Coate Water Care Company (Church View Nursing Home) Limited

Church View Nursing Home

Inspection report

Rainer Close
Stratton St Margaret
Swindon
Wiltshire
SN3 4YA

Tel: 01793820761
Website: www.coatewatercare.co.uk

Date of inspection visit:
30 October 2018
31 October 2018
21 November 2018

Date of publication:
15 January 2019

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out this inspection over three days on 30 and 31 October and 21 November 2018. The first day of the inspection was unannounced.

This inspection was brought forward, as we had received a high number of anonymous concerns about the service. The concerns generally related to people not having adequate food and fluids or being sufficiently repositioned, to minimise their risk of pressure ulceration. Senior managers within the organisation investigated the concerns and found them largely unsubstantiated. One concern identified shortfalls in the completion of care intervention charts. The incomplete records did not evidence people had received the care they required.

The service had a poor history of non-compliance in areas such as the planning of people's care and the safe management of medicines. In 2015, the service was rated inadequate and placed into special measures. In 2016, we imposed a condition on the provider's registration, as shortfalls continued and improvements were not sustained. The provider has adhered to the condition and sent us the information we required. During subsequent inspections in 2017 and January 2018, further improvements were made but these were not consistent to demonstrate a good service. Senior management told us the home was one of the services within the organisation that was not where they wanted it to be. They said the abilities of previous managers had contributed to this.

There was not a registered manager in post. 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.

A new manager had started employment at the service in September 2018. They were being supported by a manager who was the registered manager of another service, within the organisation. Both were planning to become registered managers of Church View Nursing Home. At the time of the inspection, applications to do this had not been submitted.

At this inspection, we identified some equipment which compromised good infection prevention and control. This included a shower chair that had rust on its frame and a foot operated bin that had broken. Records to demonstrate the laundering of people's hoist slings had not been completed although the format to do so was in place. Staff addressed these areas by the end of the inspection.

There were a range of audits to assess the quality of the service. Monthly management reports were undertaken and sent to senior managers for further analysis. Whilst many areas were assessed, the audits had not identified the shortfalls found at this and previous inspections.

Improvements had been made to the safe management of people's medicines. The medicines were stored

securely, receipted and disposed of appropriately when no longer required.

Some risks to people's safety such as those associated with falling and pressure ulceration had been identified. Records showed measures were in place to minimise the risks. Other areas, including one person's risk of choking and accidents with equipment, had not received sufficient focus.

Each person had an electronic care plan in place. The information was generally well written and regularly reviewed. However, some aspects of people's health care needs and the support required, was not clearly documented.

Not all staff had completed the training expected of them. Management had identified this and were reminding staff of their responsibilities to complete allocated courses. Records showed the completion of training was an "improving picture. Staff had one to one meetings with their manager to discuss their work. They were being given clear information about accountability and the standards expected of them. Action had been taken in response to any shortfalls in practice.

Improvements had been made to decision making in line with the Mental Capacity Act 2005 (MCA). Assessments of a person's capacity had been completed yet documentation to evidence this was not consistently written. Staff were aware of the principles of the Act and how they applied them in practice.

There were sufficient staff to support people although feedback about staffing levels was variable. During the inspection, the home was calm and call bells were answered promptly. People were not waiting for assistance.

People had enough to eat and drink. They were offered choice and a range of snacks between meals. Any weight loss was monitored and discussed with relevant professionals.

People and their relatives were happy with the care provided and complimentary about the staff team. People felt safe and their rights to privacy and dignity were maintained.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Infection control was compromised in some areas.

Risks to people's safety had been identified but some needed further consideration.

There were sufficient staff to support people but some feedback showed differing views.

Improvements had been made to the safety of people's medicines.

Is the service effective?

Good

The service was effective.

Improvements had been made to decision making.

People had enough to eat and drink.

A range of professionals supported people with their health care needs.

Focus was being given to staff training.

Is the service caring?

Good

The service was caring.

People were complimentary about their care and the staff team.

Interactions with people were sometimes task orientated.

People's rights to privacy and dignity were promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

A high number of concerns had been raised about the service.

Some shortfalls in care provision had been identified.

Improvements had been made to people's care plans but some areas needed further focus.

People could join in with various social activities.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The home did not have a registered manager.

Changes in managers had meant inconsistency and different leadership styles.

Focus was being given to ensure consistent practice of a good standard.

There were a range of audits to assess the quality of the service.

Church View Nursing 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 30 and 31 October and 21 November 2018. The first day of the inspection was unannounced.

The inspection was carried out by two inspectors, a specialist advisor who was a nurse and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.
To gain people's experiences of the service, we spoke with 16 people, 14 relatives and one health/social care professional. We spoke with two senior managers, two managers and 15 staff. After the inspection, we contacted four health/social care professionals for further feedback. Two of these professionals responded.

We looked at people's care records and documentation in relation to the management of the home. This included staff training and recruitment records and quality auditing processes. We looked around the premises and observed interactions between staff and people who used the service. We did not use the Short Observational Framework for Inspection (SOFI). This was because people could share their views and those who could not do this, were in their rooms and not in communal areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in January 2018, there was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations. This was because people's medicines were not safely managed.

At this inspection, improvements had been made and medicines were safely managed. The manager told us staff had worked hard to achieve this.

Medicines were receipted, disposed of and securely stored. Staff had fully completed the medicine administration records to show they had administered people's medicines as prescribed. One record however, had been amended and staff were not using the prompted date format. This did not ensure the record could be easily followed. Other records showed pictures of the medicine, alongside written instructions for their use. There was clear information about the application of a person's pain relieving patch.

