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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This was an unannounced inspection carried out on 2 February 2016.

Hillside provides a service for older people and some of whom have a diagnosis of Dementia. The service is over two floors. At the time of the inspection there were 37 people living at the service.

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.

People and staff felt there were not always enough staff deployed in the service.

Although the service used a dependency tool, we did not consider that the needs of the people using the service were being accurately recorded, in particular more people were requiring high needs care that medium as recorded. The registered manager and area manager did re-assesses everyone using the service as a result of our inspection and did change four people from medium to high care, but this did not require according to the tool an increase in staff on duty. This meant that the service was understaffed.

Some people made complimentary comments about the service they received. People told us they felt safe and well looked after. Our own observations showed that the staff were very caring, however the records we looked at did not always match our observation and the positive descriptions people had given us.

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.

Staff did not always feel well supported by the provider and the management team. The staff training records showed that not all staff had received necessary training to make sure they have the skills and knowledge required to care for all people's specific needs. Refresher training had also not been provided in a timely way or staff felt that the e-learning training was not sufficient.

Staff supervision had not been arranged on a regular basis. However the manager did provide on the spot informal supervision and support to staff. A new supervision process was being set up so that the manager would not supervisor all staff and this would be appropriately delegated to other senior staff. The manager told us that each member of staff was to have an annual appraisal to assess their performance and any further training needs.

People were complimentary about the food and were provided with enough to eat and drink. Choices of menu were offered each day.

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 was on the notice board. We also found that complaints had been listened to and actioned.

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 supporting people following decisions they had made which were in their best interest. Not all staff felt confident in the training they had received training in the Mental Capacity Act 2015 or DoLS. The manager was knowledgeable in this area and had applied DoLS and Best Interest meetings appropriately.

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 calm and relaxed. Some people did exhibit challenging behaviour on occasion due to their health condition and we saw that this was recorded and information provided in the care plan of what staff were to do in such circumstances. However talking with staff we drew the conclusion that they had not received sufficient training to deal with people's behaviours and conditions or the training had not provided them with the depth of knowledge or confidence they were seeking.

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.

People were supported to maintain their relationships with people who mattered to them. Visitors were welcomed at the service at any reasonable time and were complimentary about the care their relatives received.

During this inspection, we found a breach of regulation relating to fundamental standards of care. You can see what action we told the provider to take at the back of the full version of this 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

Staff had received training in safeguarding people

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not consistently effective

Not all staff had received appropriate training regarding the conditions people had that used the service.

Staff had not received regular supervision.

People were complimentary about the food and received enough to eat and drink.

Is the service caring?

Good

The service was caring

People's privacy and dignity was protected

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

Is the service responsive?

Good

The service was responsive.

Complaints raised were managed effectively to make sure they were responded to appropriately.

People were provided with a choice of meaningful activities supported to maintain their relationships with people who mattered to them.

What about individualised care planning?

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Quality assurance systems were not always effective in implementing actions recognised in shortfalls.

Files were not stored safely to ensure confidentiality

Care reviews were carried out.

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 2 February 2016.

The inspection team consisted of three inspectors.

We gathered and reviewed information about the service before the inspection.

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. The service had returned a Provider Information Return (PIR).

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, two staff files, management records and care records for six people. We spoke with 11 people, two relatives, three care staff, a senior member of staff, the registered manager and the area manager.

Requires Improvement

Is the service safe?

Our findings

The manager told us that there were approximately six to ten people living at the service with a diagnosis of dementia or were experiencing short term memory loss. From our observations and talking with people and staff we concluded. There were more than ten people experiencing memory problems and required staff care and support to meet their needs for their individual difficulties

When some staff had completed their shift at 17.00 hours. This meant on the day of our inspection after 17.00 hours on the day of our inspection. There were six staff on duty, but two of those staff were still in their probation period according to their name badges. We have learnt that one of those staff had completed their probation period and was awaiting a new name badge to confirm. A senior member of staff was in charge of both the two floors of the service after 17.00 hours.

The service used the regulation and quality improvement authority, staffing guidance for nursing homes June 2009, to calculate the number of staff required to be on duty. This is done by assessing each person's needs to determine if they are low, medium or high dependency. Although the guide refers to mental health, it does not specify dementia. Each dependency level equated to a number of care hours and this was used by the manager as a guide to define the number of staff required to be on duty to meet people's needs.

People's care plans did not always reflect their need. For example the dependency tool used to calculate identified one person as having high care needs. In their care plan they were assessed as being able to mobilise short distances independently with a walking aid and required the assistance of one member of staff with personal care. Yet other care plans where people were identified as requiring the assistance of two staff for personal care, were deemed as having a medium dependency requirement. The number of staff required to support the person in itself cannot determine if the person had low medium or high needs and should be assessed upon a number of factors. However we were surprised with the services findings with regard to the assessment of need for this person.

