Care Quality Commission

Cumbria County Council

Elmhurst

Inspection report

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Date of inspection visit:
24 November 2015

Date of publication:
29 June 2016

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 unannounced inspection took place on 24 November 2015. We last inspected Elmhurst in November 2013. At that inspection we found the service was meeting all the regulations that we assessed.

Elmhurst is a purpose built 40 bedded residential home. It is a single storey building, divided into four 10 bedded units, three of which are dedicated to supporting people living with dementia. All bedrooms are for single occupancy and some have en-suite facilities and there are bathing and showering facilities on each unit. The separate units each have a sitting room with a dining area and kitchenette. There are gardens to the front and rear of the home and some car parking available at the front of the building. At the time of our visit there were 30 people living in the home.

One of the 10 bedded units was not in use by people living there as work was being carried out to resolve a drainage problem. We saw during the inspection that the access door from the occupied unit was padlocked on the outside to prevent access.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 and associated Regulations about how the service is run.

We found at this inspection there was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not clear evidence that the staffing levels and range of staff skills required within the home to meet people's needs were being systematically assessed. This was to make sure staffing levels could be adjusted to make sure people were always supported in accordance with their needs and preferences.

There was also a breach of Regulation 17(Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). This was because the systems for the monitoring of the quality of the service had not been effective in some instances

The people we spoke with living at Elmhurst and their relatives made positive comments about their home. They told us that the care staff were "kind" and "Very nice". Care staff knew how to protect people's privacy and we observed this in practice.

We spent time with people on all the units during the day. We saw that the day staff offered people assistance and took up the opportunities they had to interact with them and offered reassurance if needed.

The registered provider had systems in place to make sure people living there were protected from abuse and avoidable harm. The staff we spoke with were aware of their responsibilities in protecting people from harm or abuse.

They service had safe systems for the recruitment of staff to make sure the staff taken on were suited to working there. We saw that care staff had received induction training and on going training and development and had regular supervision and annual appraisal.

We saw that people could move freely around their units and there was signage in place to support people living with dementia to orientate themselves.

Medicines were being safely administered and stored and we saw that accurate records were kept of medicines received and disposed of so they could be accounted for.

We made a recommendation to look at best practice in relation to providing evidence of who holds Power of Attorney (PoA) for individuals to help ensure that the right people had been involved in the review of DNACPR forms and decisions.

We made a recommendation that guidance was sought on care management and records to support person centred care. This is so that staff have a consistently clear picture of events and personal care needs in the care plan to refer to and work from.

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 always safe.

There was not always clear evidence that the staffing levels and range of staff skills required within the home to adequately meet people's needs were being systematically assessed to maintain consistent numbers of staff at all times.

Staff understood how to safeguard people from abuse and knew how to report possible abuse or concerns about a person's safety.

Medicines were stored safely and records were kept of medicines received and disposed of so all could be accounted for.

Is the service effective?	**Requires Improvement**

The service was not always effective.

There was no evidence of best practice used in relation to providing evidence of who held PoA for individuals and also for ensuring the review of DNACPR forms and decisions.

Staff had received training relevant to their roles to help make sure they were competent to provide the support people needed.

People were supported to have a nutritious diet. Where there were concerns about a person's nutrition they had sought advice and support from appropriate professionals.

Is the service caring?	**Good**

The service was caring.

We saw that people were treated with respect and kindness by the staff in the home and their independence, privacy and dignity were being protected and promoted. Staff also offered explanation and reassurance about what they were doing when assisting people.

Staff demonstrated knowledge about the people they were

supporting, for example information on their likes and dislikes and daily routines.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always present a clear picture of events and personal care needs for staff to refer to and work from.

Support was provided to help people to follow their own interests and faiths and to maintain their relationships with friends and relatives.

There was a system in place to receive and handle complaints or concerns raised

Is the service well-led?

Requires Improvement

The service was not always well led.

Checks and auditing of care plans and reviews used to assess the quality of care planning did not always ensure that people's care plans always had the required or accurate information.

People who lived in the home and their visitors were given opportunities to give their views of the service and make suggestions about what they wanted.

Care staff felt well supported by the management team in the service.

Care Quality Commission

Elmhurst

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 24 November 2015 2015 and was unannounced. The inspection was carried out by two adult social care lead inspectors.

During the inspection we spoke with eight people who lived in the home, two relatives, four of the care staff, a member of the domestic staff, the two supervisors on the morning and afternoon shifts and the operations manager. The registered manager was on leave but the Operations Manager was supporting the supervisors and was available during the inspection to provide information.

