Bupa Care Homes (ANS) Limited

Wilton Manor Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 28 October 2016 and 1 November 2016 and was unannounced. Wilton Manor Care Home provides accommodation for a maximum of 69 people who require nursing or person care, including people living with a cognitive impairment. At the time of our inspection 59 people were living at the home.

At the time of our inspection there was no registered manager in place for the service. The previous registered manager had left the service three weeks prior to the inspection. An interim manager had taken responsibility for managing the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection which took place on 19, 21 and 24 August 2015, we identified two breaches of regulations. The provider had failed to maintain a clean environment and to support staff and ensure that training updates were completed. The provider sent us an action plan detailing the steps they would take to become compliant with the regulations. At this inspection we found appropriate action had been taken and issues in relation to staff training and the cleanliness of the home had been addressed.

People and their families told us they felt the home was safe. All of the staff, including non-care staff, and the interim manager had received appropriate training in safeguarding and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

People were supported by staff who had received an induction into the home, appropriate training and professional development to enable them to meet people's individual needs. There were enough staff to meet people's needs.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals, such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people; they were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. Food and fluid intake was closely monitored and concerns were acted on quickly and effectively.

People and when appropriate their families were involved in discussions about their care planning, which reflected their assessed needs. There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through an annual questionnaire.

People's families and staff told us they felt the home was well-led and were positive about the interim manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

People and relatives were able to complain or raise issues on a formal and informal basis with the interim manager and were confident these would be resolved. This contributed to an open culture within the home. Visitors were welcomed and there were good working relationships with external professionals.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

Risks to people and environmental risks were managed appropriately.

People received their medicines at the right time and in the right way to meet their needs.

People and their families told us there was sufficient staff to meet people's needs.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

People and relatives were positive about the way staff treated them.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

Is the service responsive?

Good

The service was responsive.

People received care that was personalised to meet their individual needs.

Care plans were comprehensive and reviewed regularly to help ensure they reflected people's needs.

People knew how to make complaints and they were dealt with promptly in accordance with the provider's policy.

Is the service well-led?

Good

The service was well-led.

The management team were approachable. Staff understood their roles, and worked well as a team.

The provider's values were clear and understood by staff.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided.

Wilton Manor 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 inspection was also carried out to check whether improvements had been made from the August 2015 inspection.

This inspection took place on 28 October 2016 and 1 November 2016 and was completed by two inspectors and an expert by experience, who had personal experience of using or caring for someone who uses this type of care service. The inspection was unannounced.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 10 people using the service and engaged with a number of others, who communicated with us verbally in a limited way. We spoke with five members of the care staff, a member of the administration team, the chef, the head housekeeper, the interim manager, the regional director, two activities co-ordinators and the quality manager. We also spoke with 12 relatives and two health professionals.

We looked at care plans and associated records for seven people using the service. We also looked at records relating to the management of the service including staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

We observed care and support being delivered in communal areas and 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.

Good

Is the service safe?

Our findings

People and their relatives told us that the service was safe and a health professional said they did not have any concerns regarding people's safety. They commented "They have some very challenging people here, they manage them very well. Staff will look for trigger points and try all non-drug options to support them. I have no concerns".

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff, including non-care staff, and the interim manager had received appropriate training in safeguarding. Staff knew how to raise concerns and how to apply the provider's policy. One member of staff told us "If I had any concerns about the care and treatment of the residents, I would go straight to the manager, she will always respond". Another staff member told us "I would not hesitate to take matters further if I needed to and would go to CQC or the safeguarding team directly". Where safeguarding concerns were raised the interim manager conducted thorough investigations in response to allegations of abuse and worked with the local safeguarding authority to keep people safe from harm.

Where people had been identified as being at risk a clear and informative risk assessment was completed and a care plan produced which allowed effective and appropriate care to be provided. For example, one risk assessment highlighted that a person was at high risk of falls. There was clear guidance in relation to how this should be managed including equipment and actions that were needed to prevent and reduce the risk of falls. On visiting this person it was seen that staff had implemented the information within the risk assessment. Other viewed risk assessments in place included, risk of skin breakdown, risk of malnutrition and dehydration and risk of choking. Risk assessments had been developed with additional involvement from appropriate healthcare professionals, including occupational therapists, GPs and district nurses.