We raised our concerns at the time of the inspection with the manager and area manager present on the day of our inspection. They agreed to look at the staffing ratios and re-assess the needs of the people living at the service. This was done within 48 hours as agreed and although some alterations were made this did not result in any changes of the current staffing levels.

We found the way in which this dependency tool was being used to calculate staffing levels was not reflecting the actual needs of the people within the service and hence there were not enough staff on duty to keep people safe.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18 (1) Staffing.
The service has increased the staff on duty by one person per shift after our inspection throughout the 24 hour period.

We saw that there were not always enough staff available to meet the needs of people or the service had not delegated staff appropriately to meet people's needs. For example when there were no staff available in the communal areas we saw other people living in the service assisting a person who was unsteady on their feet. When staff returned to the room they told us that the person was at risk of falling. No person was funded as requiring one to one care.

People told us that staffing levels were variable. One person told us. "I feel they are understaffed on some shifts. They work their socks off." Another told us. "At times they don't have enough staff. This means I have to wait a long time." They added. "They come quickly if I ring the bell when I'm in my room, there's no problem there." A third person said. "They are very busy so it's a job to get hold of them sometimes but they do their best."

Many of the people in the service needed two staff to assist them to move and to provide personal care. On some day shifts, when there was staff sickness to cover, there were only a total of four care staff for the whole service. During weekends senior staff on duty had not always informed the manager on-call of this situation, in order that action could be taken to increase the staffing. Procedures are in place to resolve this matter

A member of staff told us. "If we only have two staff on a floor and the senior is giving medicines that leaves one carer to provide all the care." Staff told us that staffing at the weekend was at times particularly poor. The service had no available bank staff and were not using agency staff to cover sickness or absence.
A member of staff told us, "A number of residents rarely got a bath or shower because of time constraints." The care records confirmed this. The service did not concur with these findings but did consider that accurate documentation of when people took baths and showers should be kept. Another staff member told us that on one occasion they were trying to help four people, who all needed two people to assist them, to go to the toilet at the same time. Additionally staff told us that they often missed their breaks because of shortage of staff and time constraints.

We asked people and their families whether they felt safe, one person said cheerfully. "Yep!" Another said clearly. "As safe as I can be, yes." A third person answered. "I do feel safe. It is all very nice." All of the relatives spoken with felt that their relatives were safe at the service. One said. "I think my [relative] is safe here. They hasn't got out yet." Another said. "My [relative] is safe here, and that is the main thing, really."

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. Staff all confirmed the necessary checks had taken place before they started work at the service.

All of the staff we spoke with told us that they had received training in safeguarding vulnerable people. From our conversations with members of staff we were aware that they had an understanding of the different types of abuse that could occur and the signs to look out for. The service had a policy and procedure regarding safeguarding which included notifying the Care Quality Commission (CQC) of any safeguarding concerns. We were aware that information had been reported to the Local Authority and the service had worked with the safeguarding team to identify issues and to keep people safe. One member of staff we spoke with was not aware of the whistle blowing policy or how to report concerns to external authorities if necessary. We raised this with the manager and they said they would ensure that refresher training would be completed for staff to address whistle-blowing. We saw that there was a training program in place for new staff and to update existing staff regarding the safeguarding of people.

Some people spent a number of hours in wheelchairs without the footrests in place. One person who was in a wheelchair could only put one foot partially on the floor. They told us. "My legs are very uncomfortable and I've got pins and needles." We discussed this with one of the staff and they were helped to move to a more comfortable chair. The practice of leaving people in wheelchairs without footplates puts them at risk of an injury. The service may have consulted people regarding their choice about wheelchair footplates while remembering the need to operate a safe service for everyone.

In people's care plans we saw that risk assessments had been completed, including skin checking people's skin integrity, the need for bed rail, 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 people with diabetes had daily checks of their feet written into their care plans. But we could find no evidence that this was being done daily and it was not being recorded daily that staff had done this while assisting with their personal care. We understand that staff may not record this information. However the service staff should be consistent and provide an accurate record for the person in their care plan leaving no doubt of the care provided.

We saw for one person their risk assessments were not all up to date. The monthly bed rail check last completed on 11/12/15 and their Malnutrition Universal Screening Tool (MUST) was last completed 21/12/15. These records for other people were up to date while others were patchy and had not been completed for January. We considered from observing the staff that were busy attending to people's immediate needs that this was a priority over recording information. This was confirmed to us by one member of staff who knew people well and engaged with people in a kind courteous way, that they sometimes could not record all information in the care plans, due to time.

