Stour Sudbury Limited

Hillside Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 15 February 2017.

Hillside provides a service for older people, some of whom are living with dementia. The service is based over two floors. At the time of the inspection there were 36 people living at the service and one person in hospital.

The service had a 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 2014 and associated Regulations about how the service is run.

This was a comprehensive inspection to look at how the provider was meeting regulations relating to the fundamental standards of care and to check upon the implementation of the action plan supplied to the Care Quality Commission in response to our inspection of February 2016. At that inspection we rated the service as requires improvement.

At this inspection people and staff felt there were not always enough staff deployed in the service to meet people's needs and medicines were not managed safely.

Safe recruitment procedures were followed to make sure staff were suitable to work with the people at the home and there were processes in place designed to safeguard people from abuse.

The staff records showed that supervision, appraisals and training were planned but not always well attended or carried out. Although there was a clear policy for the induction of new staff this was not being implemented effectively regarding ensuring they had effective support and training.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Some people were assessed as lacking capacity to make decisions for themselves at this service. Staff were not always following best interests decision making processes when people were not able to make their own decisions.

People were complimentary about the food and were provided with enough to eat and drink. Choices of menu were offered each day. However, records of what people had eaten at lunchtime were not correct.

People had access to health care professionals but information about their visit was not always shared between staff in a timely way.

The planning of care for people included people's physical, emotional, spiritual, mental, social and recreational needs. There was information about people's likes and dislikes. However this was not always

implemented effectively because the staff were busy with meeting physical needs rather than having time for other needs to be met.

Staff were kind and caring in their approach and had a good rapport with people. The atmosphere in the service on the day of our inspection was hectic when we arrived but became calmer during the day and particularly from the support and experience of the area manager talking with people using the service and staff.

There was a system for managing complaints about the service. People and their families were listened to and knew who to talk to if they were unhappy about any aspect of the service. The complaints policy had been followed to resolve complaints made.

During the inspection we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also made one recommendation to the registered provider. You can see what action we told the provider to take at the back of the full version of the report.

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

There were not always enough staff on duty to keep people safe.

People did not always receive their medicines as prescribed.

The service had a robust recruitment policy and procedure

Is the service effective?

Requires Improvement

The service was not consistently effective

Not all staff had received appropriate induction and on-going training so that they could care for people using the service.

Important information from visiting professionals was not conveyed over the handover between shifts.

People liked the meals and there was a variety of choice.

Is the service caring?

Good

The service was caring.

Positive and caring relationships between people using the service and staff had been established

Staff were kind and caring in their approach and supported people in a calm and relaxed manner.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Peoples needs were assessed before coming the service. Improvements are needed to ensure that people are provided with meaningful activities.

The care plans were large and information was difficult to find.

Complaints raised were managed effectively to make sure they

were responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The action plan from our last inspection had not been fully implemented.

Equipment had been condemned but not effectively replaced within a reasonable timeframe or processes in place to identify that equipment is nearing being condemned.

Quality assurance systems were not always effective in identifying areas in need of improvement.

Hillside Care Home

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 checked 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 unannounced inspection took place on 15 February 2017 and we spoke with the staff on the night shift duty on 17 February 2017.

The inspection 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. Our expert had experience of older people and dementia care.

We reviewed the information we held about the service including safeguarding alerts and statutory notifications which related to the service. Statutory notifications include information about important events which the provider is required to send us by law. We asked the provider to complete 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. The PIR was returned within the required timescale.

During our inspection, we observed care in the communal areas; we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We examined records which included staff rotas, three staff files, management records and care records for five people. We spoke with 10 people, two relatives, the area manager, deputy manager of the service, maintenance and catering staff and six members of the care staff. Since visiting the service we have spoken with the registered manager and requested additional information.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 02 February 2016, we reported that the service did not have enough staff on duty at all times to meet the needs of the people using the service. At this inspection we also found ,by talking with people using the service and relatives, through our observations, discussions with staff and examination of the service's dependency tool, that staffing levels were not sufficient to meet people's needs. This was despite the action plan we received from the service following the last inspection which stated that the duty rota must reflect the needs of the residents.

