Autumn Lodge

Autumn Lodge - Bognor Regis

Inspection Report

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Date of inspection visit: 04/04/2014
Date of publication: 23/07/2014

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Overall summary

Autumn Lodge - Bognor Regis provides care to older people who require support. There were 18 people living at the home on the day of our inspection. The home is registered to care for a maximum of 19 people.

People we spoke with told us they were well cared for and safe at the home. People told us that the staff were respectful and treated them with dignity. We observed staff knocking on doors, closing doors and curtains to undertake personal care and heard people being called by their preferred names. Care plans showed that people or their relatives had been involved in decisions about the care they received. Staff we spoke with were aware of their responsibilities to keep people safe. Both the registered manager and deputy manager were clear about when to report concerns to either the local authority or the Care Quality Commission. All staff received regular training in safeguarding vulnerable adults which covered the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. People's human rights were therefore properly recognised, respected and promoted. We found that the home had policies and procedures in place to support staff and ensure that medicines had been managed safely in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. This included the administration of controlled drugs.

The home effectively met people's health and care needs because staff communicated well with people, passed information about changes regarding people's health or wellbeing between the team and they appropriately sought advice and treatment from health care professionals. One health care professional we spoke with following the inspection told us that the staff responded to people's needs and provided very effective, compassionate end of life care. The home had a 'Ten Step Dignity Challenge', a code of conduct for staff, residents and visitors which meant that people's dignity was respected and their human rights protected. The code included directives for staff including, " Zero tolerance of all forms of abuse", "Treat people with the same respect you would expect for yourself or family" and "Respect people's right to privacy."

We saw from care plans and speaking with people that their individual needs and preferences were regularly assessed and reviewed. Reviews were undertaken with the involvement of the individual or their relatives and this was clearly documented. All care plans seen included regularly reviewed Mental Capacity Act assessments and the home displayed information about the advocacy service in the entrance hall to ensure that people were aware of how to ensure their rights were protected. We saw from care plans that staff made appropriate referrals to other professionals and community services.

People's needs were met because the home ensured that care reviews and care planning was carried out with the involvement of the individual and close relatives. Care plans we examined evidenced peoples involvement in their planning and reviews. This included their interests, likes and dislikes and preferences. Mental capacity assessments were completed and reviewed regularly. The registered manager showed a good understanding around MCA and DoLS, and when this may be required. The home had comprehensive risk assessments for all aspects of people's care and their environment. People were kept safe because all staff were fully aware of these risk assessments and followed guidelines regarding minimising risks. There was a well-advertised complaints procedure which people at the home and their relatives were familiar with. People we spoke with told us, "I have no complaints but if I did I would be happy speaking to the manager."

Accident and incident reports showed that people in the home were kept safe in a well-led home. This was because there were appropriate systems in place to record and analyse the reports and any action taken as a result. One person who had recently had a fall had been referred to a physiotherapist who had recommended the provision of a walking frame to reduce the risk of future falls. This meant the home learnt from them and ensured that adverse events were less likely to occur again. The registered manager was well established and we found

Summary of findings

from speaking with staff that their leadership encouraged a positive, empowering approach. We also observed that the registered manager had an apparent insightful understanding of the home's residents and their changing needs. Staff underwent a thorough induction to the home and received training in areas such as moving and handling, hygiene and infection control and safeguarding. We saw from the staff training matrix that this was updated regularly. We saw that staff supported people and showed concern for people's welfare throughout the day's activities. People related well to staff and appeared calm and relaxed around them. The activities co-ordinator was new in post, but had recently completed dementia awareness training and this informed the range of activities organised and their personal interaction with people.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

People who used the service and four relatives told us they, or their relatives, felt safe living at the home. Risk assessments were thorough and regularly reviewed. Staff had a clear understanding of what to do if safeguarding concerns were identified.

We saw that the home was cleaned to high standard, appropriately equipped and well maintained.

There were robust recruitment procedures in place. Medicines were sourced, stored, audited and administered appropriately.

Care plans included extensive risk assessments and associated action plans to ensure people were kept as safe as possible.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Relevant staff have been trained to understand when an application should be made, and in how to submit one. People's human rights were therefore properly recognised, respected and promoted.