We saw that some people's care plans contained behaviour risk assessments with advice for the staff on potential trigger factors and advice on how to manage changes in people's behaviour.

The manager explained to us the service had emergency plans in place for evacuating the service and what to do in the event of fire. We asked how the service recorded accidents and incidents and how they learnt from such events. The manager recorded information on to a computer data base which was shared with their manager and any identified factors could in turn be shared with staff, such as where did the majority of falls occur.

Accidents and incidents were being recorded both in the daily records and appropriate forms. These informed the manager of information to put onto the computer data base. These had been had been followed up and where appropriate risk assessments had been developed or an existing ones had been reviewed. The staff we spoke to were aware of the risk assessments in place for individuals in the service. For example staff were aware of the people who were prone to falls. The manager was aware of the notifications that needed to be sent the (CQC).

We looked at medicine administration records (MAR) charts for 20 people. We found that these were all correct. Each MAR chart had a picture of the person and recorded clearly on the front sheet any allergies that were relevant to that person. We spoke with a senior member of staff and they explained to us how medicines were ordered on a monthly basis and booked into the service. They also explained how any medicines that were not required were returned to the pharmacy and also that new prescriptions could be obtained the same or next day once prescribed. We saw that the District Nurses supported the service by attending and administering insulin injections to people that had been prescribed this medicine. The senior member of staff was knowledgeable about the people, why they had been prescribed their medicines, there purpose and the potential side effects. We looked at the policy for medicines management and checked the

recording of and storage of controlled drugs, these are medicines that are covered by the Misuse of Drugs legislation 1971 (and subsequent amendments). We saw that the records were accurate and medicines were stored securely and when administered two members of staff had signed the controlled drugs book to confirm the medicine had been given and that the remaining stock was correct.

We were told that no person was able to safely administer their own medicines. The senior member of staff confirmed that they were only allowed to give out medicines when they had received appropriate training and had shown that they were competent to do so. We saw a sheet upon which staff's initials had been signed by staff alongside their name. This meant it was possible to recognise which staff member gave the medication if there were any problems.
The temperature of the medicines room was recorded daily. Medicines that needed to be kept cool were stored appropriately in a locked refrigerator. There was also a chart that recorded the temperature for the refrigerator daily.

Requires Improvement

Is the service effective?

Our findings

One person told us, "Staff seem experienced." Another person said. "The staff are good, they know what they're doing."

Staff said that staff meetings had only been started two months previously. The manager confirmed that staff meetings would be arranged regularly in the future. Staff told us that they did not always receive regular supervision. The management team had received training in supervision. The manager had documented concerns raised by staff as supervision, when they had discussed the situation with them and agreed an outcome. These meetings are sometimes referred to as informal supervision and support the formal arranged supervisions sessions.

New staff were supernumerary and worked with other staff for a two week period before being placed onto the staffing rota. This period could be extended if so required. There appeared to be some confusion, as a member of staff informed us that the probation period was for six months during which time they received supervision both informal and formal and also the induction training was within this period and not all at the beginning for their employment.

Staff told us that the majority of training they completed was e-learning. They told us that they had a competency assessment before they administered medicines or carried out any moving and positioning. Staff told us that the moving and positioning trainer worked on night duty so that it was difficult to obtain any advice on moving and positioning during the day. The service has subsequently informed us that support is available throughout the 24 hour period from a clinical support team able to provide advice.

A member of the staff we spoke with had not received training related to the medical conditions of people living in the home. One member of staff described how a person with Parkinson's disease could do more for themselves on some days than on other days but did not know why. The care staff had limited knowledge and understanding of the possible complications of diabetes and we found that not all staff had received appropriate training to be able to meet the needs of the people within the service. For example the senior staff who had worked at the service for a long time did know about the symptoms of a high or low blood sugar or what actions to take if a person with diabetes became unwell. The manager told us that they would review the training of staff both at induction and on-going in order that staff felt satisfied and confident with the training provided.

Staff told us that they would benefit from further training such as the care of people with specific health needs. In particular training in dementia as staff felt they were now caring for more people with the condition, than in the past. We found when talking to staff they responded to incidences of behaviours that were challenging usually due to people's ability to retain information. Staff had not received training on the best way to deal with the behaviour and to protect themselves and others. Therefore staff members were dealing with these situations without the knowledge required to support people.