There was not always enough staff on duty to meet the needs of the people living at the service and the impact was that the service was not always safe. A person told us, "They are a bit short sometimes, you wait a little while to get help to go to the toilet, sometimes I have an accident that is not good for them or me."

One person told us, "Everybody helps each other, staff are very good, they don't neglect you at all. There is not enough of them, they have to work very hard, they do try and make time to talk to you."

Another person told us, "I have a shower every morning, I ring my buzzer to get help with it. Sometimes I have to wait ages, I have to go into the hall and investigate what's happening. Sometimes they are here within a couple of minutes, sometimes it's 20."

Another person told us, "They have been a bit short staffed, they could do with more. Sometimes you have to wait a while but they have to rush about so much." Another person said, "Sometimes I wait five minutes sometimes it's longer, if they are hoisting someone else they will come and tell me they will be with me as soon as possible. Sometimes there is not enough of them, what can you do?"

A relative told us, "I think they could do with more staff at weekends."

Staff told us that they did not feel there was always enough staff on duty. Members of the night staff informed us that having four staff on duty made a significant difference to the timely support they could provide rather than three staff.

The staff we spoke with told us that they were frequently rushed and on many shifts there was not enough staff to provide the care the people needed at the time and they had to wait. We examined the rota and found for the seven days from 4 February 2017.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18 (1) Staffing.

The manager was not included in the care hours but we understood was often supportive to cover for duties of staff sickness which detracted from their managerial tasks. The deputy manager had some hours to focus upon management but usually worked four out of five shifts providing direct care.

Staff told us that sometimes there were seven staff on duty in the morning providing direct care and this made a true difference, in particular the impact was they could respond to the call bells much more quickly. It was reported to us that the catering team struggled with cooking and then delivering breakfasts on a Sunday morning due to the staffing compliment. The area manager investigated this while we were present and took action to improve the situation. The action was to increase the catering staffing on Sunday mornings.

We examined how the service calculated the number of staff required to be on duty with regard to the needs of the people using the service. We were not convinced from our observations of the needs of the people using the service this was totally accurate.

We spoke with four people on night duty. The service had some permanent night staff while other staff worked both days and nights. This was considered of benefit so that there was truly one team and staff could see and work with people over the 24 hour period. All of the staff we spoke with were aware that some people living at the service had complex needs and also people's needs, could still fluctuate greatly either due to physically being unwell or being more unsettled from one day to the next due to the person's dementia. A member of staff told us, "It's crazy having only three staff on duty, currently we need four and sometimes five, appreciated not all night but at times in the early part of the shift we do." The staff member further explained, "it is not the people's fault, they do not want to be ill and we want to care for them, but two nights are never the same. Of course some people we know will always need two staff where as others sometimes yes and sometimes not and of course people do deteriorate and therefore we need more time to care for them".

It is important that people receive their prescribed medicines on time for their safety and well-being. During our inspection we saw that a person had not received a prescribed medicine for seven days. The medicine was prescribed twice per day. The service had become aware of this situation from its auditing process and had reported the matter to the safeguarding authority and also had submitted a notification to the CQC.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12 (2) Safe care and treatment (g)

We spoke with the deputy manager and examined information to understand how the above had happened and the deputy manager told us about the action they put in place to prevent this happening again.

We looked at medicine administration records (MAR) charts for eight people. We found that these were all correct and there were no gaps in the MAR chart. Each MAR chart had a picture of the person and recorded clearly on the front sheet any allergies that were relevant to that person. The deputy manager explained the ordering and returning any unrequired medicines process to the pharmacy. We checked the medicines that require additional recording Three people told us the staff gave them their medicines on time and were kind explaining the medicines to them and also always offering water. We saw medicines being administered at lunch time and people told us they trusted and respected the member of staff supporting them.

We asked people and their families whether they felt safe, one person said. "On the whole yes, they are fairly good, sometimes I get one who is so quick. They are often short staffed and you notice, they are chasing each other around, you feel sorry for them in a way." Another person told us, "They are very good here, the ladies and gentlemen are very kind, they are gentle with you. They know about my problems." "They have been a bit short staffed, they could do with more. Sometimes you have to wait a while but they have to rush about so much." Another person told us, "I think I'm safe, they look after me."