Are services effective?

People received an effective service because they were consulted about every decision that related to their care and wellbeing.

People had their needs assessed and reviewed regularly. They told us they were involved in these reviews.

Staff were familiar with people's support needs and made appropriate and timely referrals to other health professionals.

Care plans were clear, personalised and regularly updated. Staff training was comprehensive and regularly updated to ensure people were receiving appropriate support.

Are services caring?

People at the home told us they felt well cared for and safe there. They told us, and we observed that staff were respectful and treated them with dignity.

People's preferences were recorded along with likes and dislikes and these were well known to staff. People we spoke with told us that every effort was made by staff to ensure their personal choices were acknowledged and accommodated.

Summary of findings

It was clear from people's care plans that people had been involved in completing advanced end of life care directives and Do Not Attempt Resuscitation (DNAR) forms.

Are services responsive to people's needs?

People's needs were responded to because the staff understood those needs and provided personalised care.

The home had a new activities co-ordinator who had organised a programme of stimulating activities as well as outings and was actively encouraging people to become involved.

People's views were sought through questionnaires, residents' meetings and the registered manager's 'open door policy'. The home had a well-advertised complaints policy and procedure in place. There was a notice regarding this in the entrance hall and copies included in people's service user guides in their rooms.

The registered manager had a good understanding around the Mental Capacity Act (MCA) and DoLS. We saw from records that mental capacity assessments were completed and reviewed regularly.

Are services well-led?

People lived in a home that was well-led by a registered manager who promoted a positive culture that was person centred, open and empowering.

We observed that the registered manager played an active role within the home, and oversaw all aspects of the home. The registered manager told us that they felt encouraged and supported by provider.

We saw that there was auditing in place with analysis and action plans. This was seen for medicines, and overall monitoring and auditing was in line with regulations.

There were no on-going safeguarding reports, however the registered manager displayed good knowledge on how and when to report.

Staff told us that staffing levels were appropriate and we were shown staff rotas which confirmed this. When staff had temporary increases in staffing to accommodate an increased support need this had been implemented by the registered manager.

We saw that accidents and incidents were logged and there were lesson to be learned processes in place with action plans to prevent future re-occurrence.

Summary of findings

What people who use the service and those that matter to them say

We spoke with six people who lived at the home, and two relatives who were visiting. People we spoke with were happy living in the home and said they felt well looked after. One person who was visiting his wife told us, "They think the world of us both and I can tell that they really love X here which means a lot to me"

We asked relatives if they felt the home took time and trouble to understand their loved ones' specific personal needs. One person told us, "Yes, a staff member came and had a chat with us at the beginning and needed to know all about X and what her requirements were."

We received mixed comments about people's lifestyle choices at the home. One person told us, "I wouldn't really get up until about 9.30am I'm not really an early riser but they have to get me up so they get me up between 7.00am and 8.00am and likewise they put me to bed about 9.45pm but at home I'd go later." Another person told us, " I do feel like an individual and I get up and go to bed as I please as I can manage to do it myself so I don't have to rely on them so much to help me."

One person told us they were involved in decisions about care. They told us, "I've a guard rail on my bed now which we agreed together would be a good idea because I was worried about falling out of bed so I feel much safer in bed now."

People and relatives alike said they felt 'listened to' and that they would feel comfortable speaking up if they needed to. People living at the home and their relatives told us they felt that it was well led in terms of knowing who to approach and the registered manager taking issues seriously.

People's comments echoed the home's own recognition of the increasing needs of the people living there. One person said, "They've had a staff turnover recently and they do seem overloaded. I know they love X and turn X regularly but they don't have much time to spend with X." Another told us, "I've no complaint on the whole for X here other than it would be lovely for staff to have more time to spend with X and have a chat now and again."

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Detailed findings

Background to this inspection

We inspected this home on 04 April 2014. We looked at all areas of the building, including people's bedrooms (with their permission), the kitchen, bathrooms, laundry and communal areas. We observed care and spoke with people, their relatives, staff and visiting professionals. We also spent time looking at records, including people's care records, medical administration record (MAR) sheets and records relating to the management of the home.