The (CQC) monitors the operation Mental Capacity Act 2005 and of the Deprivation of Liberty Safeguards

(DoLS) which applies to care homes. The manager was following the process for making DoLS applications and explained to us the applications that had been made and why. Any application or consideration of DoLS starts with the assessment of the person's capacity and their ability to make decisions. It is not until the person is considered not to be able to make the decision that a DoLS is considered. The records regarding (MCA) and DoLS were in order and correct. The manager spent much of their time completing the assessments and relevant forms. Hence doing this all themselves was highly time consuming for them and we found that not all staff fully understood the e-learning they had completed on (MCA) and (DoLS).

People we spoke with had mixed views about the food provided. One person told us. "Most of the time I don't enjoy the food." Another person said. "The food is as good as if I'd made it myself." A third person described the food as, "Not too bad." Relatives told us that they thought the food was varied and good, although one member of staff considered the evening meals somewhat basic.

We saw that the fluid and food charts which had been put into place for people whereby there was concern about their diet had been completed for everyone concerned. We saw that people were offered hot drinks and biscuits during the day. One person told us. "The food is always lovely here; both cooks are really good."

We observed the lunch meal being served and saw that the staff were understanding of people's needs and engaged with people to ensure their mealtime was enjoyable.

People told us that they saw their GP if they had any health concerns. One person told us. "I see the doctor when I need to." Another said. "I haven't needed to see the doctor but I'm sure I would see them if I wasn't well." They had regular chiropody. Staff told us that they had good support from local GPs and community nurses. They told us that there could be a wait of up to six hours to obtain a GP out of hours but said that if it was a medical emergency they always called the paramedics.

We saw records of health and social care professional visits to the service in some people's individual care and support plans Information was clear and related to people's specific care needs.. Again we were aware that much of this work was undertaken by the manager and senior team and little was delegated to the care staff. A member of staff told us that they did have time to write information into the care plans but felt very pushed to do this as they were so busy providing care and was heavily reliant upon the staff handovers for information.

Good

Is the service caring?

Our findings

Some people were unable to tell us about their care and support because they were unable to verbally communicate or articulate their views to us. So we observed staff interactions with people. We saw that staff were receptive and caring to people's needs.

People were complimentary about the staff describing them as. "Very nice", "Courteous", "Conscientious" and, "Very efficient". One person told us, "They're all very good. Everyone's nice and polite." Another person told us. "The staff work so very hard and they are fabulous."

Two relatives were visiting a person who had been admitted to the service the recently on the day of inspection. They told us. "It's a lovely home. Staff made us feel very welcome. The manager saved the room we chose even though there was a delay in their discharge from hospital."

People told us that they usually received care in the way that they preferred. One person told us. "I'm happy with the way they help me. They know what I like." One of the care staff told us.

One member of staff told us that the shortage of staff in their view made it difficult to provide person centred care. One member of staff told us. "Everything is extremely rushed." Another described the provision of care as being. "OK but would like more time and it could be better." A third staff member said. "When we're short staffed we can only provide the basics and it becomes task orientated."

We observed that some people had long fingernails and some had very chipped nail varnish. This did not uphold their dignity. We raised this with the manager and they said this would be addressed.

People told us they were happy that their privacy was respected. One person told us. "They give me privacy in my room." Another person said. "If I shut my door they don't come in, they will call me or knock and ask to come in." A third person told us. "They knock on my door and wait for an answer."

Staff supported people in a patient manner and treated people with respect. People and family members spoken with said staff treated people with respect and they protected their dignity. A member of staff described how they promoted people's privacy and dignity. They said. "I always close the door when giving personal care and make sure clothes are selected that they would like, I remind them of how they like to have their hair done."

We found the views of people were mixed regarding how the service supported them to express their views. One person said they had attended a residents meeting. While other people could not recall a meeting. We saw staff in one lounge asking people what film they wanted to watch and talking to them about what sort of films they liked to watch.

People felt comfortable and relaxed in the company of the staff members as they were joining in the activity and conversation. Relatives confirmed that they were happy with the care their relative was receiving at the

home. One of them called the carers, were just that caring.

Good

Is the service responsive?

Our findings

Care plans contained information for staff about people's likes and dislikes. We saw that one person had declined assistance with personal care in the morning. It was recorded that staff accepted this situation and returned later in the morning when the person agreed to the staff supporting them.

The manager explained that a pre-admission assessment was carried out before people were invited to visit the service. They said it was important to make sure that they could meet the person's needs before they moved in. People and their relatives or representatives had been involved in these discussions. People's needs were risk assessed by the manager. The manager said the plan was then reviewed during the initial period and necessary changes made to make sure the person received all the care and support that was required.