We observed staff as they went about their duties and interacted with people and supported people in the communal areas of the home. We also spent time looking at records, including looking in detail at seven people's care plans and risk assessments. We did this to help us see how their care was being planned with them and delivered. We also looked at the staffing rotas, staff training, appraisal and supervision records.

Some people, who were living with dementia, could not easily give us their views and opinions about the service and their care. 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 to us. It is useful to help us assess the quality of interactions between people who use a service and the staff who support them. We carried this out on two units during the morning and at lunch time.

We looked a sample of the records relating to the maintenance and management of the service and records of checks being done on how quality of the service provision was being monitored. As part of the inspection we also looked at records and care plans relating to the use of medicines.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We

looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

We did not have a Provider Information Return (PIR) when we visited. 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 registered manager had previously received and returned a PIR when asked to do so. However the registered provider had reregistered their services under a new provider name since that time. Therefore information received under the pervious registered provider name did not apply for this first inspection following the registered provider's reregistration with CQC in October 2015.

Requires Improvement

Is the service safe?

Our findings

People we spoke with who lived at Elmhurst had positive things to say about their home and told us that they were "happy" and "doing fine" living there. All those we spoke with who could express their views told us that the staff came to help them when they needed assistance. One relative told us "There seems to be enough staff when I come [Hoad View] but we usually go out so it's just in passing".

Staff told us that staffing on the day shift was "pretty good" and "usually okay". We saw on the day of the inspection that on the units where people were living with dementia there were three support staff on the morning and afternoon shifts to support the10 people on each of the units. The other unit [Hoad Hill] had two support workers on duty morning and afternoon. Staff told us that with one unit closed they now had more staff available for the other three units and so had more time to spend with people. We could see that there were sufficient care staff available during the day to support people at current occupancy. Rotas indicated this was the current level of staff on day duty with the one closed unit. We were told by staff when the fourth was open the staff levels would return to the previous level with two support workers on each unit where people with dementia lived.

We were told it was also "better on night duty now" with one unit closed and that "usually" there were three staff on night duty for all units whether that was three or four units. We were told by staff "There are odd nights when there are only two". Staff rota's indicated that there should currently be three night staff on duty with the one unit closed and also when all four units were open. But that figure could be affected by staff sickness or leave. This approach to staff deployment indicated a lack of consistency in relation to ensuring staffing were always based upon peoples identified needs.

The people we observed during the inspection living on Hoad View were male however we were later informed that two of the service users living there were female although we did not meet them. The male member of staff at the time of the inspection was working on another unit with predominantly female occupants. This could limit people's choice on Hoad Unit should they prefer a male carer for aspects of their personal care. We were later informed by the registered manager that although staff are rostered on to a unit it is regular practice in the home for support staff to attend to people on other units if it is preferred by them to have a carer of a specific gender.

We asked the supervisor and the operations manager about how staffing levels were determined and monitored to make sure the staff level and skill and gender mixes were always appropriate to meet the needs of the people living there. They confirmed to us that the registered provider had not provided formal tools or systems for the registered manager to use to determine and monitor the staffing levels or the effect on staffing of changes in people's dependency or behaviours. Such tools would evidence good and safe practice as they assist in formally assessing and determining the staffing levels needed to meet people's assessed needs. This is because needs can change at any time and staffing needs to be promptly adjusted to respond to any changing needs and circumstances of the people living there.

The operation's manager told us that the registered provider was in the process of developing a tool to

monitor people's needs and dependency. When this was implemented it would enable manager's to take a more systematic approach to determining the number of staff required to meet people's needs and keep them safe. However this system had yet to be implemented and in the meantime there was a lack of consistency in determining the level of staffing needed to keep people well supported and safe. There was no evidence that the staff levels and range of staff skills required were currently being assessed to make sure people were always safe and well supported in accordance with their needs.

This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was not clear evidence that the staffing levels and the range of staff skills required within the home to consistently meet people's needs were being systematically assessed. This was to help make sure staffing levels could be adjusted to make sure people were always safe and supported in accordance with their individual needs and in a person centred way.

All the staff we spoke with told us that they had received training on recognising possible abuse and knew what they should do if they felt someone needed to be kept safe from abuse or possible abuse. They told us they would report it to the supervisors or registered manager to look into and pass on to social services. Staff were also aware of the procedures for reporting bad practice or 'whistle blowing' and told us they would report poor practice if they saw it. Training records indicated that all care staff had received this training.