Where an incident or accident had occurred, there was a clear record, which enabled the interim manager to identify any actions necessary to help reduce the risk of further incidents. For example we saw that one person who had had a series of falls had been referred to the falls clinic and a second person had been referred to a specialist in supporting people with Parkinson's disease.

The interim manager had assessed the risks associated with the environment; these were recorded along with actions identified to reduce those risks. These included risks relating to, obstructed walkways, the use of window restrictors, hot water and the use of the ride on mower.

People and their families told us there was sufficient staff to meet people's needs. One relative said "The staff always seem to be busy, but don't rush my relative" and a person told us "They [staff] are very busy but help me when I need it". Staff we spoke to confirmed they were very busy but that this did not affect people's safety. One staff member told us "We don't often get the time to just sit and chat to the people or aid them in activities".

The interim manager told us that staffing levels were based on the needs of the people using the service.

There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime, bank staff and agency staff. The interim manager was available to provide extra support when required. A health professional told us "What I like is that I see the same carers on the floor which is good for continuity".

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. A DBS check will identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. However, the records did not always show where gaps in the employment history of potential new staff were fully explored. We raised this with the interim manager who took action to ensure this was correctly recorded in the future.

People received their medicine safety, as prescribed and on time. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine'. One person told us "I feel quite safe here and I always get my medicine on time". Suitable arrangements were in place for obtaining, storing, administering and disposing of medicines. Staff administering medicines had received appropriate training and had their competency assessed. Nurses were observed administering medicines competently; they explained what the medicines were for, did not hurry people and remained with them to ensure that the medicine had been taken.

There were suitable systems in place to ensure prescribed topical creams and ointments were applied correctly. This included body charts to identify where specific creams should be applied and records completed by care staff to confirm application. Topical creams had an 'opened on' date to help ensure these were not used after the safe time limit. Nurses told us they checked the topical cream application charts to ensure care staff were applying these as prescribed.

Clear guidance had been developed to help staff know when to administer 'as required' (PRN) medicines, such as pain relief and medicines to help reduce people's anxiety. Where people were not able to state they were in pain, a pain assessment tool was in use. This was used to support the decision as to why PRN pain medicine was given or not on each occasion. Where medicines were prescribed with a variable dose the dosage and time the medicine was given was clearly documented.

Staff respected people's rights to refuse prescribed medicines. The nurse described the action they would take if medicines were declined. There was a procedure in place for the covert administration of medicines. This is when essential medicines are placed in small amounts of food or drink and given to people. We saw all the correct documentation had been completed correctly, in line with the current legislation that protects people's rights.

People experienced care in an environment which was clean and appropriately maintained. The head of housekeeping, who was the infection control lead and care staff had received infection control training. While observing care we saw staff using their personal protective equipment, such as gloves and aprons when supporting people in line with the Department of Health Guidance. The interim manager had completed an infection control risk assessment and infection control audits had been carried out to ensure people were safe.

There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire. Fire safety equipment was maintained and tested regularly.

Good

Is the service effective?

Our findings

A health professional told us "The staff are knowledgeable about the people they supported. I don't have any concerns about the staff's ability to look after people effectively; they know their patients really well". Another healthcare professional said "Staff are knowledgeable about the people and understands their needs".

Staff sought verbal consent from people before providing them with care and support by checking they were ready and willing to receive it. We heard staff gain people's consent. Records confirmed that staff complied with people's wishes; for example, one person had declined to have a shower and another had declined to take part in an activity, this was clearly documented and staff had respected each person's decision.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. All care files we viewed contained completed capacity assessments which highlighted the person's ability to make particular decisions. We saw that these had been completed with the person and staff had consulted with relatives and professionals. Decisions taken had been appropriately documented, including information as to why they were in the person's best interests. For example, we saw best interest forms in place for decisions in relation to the use of bed rails and sensor mats.

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 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 found the provider was following the necessary requirements. DoLS applications had been made to the supervisory body with the relevant authority for all of the people using the service. The interim manager carried out a review of the applications on a regular basis to ensure they were still required. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option.

At our inspection in August 2015 we found the provider did not ensure that staff received appropriate support and training to enable them to carry out the duties. During this inspection we found that people were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their

suitability to work on their own. Staff were also required to complete a workbook, similar to the principles of the care certificate, which needed to be signed off by a senior member of staff. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. One staff member said "Things have defiantly improved, we get more training and supervision now, the management is very supportive".