The inspection team consisted of a lead Inspector, a supporting Inspector and an Expert by Experience who had both professional and personal experience of care for older people.

The inspection was part of the first test phase of the new inspection process we are introducing for adult social care services. 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 regulations associated with the Health and Social Care Act 2008.

Before our inspection, we reviewed all the information we held about the home and asked the provider to complete an information return about the home. We used all this information to decide which areas to focus on during our inspection.

On the day of our inspection we spoke with six people living at the home, two relatives, four members of care staff, the registered manager and the owner.

Are services safe?

Our findings

People that we spoke with told us that they felt well cared for and safe there. People told us staff were respectful and treated them with dignity. We observed staff knocking on doors, closing doors and curtains to support people with personal care and heard people being called by their preferred names.

We looked at five care plans. These showed us people and or their close relatives had been involved in decisions about the care they received. We saw in one care plan that changes had been implemented to ensure staff were able to monitor their nutritional intake. This decision had been made with the involvement of the individual and their family. This meant that people felt safe because their rights and dignity were respected and they were involved in making decisions about any risks they may take.

People were safe because staff we spoke with were aware of their responsibilities in relation to safeguarding. They were able to give examples of various forms of abuse and knew where to find the telephone numbers for the local authority if they needed to raise a safeguarding alert. The registered manager and deputy were clear about when to report concerns and knew what incidents needed to be reported to either CQC or the local authority. This meant that people were safe because staff knew what to do when safeguarding concerns were raised and they followed effective policies and procedures.

We examined care plans and saw that risk assessments had been completed for all identified risks including falls, moving and handling and mobility. Care plans showed clearly that people were involved when the risk assessments were written so that they were comprehensive and based on all relevant information. Detailed environmental risk assessments had been completed by the registered manager. These included detailed guidelines for staff such as making sure they checked water temperatures of baths before bathing people and keeping a record of these checks. We saw these records and also saw evidence by signature that the registered manager audited and reviewed these and other aspects of care regularly.

We saw from advanced care plans and Do Not Attempt Resuscitation (DNAR) directives that people were involved in decisions about their wishes in the event of their death.

We looked at accident /incident reports and saw that they included comments about action taken to prevent a re-occurrence. These reports were audited quarterly by the registered manager for frequency and recurrence and to identify people who might need referring to the falls team. One person who had recently had a fall had been referred to a physiotherapist who had recommended the provision of a walking frame to reduce the risk of future falls. This meant that people were safe because the home had an effective system to manage accidents and incidents and learn from them so they were less likely to happen again.

We saw that the home was cleaned to high standard, appropriately equipped and well maintained. Staff worked to cleaning schedules. People we spoke with told us, “The whole place is cleaned regularly and thoroughly.” We examined these and saw that they were regularly checked and all areas were subject to regular deep cleaning on a rota basis or as necessary in the event of accidents or changes of occupancy.

We looked at the management of medicines within the home. We found that the service had up to date policies and procedures in place to support staff and ensure that medicines were managed in accordance with current regulations and guidance. There were systems in place to ensure that medicines had been stored, administered, audited and reviewed appropriately. This included the administration of controlled drugs. A locked drawer was seen in people’s bedrooms if they wished to self-administer medicines. However at the time of our inspection all medicines were being administered by appropriately trained staff. We saw that Medicine Administration Record (MAR) sheets were fully completed and people had received pain relief when they needed it. This meant that people received their medicine as prescribed. There was no indication to suggest that medicines were used inappropriately to control behaviour.

The registered manager had a good working knowledge around Deprivation of Liberty Safeguards (DoLS) and mental capacity. All care plans seen included regularly reviewed people’s assessments under the Mental Capacity Act. Staff received appropriate training to meet needs of people in the home, including dementia care. This meant that the home understood the requirements of the Mental Capacity Act 2005, its main Codes of Practice and Deprivation of Liberty Safeguards, and put them into practice to protect people. CQC is required by law to

Are services safe?

monitor the operation of the Deprivation of Liberty Safeguards. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards. While no applications had been submitted, proper policies and procedures were in place but none had been necessary. Relevant staff had been trained to understand when an application should be made, and in how to submit one. People's human rights were therefore properly recognised, respected and promoted.