We saw in in a care plan that one person had returned from hospital with bruising. The bruising had been recorded on a body map. We raised this with the operations manager who addressed this immediately and contacted the appropriate agency to discuss. The registered manager later confirmed to us that the origins of the bruises had been identified and were not taken forward as a safeguarding matter by the local authority.

We found that the home was clean and tidy and there were no lingering unpleasant odours. The moving and handling equipment we saw, such as hoists and bath aids, were clean and being maintained. Records indicated that the equipment in use in the home had been serviced and maintained under contract agreements and that people had been assessed for its safe use.

We noticed that there were damaged areas of plaster and woodwork on corridors and in doorways and bare woodwork and shelving that was not easily cleanable. The operations manager confirmed that a refurbishment of the home was being scheduled for the spring and would include these areas.

Externally we saw that some areas and paths used by people living in the home had areas of moss and old leaves that made them potentially slippery and unsuitable for people to walk on. The supervisor told us that this had already been raised corporately and they were to be power washed to remove the moss. However when we inspected they posed a risk and limited people's use of outdoor space.

We saw that work was underway to resolve a longstanding drainage problem on one of the units in the home. As a consequence the unit was empty and closed off to the people living there. We observed during our inspection that the access to this unit was locked with a padlock to prevent unauthorised access. The supervisor we spoke with and the operations manager confirmed that this area of the home was kept locked and that an internal risk assessment was in place to help reduce risks to people living there.

During this inspection we looked at the way medicines were managed and handled in the home. We found that medicines were being safely administered and records were kept of the quantity of medicines kept in the home. We saw that there were appropriate arrangements in place in relation to the recording of

medicines and records were signed correctly when medicines were given out. We counted seven medicines and compared the quantities against the records and found all the medicines were correct.

We looked at the recording and storage of medicines liable to misuse, called Controlled Drugs that were being stored at the time of the inspection. We found that this was being done correctly and safely. We saw that medicines requiring refrigeration were stored within the recommended temperature ranges.

We checked the recruitment records for four new staff members. We saw that safe recruitment procedures were in place to help ensure staff who were employed were suitable for their roles. This included making sure that new staff had all the required employment background checks and references taken up.

Requires Improvement

Is the service effective?

Our findings

The staff we spoke with were able to tell us about the needs, interests and personal preferences of the people they were supporting. Many of the people we saw and spoke with could not easily tell us what they thought about their home or their views on the service they received. A relative we spoke with told us that they had found the staff knowledgeable and had kept them informed of their relative's health.

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). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We spoke with the staff on duty to check their understanding of MCA and DoLS. They understood the principles involved and how to make sure people who did not have the mental capacity to make decisions for themselves should have their legal rights protected.

The care plans we looked at had records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were being used when assessing a person's ability to make a decision. Mental capacity assessments had been done concerning making a decision on 'do not attempt cardio pulmonary resuscitation' (DNACPR) and families had been involved in meetings about best interests. We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. No one living there had an advance directive to indicate particular treatment preferences in the event of not being able to make a decision. We found that one person had returned from a hospital admission with a DNACPR in place but this had not been reviewed following re admission to make sure it still reflected their situation accurately.

We noted that the information around who held Power of Attorney for a person was not always clear in people's care plans and there was not always evidence seen of the authority. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or care and welfare needs. It was not always clear which of these applied. As a result it was difficult for care staff to know who held legal authority to make decisions or be consulted about health and welfare on someone's behalf or if this was just for finances.

We recommend that the registered provider followed best practice guidance in relation to confirming who holds PoA for individuals and had the legal authority to be involved in the review of DNACPR forms and decisions. This is so that if the registered provider has any concerns that a person's health has improved or where there are errors on the form they can query this with whoever signed it.

We could see that staff training was being monitored and planned for by the registered manager across the year. We looked at the staff training matrix and what training had been done and what was required. We saw that staff had done induction training when they started working at the home and they received regular supervision with their supervisors to support them in their practice. We could see that training had been provided for staff on mandatory topics, such as moving and handling, infection control, emergency procedures, equality and diversity, safeguarding, mental capacity legislation and also dementia awareness to help that understand this and support people living with the condition.

We saw that people could move freely around their units and there was signage in place to support people living with dementia. This kind of visual information was to help them to orientate themselves within the home.