Recorded in people's care plans, we saw that risk assessments had been completed, including checking people's skin integrity, the need for bed rails, manual handling needs and call bell risk assessments. However, we saw that these risk assessments were not always put into practice. For example we found that a person with diabetes did not have a risk assessment explaining how to provide care if they experienced hyperglycaemia or hypo glycaemia. There was no record in a person's care plan they had attended their diabetic eye screening appointment. The catering staff knew the people with diabetes and were aware of how to help them meet their dietary needs.

We recommend that the service consider current guidance on supporting people with a diagnosis of diabetes and how to accurately record this information with regard to risk assessments

A member of the maintenance staff informed us about fire safety and the weekly checks they carried out regarding the safety of the building.

The manager analysed accidents and incidents including any falls that people experienced to learn any lessons from the situations. We saw that the service had involved appropriately other professionals for advice regarding falls and distressed behaviour in response to situations or other people using the service. A member of staff told us about how they recognised when someone became anxious or distressed and the actions they took to prevent the behaviour becoming increasing challenging which helped to keep the person, and others, safe from harm.

A member of staff told us about the safeguarding training they had received and their understanding of how to keep to people safe. They were aware of how to report any allegations of abuse, protect people from the risk of abuse and how to report incidents of abuse. The deputy manager and a member of staff told us how to implement the correct procedure for informing the local authority, contacting relevant healthcare professionals and notifying the Care Quality Commission. Staff had completed training in the safeguarding of vulnerable adults.

The service had a recruitment policy and procedure in place. This required the completion of an application form, from which staff were then short-listed. Records showed that the service carried out proof of identity checks, took up references and carried out criminal record checks with disclosure and barring service (DBS) prior to a candidate being offered a position.. All of the staff we spoke with told us checks had taken place before they started work at the service and this was confirmed in the staff files. Each file we saw contained a detailed job description for the position and there was a contract of employment.

Requires Improvement

Is the service effective?

Our findings

In order for staff to provide effective care this requires that they have been trained and have on-going support. We saw there was a training plan in place and some training had been provided. We were also aware that the service had sought the support of the local authority to provide training to the staff, however this was not always well attended and there were gaps in the attendance of the training record. One member of staff told us, "We are really rushed and do not always have time to attend the training or have supervisions." A member of staff told us that the manager and deputy manager were very helpful at resolving matters as they arose and were supportive, but when busy, planned supervision could slip.

We saw that the manager had booked appointments for supervision and annual appraisals but these were not always carried out. There was a planned process in place to support new staff. However in one person's induction book the record was completed for only one training session. They had been at the service for three months and there was no record of meetings with senior staff, or their buddy to discuss their progress. The service had an induction and on-going support process for new staff but this was not effective.

Staff we spoke with were aware of a buddy system to support new staff but were not clear upon the role or when they should support new staff. We spoke with a member of staff who considered since they had been at the service the training provided was of a good standard, but thought the training should have been delivered more quickly than was the current process.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The service had a policy and procedure in place to follow the process for making DoLS applications and mental capacity assessments. The records in two people's care plans regarding MCA and DoLS were in order and correct. However in one care plan there was no record that the service had worked with the person regarding identifying who had lasting power of attorney, (LPA). This is very important so that the person with the LPA can be involved with the person's care and support them in best interest meetings. The deputy manager told us they would contact the family of the person to resolve this matter. In another care plan the service had worked with a relative who had LPA for their relative and we saw communication had been recorded about decisions made.

A person beard had been shaved off without gaining the persons consent or consulting the family for a best interests meeting to discuss the options regarding the difficulties encountered by the persons beard. This was discussed in our feedback to the area manager and we were informed that in such instances in the future the service would consult and work with relatives thought the best interest process.

People told us they liked the food provided, it was tasty and varied and they thought the catering team were skilful. One person told us. "Most of the food is alright, I had bacon and eggs for breakfast." Another person told us, "Food is very good." Another person said, "Food's good, they don't rush me. The cook came round today like for tomorrow. If I don't like the two things, I can always have a sausage, I love my sausages. On a Wednesday we have a buffet."