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicines training, safeguarding adults, fire safety and first aid. Staff had access to other training focused on the specific needs of people using the service, such as, dementia awareness, managing behaviour we find challenging, skin integrity and use of syringe drivers. Staff were also supported to undertake a vocational qualification in care. A health professional told us "Staff appear well trained and know what they are doing". Staff comments included, "We get loads of training" and "We are always doing training".

Although staff received support through supervisions, these were sporadic. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. The interim manager told us they had identified this concern as part of their audit of the service. They showed us a copy of the programme of supervisions they had put in place to ensure staff received supervisions and annual appraisals in line with the provider's policy.

People had varied views on the quality of the food offered. Most people told us that the food was good and commented on a large range of choices that were available. One person told us "Food here is very good and I always get a choice", another person said "The food could be better" and a third said "There had been an improvement in the food we get".

Meals were prepared by the chef and served by staff who all demonstrated an awareness of people's likes and dislikes, allergies and preferences. People were supported to have enough to eat and drink and we saw drink and snacks being offered throughout the day. Food was prepared in the main kitchen on the ground floor of the home and meals were delivered to each floor in hot trolleys, where it was served at the same time. Staff spoke with people before each meal to explain what options were available. Where appropriate staff used pictures to help people understand what meals were available. People were provided with alternative food choices, such as a jacket potato, omelette or a sandwich if they didn't want what was on the menu. Staff offered people choice over the size of the meal they preferred, small, medium or large. During lunchtime we saw one person decline the meal that had been served and they were provided with an alternative of their choice, which was also declined when served. We discussed this with the staff who explained that this often happened and the person would accept food later in the day. Care staff was seen fully supporting those that could not eat independently and this was done in a patient, respectful and unhurried way. People's food and fluid intake was monitored where people's nutritional intake was poor and this was supported by the use of individual food intake diaries. Staff checked these at the end of each shift to ensure that appropriate actions could be taken if necessary.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. A health professional told us that staff were "Always really helpful. They do everything they can to make my job easier and have things ready for me". They added "If they call me I know they need my help. I am only called out when I am needed".

Good

Is the service caring?

Our findings

Staff treated people with kindness and compassion. One person told us "The staff are really nice" and another person said "It's good here, I am well looked after by the carers and the nurses". Relatives of the people using the service comments included "The staff are very caring and helpful; [my relative] is very well looked after", "We are very happy with the care here, we have no complaints" and "The staff are so respectful, and some are absolutely lovely. They really do care about the people here".

Interactions between people and staff were positive and friendly. We heard one person say to a member of staff "I love you", and then they kissed the staff member on the cheek, the staff member responded by holding the person's hand and engaged them is conversation about their life and family. Staff knelt down to people's eye level to communicate with them and we heard good-natured banter between people and staff showing they knew people well.

Staff treated people with dignity and their privacy was respected at all times. One person told us "I am treated in a dignified way by the staff here". Staff were able to describe the practical steps they took to preserve people's dignity and privacy when providing personal care. This included ensuring doors and curtains were closed and making sure people were covered. We observed staff knocking on doors, and asking people's permission before entering their bedrooms. Confidential care records were kept securely and only accessed by staff authorised to view them.

Care plans included specific individual information as to how people wanted to be cared for and things that were important to them. For example, one person's care plan stated "[Person] likes to remain in their room and watch television, staff to ensure that [person] has everything in reach, including the bell and television control". When we visited this person in their room it was evident that the information in the care plan had been followed. Another care plan highlighted the person's preference in respect of the gender of the staff member who would support them with personal care. Care plans contained 'This is me' and 'My day, my life, my story' records which included detailed information about the person's, care needs, likes and dislikes, family and personal history, past jobs and hobbies and interests. Areas highlighted in these were discussed with staff who demonstrated that they knew the people they cared for well. For example, one person didn't have her handbag which is very important to her, this was noticed by a staff member who fetched it immediately. We also saw a staff member enter a person's room to tell them that a programme that the person particularly enjoyed was just about to start.