To help us get a better understanding of people's experiences we used the Short Observational Framework for Inspection (SOFI). We did this on two of the units where people were living with dementia. At lunch time we saw that people who required support with eating received this in a respectful way with staff prompting people with their meals and asking them what they wanted to eat and drink. We looked at care plans for people that indicated if they might need help or have their food cut for them to aid eating. We saw that staff acted in line with individual's plan.

We saw that people living at Elmhurst had nutritional assessments done to assess their needs and any risks when eating. There was also information on specific dietary needs such as diabetic diets and soft and pureed meals. One person required both and we could see that they had been assessed by the speech and language therapist (SALT) and a management plan was in place based on their advice. People had their weight monitored according to the assessed risk; some people were being weighed more frequently as a result of a higher risk. We noted that one person on a reducing diet had not had this reassessed following their weight loss. This had not been be reviewed to assess if they did need an adjustment in their calorie intake as their weight had decreased. A visitor we spoke with told us their relative had told them that they enjoyed the food provided.

Care records and daily diaries indicated that people had access to health care professionals to meet their individual health needs. The care plans and records that we looked at showed that people were being seen by appropriate professionals to meet their physical and mental health needs. We saw that people's nursing needs were attended to by the district nurses.

Good

Is the service caring?

Our findings

We spent time on all the three units where people were living observing how staff supported and interacted with people living at Elmhurst we spoke with the relative of one person living there and they told us they had found the staff to be "understanding" and generally very kind and helpful". The relative asked the person what to tell us what the most important thing for them had been about living there They told us it was that the staff are "Very kind to me".

We looked at the recent cards and letters that relatives of people who had used the service had sent to the home to express their appreciation of the care their loved ones had received there. One person had written that staff at Elmhurst were "one in a million".

We saw that people's privacy was being respected and that staff protected people's privacy by knocking on doors to private rooms before entering. People told us that the supervisor got the doctor when they wanted them and that doctors and district nurses saw them in their bedrooms for medical examination or any discussions. Procedures and information were in place about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

Where people were living with dementia there was signage to show people what different areas were for. This was to help people with memory problems to be able to move around their home more easily and more independently. We saw that there were examples of a caring approach by staff during daily interactions. For example we saw that staff offered people reassurance when they showed signs of distress and allowed them time to express themselves. We saw as staff went around the home and carried out their duties that they took up opportunities to speak with people. We observed warm and genuine expressions of empathy and concern from staff and a lot of laughter and general conversation.

We saw that staff maintained people's personal dignity when assisting people with equipment and when helping transfer people from a wheelchair to an easy chair. Staff also offered explanation about what they were doing and why.

We saw that people had been able to bring some personal items into the home with them to help them feel more comfortable with familiar items and photographs around them. All bedrooms at the home were used for single occupancy. This meant that people were able to spend time in private if they wished to.

Training records indicated that not all staff had received formal training on supporting people at the end of life. However several members of staff had been able to take part in the 'Six Steps' palliative care programme through local hospice facilitators. This programme supported staff to develop their skills and roles around end of life care so people receive timely care and support as their condition deteriorates.

We looked at a recent letter sent by relative's following the death of a person who had lived in the home. The relative's thanked the home for ensuring the person had been well cared for. They said how impressed they

had been by their relative's neat appearance and how well staff had attended to personal care for the person. Finally they thanked the staff for making the family so welcome and treating their loved one with such respect when they passed away with "great sensitivity and compassion".

Requires Improvement

Is the service responsive?

Our findings

During our inspection we observed staff and people living there go about their daily life in the home. We saw that daily routines were flexible depending on what people they wanted to do. We saw people going out for the day with relatives and going out for lunch with them. We saw that a member of staff was allocated on the rota for overseeing social and recreational activities on a daily basis.

We saw on the home's notice boards many pictures of social events and celebrations that people living there had taken part in, including a trip out to Blackpool, the home's Summer Fun Day that was open to the local community, a sports day and participating in the local community 'lantern parade' and also gardening activities. Information on people's preferred social, recreational and religious preferences were recorded in individual care plans.

People's care records showed that their individual needs had been assessed before coming to live in the home. This helped to make sure the home was able to meet the person's needs before they arrived. We saw that people's needs and risks were being assessed and identified. Staff we spoke with had a good understanding of people's backgrounds and lives and what was important to them.