Are services effective?

(for example, treatment is effective)

Our findings

It was clear from care plans that people had been involved in their assessments and reviews. We saw that care documentation had been signed by the person or their close relatives. People we spoke with confirmed this. One visiting relative told us, "The manager came and had a chat with us at the beginning and needed to know all about X and what her requirements were." They also told us there were regular residents' meetings and questionnaire type surveys to gain their views on the running of the home. Some residents told us that they weren't aware that there had been any meetings but they had been given questionnaires asking for their views about the home.

At previous meetings, which had been chaired by the activities' co-ordinator, people had been asked what activities they would like to have within the home and this had been acted upon. People we spoke with said they felt able to speak to the registered manager or staff at any time if they had any issues or suggestions.

Care reviews had been compiled with the involvement of the individual and/or their relative and included 'this is me' information about people's backgrounds and significant life events. Care plans included information for staff about people's likes/dislikes and preferences. This meant they were personalised and gave new or agency staff a good insight into the individual as well as their support needs.

Advanced care plans showed peoples involvement and wishes in the event of their death. There were also regular reviews of people's mental capacity. We saw information regarding the advocacy service displayed in the entrance hall. This meant that people could express their views about their health and quality of life outcomes and were aware of services that could speak on their behalf if they wished.

We saw that there was support and equipment in place to support people who had reduced mobility. Wheelchairs, hoists and walking frames were seen within the home. Care plans and risk assessments were reviewed and updated regularly. This meant that people experienced care, treatment and support that met their needs and protected their rights.

There was evidence that reviews had been referred to GPs for review when people were taking 'as required' medicines on a daily basis. We saw evidence in care plans that GPs were involved in people's healthcare, along with community nurses. There were also appropriate referrals to other health professionals such as physiotherapists and dieticians. This showed that care and treatment was planned and delivered in a way that ensured people's safety and welfare.

Staff we spoke with told us they had received all appropriate training and undertook regular refresher or update training. They also told us that they received extra training in areas such as

dementia. This was confirmed by records we examined. These also showed that all staff had received training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) in addition to safeguarding vulnerable adults training. They told us they felt supported by the management and 'listened to' at staff meetings.

We saw evidence that staff had regular supervision with their senior care worker or the registered manager and also had annual appraisals. Staff spoken with said they felt supported and suitably trained to meet the needs of people in the home. All felt able to speak to the registered manager if required. We also spoke to the new activities co-ordinator who knew the residents well already as individuals. They were very enthusiastic and keen to start getting people out and about, using more life-story work, and spending time with individuals in their rooms. They had recently undertaken some dementia awareness training we observed that they demonstrated an insightful approach during their interactions with residents.

Are services caring?

Our findings

During our inspection we found that staff at the home were caring and patient. They were supported in this by the home's management and policies. People were encouraged and supported to maintain independence when possible. Staff were seen to respect people's individual behaviour. One person was in the habit of putting themselves on the floor if they got too hot. Rather than discourage this, staff had put measures in place to ensure their safety and that of other people in the home. Staff were reviewing arrangements with family members to ensure the person's needs continued to be met.

We saw that care plans were stored securely when not in use. All staff we spoke with told us they had signed a confidentiality clause as part of the home's induction process. This was confirmed in staff files we examined and meant that people were assured that information about them was treated in confidence.

We saw and heard examples of kindness and compassion during our visit with staff speaking to people in a respectful, dignified manner, offering choice, support and encouragement. We saw dignity and respect were demonstrated in the way staff knocked on people's doors and waited for an invitation before entering. One person told us, "Can't fault it, they're very kind." Another said,"I would recommend it here and be happy to tell people how good it is." We also observed that staff used people's preferred names and explained what they were about to do and checking with the person that it was okay before providing any personal care. This meant that people were able to have privacy if they needed and could be as independent as they wanted.

