a 24 hour period. Regulation 18. 1

Regulated activity	Regulation
Accommodation and nursing or personal care in the further education sector Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People's medicines were not in stock all the time, which meant they did not receive their medicines to aid their health and well-being. Staff did not follow safe practices when administering medicines. Regulation 12. 2 (f) (g)