We saw that fluid and food charts had been put into place for people where there was concern about the person's diet. We saw risk assessments in place for anyone that the service had a concern over regarding allergies or risk of choking. Some of the food was pureed and we saw in the care plans the reasons why. The catering staff were knowledgeable about people's dietary needs. The area manager told us about how the catering team were informed of information about people upon admission regarding their nutrition needs.

We saw a member of staff recording the quantity of what people had eaten for lunch but as they were not present in the dining room all of the time while lunch was served. Staff were coming and going and taking plates away, when people had said they had finished their meal. The information about the quantity of food was not totally accurately recorded, regarding how much a person had consumed for lunch. The deputy manager explained to us that this was not the correct procedure and said they would address with the staff. The senior should be present to accurately record this information or in the event that they are called away another member of staff should take on this responsibility to ensure the records are accurate.

We also brought to the staff attention that a person had not eaten anything other than a sandwich for two days according to their food diary. We were aware this was not accurate from our own observations during the inspection as were the staff but the record had not been corrected. The deputy manager was addressing this situation by talking with the staff to ensure the information was accurately recorded.

We looked at people's records and saw that people were weighed monthly but if there were concerns then people were weighed more regularly and these records were up to date.

During our inspection, we saw professionals, including district nurses and GP's, attending to people either as a matter of routine or they had been called by the service due to concerns. One person told us, "The GP is lovely, very helpful." They also said that the staff were kind and would summon the GP for them.

We saw that appointments for meeting with other professionals such as audiologists and dentists were made. We noticed that for two people the professional's visit had not been recorded sometime after they had visited. The member of staff told us that this was not always done at the time but at the end of the shift. They considered that it would be better to record straight away and also ensure the visiting professional also had access to the notes so that they could record directly. While they were doing this the staff member would record on the daily handover sheet. This would then ensure all on-coming staff would be aware of the professionals visit. We listened to the handover of information from the early to the late shift staff. This information regarding the professionals visit was not recorded on the handover sheet or verbally communicated at the handover.

Good

Is the service caring?

Our findings

People who used the service and their relatives were content and complimentary about the care and support provided. One person told us, "The staff are great the way they muck in together when they are short of staff." Another person expressed their support for the staff while concerned there was not enough of them. They told us, "I would say the number of staff is in the negative column, it's frustrating to say the least. They do a fantastic job, I have nothing but admiration. They try to accommodate me whenever they can, they are always friendly."

People were encouraged to maintain their independence. One person said, "Staff are very good, they let me do what I can for myself. All of them knock before they come into your room."

We observed a person crying in a room, a member of staff was with them and offering words of comfort. They had heard some upsetting news and the staff member was both caring and supportive.

We saw staff communicating with people in various ways including hand gestures as well as talking to people in a polite and respectful manner. Prior to any care being provided we saw that staff approached the person from the front so that they could easily recognise them and gained their consent before providing any care. One person told us, "I get on with them alright [staff], they are polite." Another person told us, "I have a bath 2-3 times a week. I get up early so I can have a shower, 6.30, when there is a lot of people waiting it's a nuisance."

We observed staff interacting with people in a caring manner and supporting people to maintain their independence with mobility and decision making about what they wanted to do. One person told us, "I cannot quite wash all of myself and that is when the staff are good and help, they let me do what I can and that is what I like."

The staff had discussed with and listened to people's views. People's bedrooms were individualised with their own furniture and personal possessions. One person told us about how the staff had helped them to move in. They spoke warmly about the housekeeping team, how they supported them and ensured their room was always neat, tidy and clean.

One person told us they were happy to live at the service. It was easy for their relatives to visit them and they enjoyed going out regularly. They told us they were involved in the planning and review of their care. They told us that they did not need much support but enjoyed the meals and staff were there should they need them.