There were policies and procedures in place to ensure staff understand how to respect people's privacy, dignity and human rights in the care setting. We saw evidence in care plans of regular reviews of people's mental capacity and there was information about the advocacy service displayed in the entrance hall of the home. We also saw the home's '10 Step Dignity Challenge', an in-house code of conduct to promote dignity and respect, advertised here. This included areas such as a zero tolerance level towards abuse, the adherence to the provider's confidentiality policy and people's right to privacy. In this way staff were encouraged to promote respectful behaviour and positive attitudes.

Residents meetings had taken place, chaired by the activities co-ordinator, where people had been asked what activities they would like to have within the home. We saw evidence of regular residents' survey questionnaires which were collated and analysed and meetings which were minuted. People we spoke with told us they felt able to speak to the registered manager or staff if they had any concerns. There had been some dissatisfaction voiced by people previously about the lack of stimulating activities which the home had listened to and responded positively by employing the new activities co-ordinator. One person told us, "I've no complaint on the whole for X here other than it would be lovely for staff to have more time to spend with X and have a chat now and again."

People told us they were involved in informal meetings in the lounge regarding the way the home was run and regularly completed questionnaires to gain their view of the home. Care reviews had been done with the involvement of the individual and/or close relatives and we saw signatures confirming this. This meant that people and those that matter to them were encouraged to make their views known about their care, treatment and support, and these were respected.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found from looking at records and from speaking with staff that there was a minimal turnover of staff. This meant that staff were familiar with the people's individual needs. Residents, relatives and visitors were encouraged to make their views known via questionnaires. The home also held regular residents' meetings and the registered manager had an 'open door' policy which all staff and people at the home were aware of. This meant that there was an atmosphere of openness and awareness of people's concerns within the home.

Care reviews and care planning were completed with the involvement of the individual and close relatives. One person said, "My family member is actively encouraged to be as independent as possible. Their support worker knows them as well as I do." All the relatives we spoke with where people lacked the capacity to make such decisions for themselves confirmed they were involved in decisions around their family member's care. One person told us, "I do feel like an individual and I get up and go to bed as I please as I can manage to do it myself, so I don't have to rely on them so much to help me." Another told us, "Oh yes they asked me all about me and asked me lots of different questions." This showed that staff actively sought, listened to and acted on people's views and decisions.

Advocacy support was provided when needed. We saw evidence in care plans that mental capacity assessments were completed and reviewed regularly. The registered manager of the home showed a good understanding around MCA and DoLS, and when this might be required. We saw that there was information regarding advocacy available in leaflet form. If a person did not have capacity, best interest meetings were arranged to make decisions about their care. This meant that a person's capacity was always considered under the Mental Capacity Act and

People received care and support in accordance with their preferences, interests, aspirations and diverse needs. One person told us, "They came and interviewed me." Care plans we examined evidenced people's involvement in planning and reviewing. This included interests, likes and dislikes and preferences. Staff we spoke with told us, "I've been here 9 years and I absolutely love it. I think because it's a small home its cosy and I love knowing their loved ones and knowing all about them as individuals."

We were shown the activity schedule and a timetable of days out that were planned. The home had appointed a new activity co-ordinator who had an open and supportive manner which encouraged people to participate in activities. On the day of our visit nine people attended the morning activity of a quiz and a further activity 'day at the races'. People told us they really enjoyed the activities provided. The registered manager told us they went to great lengths to provide appropriate and stimulating activities.

Evidence was seen in care records that people had been encouraged to maintain relationships with family and friends. One person told us that they went out up to three times a week with her family, and also regularly attended in-house activities. People were enabled to maintain relationships with their friends and relatives.

The home recognised the risks of social isolation and loneliness and had systems in place to minimise this. One person's care plan dealt with their inability to leave their bed. A care plan had been written around the fact that they were 'at risk of isolation'. This included information and advice for staff on how to reduce and prevent the person from becoming isolated. This individual had been placed in a room close to the main lounge so they were able to hear music when it was being played. Their family had been involved in all decisions and told us they felt happy that the home was meeting this person's needs. The activity co-ordinator and the registered manager had also met to come up with appropriate one to one activities for this person to further help prevent feelings of isolation. Staff were seen to enter their room regularly. This meant that the service recognised the risks of social isolation and loneliness and had systems in place to minimise this.