Staff supported people to maintain family relationships and relatives told us they were always made to feel welcome and could visit at any time. One relative said "We visit every day if we can; the staff are very nice and there is no restrictions on visiting as far as we know" and another relative said "We can visit any time; we are always made to feel welcome".

People's independence was promoted. At lunch time staff encouraged a person to eat without taking over and provided appropriate aids to support them to be independent, such as plate guards and specialist cutlery. Care plans specified what people could do for themselves and what they needed help with. For

example, one stated "Give person their call bell and explain to them how to use it". Another plan stated "Staff to make sure that the bed control is available to person, as they are able to use this". We observed one person being supported by two members of staff to mobilise. The staff provided the person with appropriate equipment and assisted them in a kind, reassuring and unhurried manner.

Staff showed concern for people's wellbeing in a caring and meaningful way and took practical action to relieve people's distress and discomfort. One person became distressed during our visit and staff members responded quickly providing them with reassurance, comfort and additional support as required.

Good

Is the service responsive?

Our findings

People received personalised care and support that met their needs. A health professional told us that staff responded to people's changing needs, they said, "Staff work together, with me and families to manage patient's needs". Another health care professional said "The staff are very prompt at referring any residents to us if they require nursing input" A relative told us "The staff will always provide my relative with the care they need and get additional support if required".

When people moved to the home, they and when appropriate their families were involved in assessing, planning and agreeing the care and support they received. Individual care plans were well organised and the guidance and information in these were detailed. People and relatives had signed care plans confirming their involvement. One relative told us "I can look at my relatives care plan any time, it gives me clear and up to date information how my relative is".

People's care plans provided information to enable staff to give appropriate care in a consistent way. They were individualised and detailed people's preferences, likes and dislikes and how they wished to be cared for. People received personalised care from staff that supported them to make choices and were responsive to their needs. Comments in care files included "Staff to offer [person] choices at all times", "Speak clearly and slowly and give [person] time to respond" and "Person needs support to make complex decisions".

We saw people being supported by the staff as described in their care plans to maximise their independence. Records of daily care confirmed people had received care in a personalised way in accordance with their care plans, individual needs and wishes. Staff were able to describe the care provided to individual people and were aware of what was important to the person in the way they were cared for. Care plans were reviewed monthly or more frequently if needs changed by the qualified nurses on the nursing floors or the senior carer on the residential floor.

Relatives had the opportunity to regularly talk to the interim manager and staff both formally and informally. Staff notified relatives at once of any change to medication, illness or circumstances in the home. One relative told us "I received a call this morning from the nurse, to tell me that [my relative] had had a fall". We viewed this person's care plan and the incident and action taken was well documented. Another relative said "We are fully involved in [my relative's] care and kept informed".

Staff were kept up to date on people's needs. Staff had a handover meeting when they arrived on shift. This meeting provided the staff with a range of important information about people's conditions and included any special instructions for staff. For example, if anyone needed to be weighed or had additional care needs.

People were provided with appropriate mental and physical stimulation through a range of varied actives. The service employed two activities co-ordinators and also purchased external entertainment, such as singers. Actives were provided both in groups and individually and were adapted according to the likes and preferences of people on a day to day basis. People who remained in their bedrooms by choice or through

care needs were given the opportunity to receive one to one activities. One member of staff told us "During room visits we will sometimes sit and talk to the person, provide them with some pampering or read to them, the choice is theirs". People and their families were kept informed of up and coming events and daily activities though the activities notice board and directly from the staff. Actives included reminiscence, games, music, armchair exercises, word games, quizzes, gardening and arts and crafts. The home often held events such as Halloween party, Christmas fair, food tasting events and regular party buffets.

During both days of the inspection we saw people being encouraged and supported to take part in activities, where people declined their choice was respected. On day one of the inspection we saw seven people being supported to carve pumpkins for the up and coming Halloween party. On day two of the inspection we witnessed three members of the care staff making craft fireworks with the people on one floor while a parachute game was underway elsewhere in the home. During these activities the people were totally engaged and many of the people were smiling and laughing.

Staff were responsive to people's religious beliefs and were supported and encouraged to maintain these if they wished. A member of the activities staff told us that when a person moved to the home they would receive a one to one meeting to discuss their beliefs and any religious needs they may have. This staff member told us that during one of these meeting a person had highlighted a particular religious belief that none of the staff had any experience or knowledge of. The staff member researched this, contacted a local spiritual leader and attended an appropriate service so that they could better understand this person's beliefs to support them to maintain it. The home also provided regular communion and people and their families were invited to attend.