We looked at care plans for seven people in detail. We saw that people's needs and risks were being assessed. People had risk assessments in place to inform their care planning and the support they needed from staff in personal care. For example, we saw that where people had shown behaviour that was challenging this was being formally assessed and the support needed was detailed in the care planning records for staff to follow. We also saw that specific conditions had been assessed for risk and were being managed such as diabetes. We saw that care plans contained information for staff on what aspects of the condition needed to be monitored and how to respond should a person's blood sugar levels rose too high or fell too low. This meant they could then receive appropriate treatment or medical intervention.

However we found that for one person the information held in their care plan was not accurate or up to date following a recent admission to hospital and held conflicting information and inaccurate dates. For a period of 13 days we could not find in the person's care plan how their care had been managed. There was no information in the care plan regarding the person's return to the home and what the management plan was or the reason for the admission in the first place. The person had returned from the hospital with equipment to help correct a longstanding manual dexterity problem, having been assessed by an occupational therapist during the hospital admission. Neither the original physical problem or the management of the corrective equipment was stated in the person's care plan for staff to follow.

We recommend that the registered provider seeks guidance that is based on current best practice, on care management planning to support person centred care. This is so that staff can have a consistently clear picture of events and personal care needs in a person centred care plan to refer to and work from.

We observed that information was being kept on this person's care needs in three different records and that dates had not been accurate within the different documents causing confusion from the point this person

returned to the home from a stay in hospital. Information was being put in a staff diary and a supervisor's diary and only by referencing the information held in the three care records could we establish what had taken place. While we did not find this had happened elsewhere in other people's care plans it did indicate that fragmenting information about a person and their needs does not reflect a person centred approach and can cause confusion in care record keeping.

We saw that people had a 'hospital passport', this had information about the person, their health and care needs, medication and what they needed in order to support them. This was to help make sure that should a person need to transfer to another care setting quickly all the relevant information would be available.

The service had a complaints procedure that was available in the home for people. The registered provider had a system for recording, investigating and learning from any complaints they received. The relatives we spoke with said they had not had reason to make a complaint so far.

Requires Improvement

Is the service well-led?

Our findings

People who lived in the home were being involved in the way their home was being run and told us that they had an opportunity to give their views at regular meetings. We looked at the minutes of the last 'resident's meetings' in September that had been attended by 10 people living there. We saw that people had discussed a range of issues about what they wanted in their home, such as menus, having more trips out, the Halloween and Bonfire Night activities. We saw that people's suggestions had been followed up, for example a taxi firm had been contacted to book for 'mystery tours' and their ideas about having a buffet style tea had been passed to the cook.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). All the staff we spoke with told us that they were well supported in the home and felt that they could speak with the manager or supervisors at any time. They said they had regular staff meetings and individual supervision and annual appraisals to discuss work practices, performance, any problems and any areas for personal development. Staff we spoke with told us that, if they raised a concern with the registered manager, they were listened to.

There were systems to assess the quality of the service provided in the home. The operations manager also visited the home on a monthly basis to do service checks and monitor quality. We were told that during the visits the operation's manager had spoken with people in the home, staff on duty and any visitors to the service. This meant people were regularly given the opportunity to raise any concerns or to make suggestions about the development of the services to a senior person within the organisation.

Monthly reviews had been carried out on people's care plans and medication checks and audits had been done to help make sure the systems being used were effective in minimising risk and maintaining accurate information. We found an exception to this where an error in care records and information had not been identified on review. This had resulted in confusion over the accuracy of information held and on the monitoring of a person's care needs and condition following a hospital visit.

There were systems in place for reporting incidents and accidents in the home that affected the people living there. We saw that these had been followed and if required CQC had been notified of any incidents and accidents.

There was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good Governance). This was because the systems used to help identify where quality and/or safety had been compromised had not been effective.

We saw that records of cleaning routines were also checked to help make sure the cleaning schedule had been followed and to help make sure the premises and equipment were kept clean. An infection control audit had been carried out in February 2015 and as a result and action plan had been put in place and the action required had been to make infection control more comprehensive and effective.

We saw during our inspection that the supervisor was accessible to staff and spent time on the units where people lived and engaged in a positive and informal way with them.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met This was because the quality monitoring system used to help identify and assess where systems had failed had not been effective so proper action had not been taken promptly. Regulation 17 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing. How the regulation was not being met: There was not clear evidence that the staffing levels and range of staff skills required within the home to consistently meet people's needs were being systematically assessed. This was to help make sure staffing levels could be adjusted to meet changing needs and make sure people were always safe and supported in accordance with their needs and in a per