We saw the home's complaints' policy. This required all complaints to be acknowledged within 24 hours and investigated within seven days. There was then provision for the person to be referred to either CQC or the Local Government Ombudsman if they were still not happy. We were shown the home's complaints file which showed that when complaints had been received they were dealt with in accordance with the policy. This policy was clearly displayed on the wall in the entrance to the home and a copy was included within the home's Service User Handbook. People we spoke with were aware of the policy

Are services responsive to people's needs?

(for example, to feedback?)

but told us they were comfortable speaking to staff if they had an issue and were confident they would be taken seriously. This showed that concerns and complaints were encouraged, explored and responded to in good time.

Are services well-led?

Our findings

We found there was a transparent open culture at the home which had a friendly, open feel, and we saw that people moved around the home freely. People we spoke with told us, ""This is a nice place and its very comfortable and its well organised too."

Staff we spoke with were aware of the whistleblowing policy, and the CQC whistleblowing policy was seen to be in place in the homes policies and procedures. This showed that staff were supported to question practice and those who raised concerns and whistle-blowers were protected from untoward repercussions.

Investigations, where required, into whistleblowing, safeguarding, complaints/concerns and accidents/ incidents were thorough, questioning and objective. Where required, action plans were monitored to ensure they were delivered.

We saw that there was auditing of accidents/incidents in place with analysis and action plans to prevent or minimise re-occurrence. We saw regular audits were in place in relation to medicines, and overall monitoring and auditing was in line with outcomes and regulations. There were no on-going safeguarding reports, although the registered manager displayed a good knowledge about how and when to report. This meant that there were effective arrangements to continually review safeguarding concerns, accidents and incidents.

The registered manager played an active role within the home, and oversaw all aspects of the home. This included working on the floor administering medicines, and taking responsibility for the day to day running of the home, supported by the provider if needed. The registered manager told us that they felt encouraged and supported by provider. We found a clear set of values within the home overseen by a good supportive management team.

There was consistency between what leaders and staff said were the key challenges, achievements, concerns and risks. We found consistency between what the provider and registered manager told us, and what we evidenced during the inspection and from feedback given to us by staff and people living in the home. This showed that there was an openness throughout the home and good communication between residents, relatives, staff and management.

Resources and support were available to the registered manager and the team to develop and drive improvement. There were resources in place to support the registered manager and staff. The registered manager was in the process of sourcing further information for staff regarding dementia care to further enhance training received and ensure people's needs were met.

Emergency plans were in place through an arrangement with another care home and use of the nearby cinema in the event of a need to evacuate the home. There were Personal Emergency Evacuation Plans (PEEPS) in place for all people living at the home and we saw records confirming that regular fire safety checks had been carried out. Staff we spoke with understood the PEEPS and their role in them.

Risks at team, and where appropriate, directorate and organisation level were anticipated, identified and managed. We saw from care plans that dependency levels were assessed and reviewed regularly and examined in relation to staffing levels. During our visit we had a discussion with the registered manager and provider regarding the increasing support needs of people in the home. Both reassured us that staffing levels would be increased to meet the needs of people in the home whenever necessary.

Staff we spoke with were motivated, caring, well trained, supported and open. The registered manager worked a variety of shifts including a night shift to check whether staffing levels were adequate and to monitor and review staff performance. Staff spoken with said they felt that staffing levels were fine at the moment but that some days were busier than others. Staff told us that staffing levels were appropriate and we were shown staff rotas which confirmed this.

We saw the registered manager had responded when a staff member told them they felt staffing levels needed to be amended. There was a staff meeting organised promptly. The minutes of the meeting showed that a number of staff who were not able to attend in person had been contacted by the registered manager to gain their views. All staff who responded stated that staffing levels were appropriate at that time. This meant that there were enough qualified, skilled and experienced staff to meet people's needs.

Are services well-led?

The registered manager demonstrated a very insightful understanding of the home's residents and their changing needs. Our inspection identified that while staffing levels at that time were appropriate, people's increasing needs meant that staffing levels would soon need to be increased to provide a continuing high standard of care and support. The registered manager had already recognised this and was monitoring the situation closely so that appropriate staffing level increases could be implemented when necessary.