We saw the assessment process that was in place and were told by the manager that a detailed assessment of people's needs was planned to determine if the service could meet the person's needs. However the pre-admission form was not particularly detailed to assess the needs of people who had dementia or short term memory loss at the time of pre-admission assessment. If a limited assessment was carried out there would be a risk of people being admitted when the service could not meet their needs.

Assessments of need had been carried out to determine if the service could meet people's needs. We also saw that reviews of care were also carried out by the manager to address any change of the person's needs. We saw that the manager had put a great deal of work into the review and there had been involvement with the person and their families. However in some cases it was not clear that other staff had been involved.

The care plans were written in person-centred style with emphasis upon what the person could do for themselves.

People told us that they enjoyed some of the activities. One person said. "I really would praise the activity coordinator. They come up with such good ideas." Another person told us. "I really want to go into town but there's no one to take me."

There was an activity co-ordinator in post. During our visit we saw an exercise group and a game of skittles taking place in one of the lounge areas. People encouraged each other to join in and staff involved showed an understanding of people's abilities and tailored the exercise to suit the people's needs and abilities.

There was a timetable of weekly organised activities displayed in the service. Time was allocated for one to one activities for people who chose to not engage in group pursuits who chose to remain in their room instead.

People told us that there were a wide range of organised activities available for them which included quizzes, exercise classes, cooking and poetry reading. People also told us that in the summer there were organised day trips.

A number of people told us that they had not made any complaints. One person told us. "I've never had to make any complaints."

The service had complaints policy and procedure in place and information about how to complain was available at places around the service and also people were given this information when entering the service 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 compliant had been responded to promptly and with a desire to resolve the problem.

Requires Improvement

Is the service well-led?

Our findings

The service had a statement of purpose and a registered manager in place.

People and relatives spoke highly of some staff. One relative said. "The manager always has time for me." Another relative said. "We are always welcomed by the manager."

Staff told us that the manager worked very long hours and was committed to providing a good service. However some staff and people who used the service said they did not see the manager very often and this was because of the management duties they were required to perform. Staff said that when they did approach the manager they tried to help and support them.

The aim of the service was to provide sensitive care built on individuality, independence and personal dignity, thus allowing people to live as normal a life as possible. We found that staff had an understanding of the aims of the service. When asked, one staff member told us. "We want to care for people how they want to be cared for and help them remain as independent as possible." The frustration we noted from some staff was that they considered there was insufficient staffing and hence could not meet this aim fully.

Some of the audits we looked at examined whether records had been completed but not at the quality of the information provided. For example we found the manager had completed notes and audits on people's care plans. However, we found that the action points were repeated and on-going over several months which meant that they were not addressed. It was not clear once an action had been identified who was going to do this and by when.

There were systems in place to review the quality of the service. Monthly and weekly audits seen addressed areas such as health and safety, fire regulations and accident and incidents. Medicine audits were also carried out. However we could not see that the information was communicated to all staff regarding improvements and actions that had been identified from the audits.

At the start of our inspection when we were shown around the service. We saw a new initiative of a shop some people using the service and volunteer relatives would become were involved in running. This had created an interest and enthusiasm amongst both people and staff.

We were also aware that the service continued to upgrade the accommodation and decorate. We reported an odour coming from a communal lavatory area which was quickly resolved.

Our major concern was that the dependency tool used was only as good as the information provided and the staff were extremely busy providing care that the manager completing the tool may not have had all the relevant information. For example when a person required two staff to support them we were surprised to see that this did not mean that there care needs were not assessed as high. We were also concerned about the lack of formal supervision, planned and carried out yearly appraisals and also the training provided to staff at induction and on-going regarding people's conditions. Part of the staff feeling unsupported was

because senior staff worked together on many occasions in the same area of the service while less experienced people worked together in other parts of the service.

We were aware that a handover was carried out in a lounge with people present and television on showing a movie. Although it was considered people were hard of hearing and hence would not hear it was inappropriate as people walked in and out of the lounge and staff had to lower their voice on these occasions. The manager informed us that consideration would be given and handovers would take place in a different and appropriate location.

We also addressed with the manager the security of people's notes which were in a locked cupboard in a lounge. The key was stored on a hook behind the cupboard and hence it would have been quite easy for anyone to have unlocked the cabinet. The manager told us that this would be quickly resolved.

The service did operate a resident of the day scheme which meant that particular attention was placed upon ensuring the persons care plan was reviewed and discussions took place with them regarding any needs or suggestion they may have.

The manager was aware of when notifications had to be sent to the (CQC). These notifications tell us about any important events that had happened in the service. The manager contacted us regularly and appropriately and this demonstrated the manager understood their legal obligations.

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 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014. Staffing People who use services were not kept safe because of inadequate staffing. Regulation 18(1).