The deputy manager told us that they would involve advocates if the need arose to support people. A member of staff told us about the ways in which people's confidentiality was maintained. They spoke about how information about people would only be shared with other people who had the right to know it. They explained that shift handovers were conducted in private out of earshot. The venue for the handover had changed since our last inspection and this now enabled sensitive information to be handed over on a need

to know basis.

One person told us, "I go to the resident meetings if someone comes and takes me." Upon further discussion we learnt that the person had attended meetings, but felt the staff were very busy on the last occasion and did not want to make a fuss to attend the meeting, but they would have liked to have gone.
Relatives told us that they could visit people at the service whenever they wanted to. One relative told us, "They do a very thorough job. They have made it clear to me that they are here for me as well as [my relative], they have been very supportive."

One person told us they had lived at the service for a number of years. They liked the staff and their room. They said, "It isn't too bad really, you get looked after. Staff are pretty good, they help me dress in the morning and get to bed at night." They informed us that they did not really need any other support and it was their choice when they went to bed.

During lunchtime, we saw staff talking and laughing with people who used the service, there was a friendly while respectful atmosphere in the dining room. One person told us, "I was lonely before I came here but not anymore. I would like more things to do, it is nice when we go out in the bus and a new person has started, I think they are going to do entertainments that will be nice." They explained the last person had sought their views and had done their best to these things into account for example with finding films for them to watch.

Requires Improvement

Is the service responsive?

Our findings

Some people told us they received personalised care which was responsive to their individual and specific needs. One person told us, "The staff are very kind."

The deputy manager explained the care plans were of a standard layout so that it was easy to find information. One person was receiving support for the care of a pressure sore and finding this information and how it was monitored was not straight forward in their care plan. However the information was recorded.

All of the care plans we looked at contained an assessment of the person's needs prior to the person moving to the service. Some people's needs were complex and of a high dependency. The service did continue to assess people on a monthly or more frequent basis as required and this information was recorded in the care plan. However we could not be sure that this information of dependency needs was fully accurate and reflected in the staff rota to ensure there were sufficient staff on duty at all times to meet people's needs. Some staff told us that the care plans were very large in volume and that meant at times information was difficult to locate.

The care plans had been based upon a person-centred approach and we found some people were quite content with the service. One person told us, "This is a lovely place, the staff are nice and I am very happy here." However, another person told us, "I expect I've got a care plan but I'm not involved in it." Another person told us, "I think I have a care plan, they do have meetings but I've never been to any of them". Another person told us, "I have never been to one of the meetings for us." They further explained that they would like to attend.

Another person told us, "I go to the resident meetings if someone comes and takes me." Upon further discussion we learnt that the person had attended meetings, but felt the staff were very busy on the last occasion and did not want to make a fuss to attend the meeting, but they would have liked to have gone.

We met the new activities person who had commenced the week prior to our inspection. They informed us of ideas they had and were planning to meet all of the people living at the service to further develop the activities available. One person told us, "I sort of get used to being on my own, I just put up with it. There is a new activities woman, she came and introduced herself last week. They don't have enough time to just come in for a chat, they have to sort out their bingo and stuff and they know I am not interested in that sort of thing." The person was hoping that the new activities person would have more time than the last person to support them.

One person told us, "I do get bored, I go back to my room. We do have quizzes and the bingo's alright". Another person told us, "I like quizzes, I'm no good at colouring, I get a little bored, there is not much to do. I like gardening." Another person told us, "I used to go to church, they have services down there but I don't go, too much trouble." Upon further discussion we found this was for two reasons, the person was not always sure when the service was and did not like to trouble the staff, as they knew they were busy. The staff were

good at recognising and responding to the physical needs of people but didn't have time to meet people's social and well-being needs. The care plans were clear in some respects and staff knew for example about people's needs regarding moving and handling, but these other needs of attending church and activities were not as well documented and planned.

One person told us, "I was lonely before I came here but not anymore. I would like more things to do, it is nice when we go out in the bus and a new person has started, I think they are going to do entertainments that will be nice." They explained the last person had sought their views and had done their best to these things into account for example with finding films for them to watch.

On the day of the inspection we observed staff interacting with people about current events and singing along to well-known songs together. We saw that the service had a resident of the day procedure. The purpose of this is for the care plan to be reviewed and staff checked upon the person's overall well-being to see if there was anything they would like done.