The interim manager sought feedback from people and their families on both a formal and informal bases. The interim manager had an open door policy and was happy to meet with the people and their relatives whenever they needed support or to raise issues or concerns. One relative told us "I can go to the manager at any time, they are very approachable" and another relative said "The manager has been very responsive to past concerns I have raised about my relatives care". Relatives and residents meeting are held quarterly and meeting minutes were made available to the people and their relatives on request.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided. Posters were displayed at various locations around the home drawing people's attention to a 'Speak up Service' which is a confidential phone line where people could raise concerns or issues anonymously if they wished. The interim manager explained the action they had taken when complaints or concerns had been raised. They had also reviewed each concern or complaint to identify lessons learnt which were fed back into the organisation.

Good

Is the service well-led?

Our findings

A health professional told us they did not have any concerns over the management of the home. They said they the felt the home was "Very well organised; a good environment. I like coming here". Another health care professional said "The staff are well organised".

There was no registered manager in place for the service. The previous registered manager had left the service three weeks prior to the inspection. An interim manager had taken responsibility for managing the home but had not yet registered with the commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Although there was no registered manager in place there was still a clear management structure. This structure consisted of an interim manager, heads of departments, nursing staff, senior care staff and the regional manager. Staff understood the role each person played within this structure. Both the interim manager and regional director were present throughout our inspection and were responsive to requests for information and support from the inspection team, people using the service, staff and visitors.

Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They confirmed they were able to raise issues and make suggestions about the service and care provided in their one to one sessions or during staff meetings and these were taken seriously and discussed. Staff commented on the improvement of the service over the last 12 months and their comments included, "Things have really improved, the interim manager is really supportive" and "The atmosphere, care and environment has changed for the better over the last few months".

The management team encouraged staff and people to raise issues of concern with them, which they acted upon. One staff member said "The interim manager is very approachable; she listens to us and will always respond to any issues or concerns we raise". The interim manager carried out an informal inspection of the home during a daily walk round; this was done to look at the safety within the environment and talk to the people and staff. Where issues or concerns were identified these were immediately addressed or an action plan was created and managed through the regular meeting processes.

The providers were fully engaged in running the service and their vision and values were built around 'delivering high quality care, while running a commercially successful business'. Regular management and staff meetings provided the opportunity for the interim manager to engage with staff and reinforce the provider's values and vision. The vision and values of the service and how these related to their work was discussed with the care team, who all demonstrated a clear understanding of them. One staff member said "The people always come first, it is about them". Another staff member told us "We work hard to provide high quality care to everyone living here".

The provider had suitable arrangements in place to support the interim manager, for example regular meetings, and visits from the regional director which also formed part of the provider's quality assurance process. The interim manager confirmed that support was available to them from the provider. They were also being mentored by and able to raise concerns and discuss issues with the registered managers of other near-by locations owned by the provider.

Robust quality assurance systems were in place to monitor both the safety of the environment and the quality of the clinical care provided. Routine checks and audits were regularly carried out for a range of areas to enable the interim manager to monitor the operation of the service and to identify any issues requiring attention. The interim manager carried out regular audits which included infection control, the cleanliness of the home, resident involvement and care plans. There was also a system of audits in place to ensure that safety checks were made in respect of water temperatures, the medicine cupboard temperatures and fire safety. Weekly medicine audits were completed by the night staff and the interim manager completed full medicine audits monthly which covered all areas of medicines management. In addition, the provider had developed an audit for 'resident of the day', this allowed the interim manager to concentrate on one care record and ensure it was reviewed fully.

Other formal quality assurance systems were in place, including seeking the views of people about the service they received. Surveys had just been sent out to people and relatives at the time of our inspection. We were told by the interim manager that completed questionnaires would be sent directly to the provider to review. The provider would then compile a report of the finding and an action plan would be developed and implemented.

Although not registered the interim manager understood the responsibilities of a registered manager and was aware of the need to notify the Care Quality Commission (CQC) of significant events regarding people using the service, in line with the requirements of the provider's registration.

The rating from the previous inspection report was displayed in the reception area and on the provider's website.