The music therapist arrived later in the day, they interacted with all the people in the lounge, and each person was given an instrument to play if they wished. We observed at this point an easy rapport between staff and people using the service.

We asked people what they knew about the complaints system. One person told us. "I've never had to make any complaints." Another person told us they knew the manager and were confident they could talk with the manager and they would sort out anything for them.

The service had a complaints policy and procedure in place and information about how to complain was available at places around the home and also people were given this information when they moved in as part of the introduction pack.

We saw that the complaints policy and procedure were at the front of the complaints folder for staff to follow when investigating a complaint. There was a comprehensive complaints matrix which gave evidence of written responses to all complaints from the manager. We saw that each complaint had been responded to promptly and with a desire to resolve the problem. A relative told us, "I've had one complaint, the state of my [relative], the pillowcases were dirty, their finger nails were dirty, they were dirty. I was very cross, I wrote a letter which they acknowledged and since then it's been perfect. I sometimes come on different days to check."

Requires Improvement

Is the service well-led?

Our findings

As a result of our last inspection of February 2016, the service had provided an action plan of how it was going to improve. We worked through the action plan at this inspection and saw that the service had tried to implement the action plan and indeed some improvements had been made. However this had not been fully implemented and effective, particularly in relation to having sufficient staff on duty to meet peoples assessed needs.

A positive culture of person centred care was not being fully achieved. We found a person wished to attend the residents meeting, required staff assistance to do so, but had not attended as did not wish to cause a fuss and put the staff out when they were busy.

New members of staff required support to learn about person-centred care and hence require supervision and training when joining the service. The record in the induction book showed after three months, they had not received supervision and only one piece of training.

Staff meetings were planned but the attendance was at times was poor and hence an opportunity lost for all of the staff to discuss how they can work together to provide a positive culture for the service. One member of staff explained to us, "This is not our workplace, it is their home." They further explained the ten at ten meeting each day. This is when the senior staff meets to discuss any issues or important information that needs to be discussed, actions to be taken and the relevant information shared with the staff.

There was a registered manager in post and the service had a statement of purpose. The aims and objectives of the service with regard to the statement of purpose were not always being achieved. For example, there was not effective regular and on-going monitoring of the service. Equipment had been condemned in the kitchen and not replaced in a timely manner, resulting in staff using their own personal equipment. The system in place operated by the staff should be effective so that the manager is aware and can plan in an orderly manner to take the necessary and corrective action, so that equipment is replaced appropriately.

Good management and leadership would ensure that people's needs were accurately assessed and sufficient staff were on duty to meet those needs. The service used a dependency tool which would determine from the information provided, if the persons care needs were either high, medium or low. For the dependency tool to work effectively it is dependent upon the assessed information provided being accurate and we had concerns that this was not the case.

The staff told us that they liked the manager, deputy manager and also the area manager. They found them all approachable and helpful. One person told us, We've had [manager] for some time thankfully, I've no complaints she's always been alright to me." However we did detect that staff were becoming tired of working in a way that meant they were, in their view, frequently short of staff. Their view was that for the current needs of people using the service one more staff member would make a lot of difference.

The area manager, as a result of our feedback, made immediate changes which included changing the duties of the night staff so they could focus upon care and not have to be so concerned with the laundry. The changes to the weekend catering staff rota meant they could focus upon cooking.

The deputy manager explained to us the duty cover, over the 24 hour period. The manager and deputy took it in turns to provide an on-call 24 hour support service to the senior staff when they were not on duty at the service. Staff told us, "The management team are always busy like us, we have to go to them with problems and we always sort things out at that point. I do not think there is time to plan everything ahead which is how it should be, such as training."

The quality assurance system in place was not always effective. We saw that peoples falls were monitored and acted upon as were maintenance issues and fire safety equipment. However the audits in place had not identified a medicines mistake, gaps in the induction of new staff nor gaps in the recording of daily records for people.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users including the proper and safe management of medicines. Regulation 12 (2) (g)

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 Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Act Regulations 18 (1)