Staff followed procedure when administering medicines although one medicine, to be taken "as required" for a nebuliser, was left with the person. The member of staff explained they did this, so the person could take it at a time of their choosing. The manager and senior managers told us this practice had been risk assessed and the person was deemed safe to manage the medicine independently.

The home was clean, although there were some areas which compromised infection control. For example, there was a flip top bin in a bathroom and the foot mechanism on another bin had broken. This meant any waste could not be discarded without touching the lids, increasing the risk of contamination. The framework of a shower chair was rusty and a box containing a resuscitation mask was stained. There was some dust in less visible areas such as behind radiators and on door guards. Some food accompaniments in the kitchenette had passed their expiry dates. The manager and senior manager confirmed these areas were addressed once brought to their attention.

Staff told us people's hoist slings were regularly laundered but the written record to evidence this had not been completed. There were no records to show when the material on the manoeuvrable privacy screens were laundered. Infection control audits had taken place but the checks had not identified these areas.

Records showed some risks had been identified and measures were in place to minimise them. This included risks associated with falling, malnutrition and pressure ulceration. However, a risk plan had not been completed until three days after an incident with a bed rail. One person had been assessed as being at risk of choking. Whilst acknowledging the person had capacity to choose what they wanted to eat, limited information was available to staff to enhance safety. There were conflicting views about the foods the person should avoid. On one occasion, the person was coughing whilst eating. Staff did not investigate or document this. This did not enable accurate monitoring of the person's choking. Records showed another person had experienced two accidents whilst being assisted with the hoist. This was despite instructions in their care plan, which stated, "Staff must monitor [person's] legs when transferring her".

Staff understood the principles of safeguarding and how to report any concerns. This included informing other agencies such as the local safeguarding team, if deemed necessary. Safeguarding training formed part of the provider's mandatory training programme. There were posters displayed on notice boards about minimising and reporting abuse.

People told us they felt safe. One person said, "I really, really do feel safe living here, I was apprehensive before I moved here and wondered if I would be safe, but I am". Relatives had no concerns about their family member's safety. Specific comments were, "I know that she is totally safe here" and, "Residents are definitely safe here, they are very well looked after".

There were enough staff to support people. The manager and senior managers told us staffing levels were regularly reviewed using a formal dependency tool. The home used agency staff to cover for staff vacancies, sickness and annual leave. The manager told us the same agency staff were used to ensure continuity. Information sent to us, as part of the condition of registration, showed the number of agency staff was reducing. During the inspection, the home was calm and staff went about their work without rushing. People were not waiting for assistance and call bells were answered quickly.

There were variable views about whether there were enough staff on duty. Some people felt staffing numbers were low. One person told us, "The bells are ringing constantly. Many are saying they want the toilet but to me, it's not so bad after the morning rush". Another person said, "There are only 2 of them for 14 of us in the morning and they haven't got time to blow their noses". One member of staff said they had time to talk to people whilst assisting with care interventions but not informally outside of these times. Relatives told us they felt there were enough staff.

A staff member told us the skill mix of staff could better. On the night spoken about, records showed there were two relatively new members of staff, an agency staff member and a bank nurse. Whilst this indicated a lack of experience, the manager told us the staff were competent and knew people and their needs. They said they were available if required and would not leave the home understaffed or with unskilled staff.

A clear recruitment process was followed. All applicants completed an application form and attended a formal interview. References were gained which gave information about the applicant's work performance and character. They were required to complete a Disclosure and Barring Service (DBS) check and health declaration. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. Records showed the manager had considered some information raised within a DBS, before offering an applicant a position. However, the applicant had not declared this on their application form.

Action was taken and lessons learnt, when anything went wrong in the service. For example, reflective practice took place after a member of staff had left a medicine, which had additional storage requirements, in the manager's office.

Good

Is the service effective?

Our findings

At the last and previous inspection, we found some people were not supported to make decisions in line with the principles of the Mental Capacity Act 2005 (MCA). A requirement was issued to address this.

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 made on their behalf must be in their best interests and as least restrictive as possible.

Improvements had been made to this area. Staff understood the principles of the Mental Capacity Act 2005 and assessments to show people's capacity to make certain decisions, had been undertaken. Some information was comprehensive and showed the principles of the MCA had been followed. Others were less detailed. For example, some assessments did not show who had contributed to the decision being made, or if the least restrictive options had been considered. The manager confirmed these assessments were not to their standard and would be repeated without delay, to ensure a consistent approach.

People told us they were encouraged to make decisions about their care. One person said, "I have got a voice here and that is very important to me." Staff told us they encouraged decision making. They said they asked for consent and explained what they were going to do when undertaking any care intervention. A relative confirmed this and said, "They do try to get him up but he often says no. They do respect his wishes". Staff were consistent in their approaches, when managing any resistance to care.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager told us DoLS applications, had been made as required, but all except one were awaiting authorisation.

People were appropriately assessed before moving to the home. Written assessments showed information about the person's needs and the support they required. The information was used to form the basis of the individual's care plan. People and their relatives were involved in the assessment process.

The manager had identified not all staff had completed the training expected of them. They told us staff had been reminded of their responsibilities in this area. The manager said as a result, the completion of various courses was an "improving picture". Training records given to us during the inspection demonstrated this.

Staff were complimentary about the training provided. They said much of the training was undertaken "on line", with some courses "face to face". One member of staff told us, "Training is good. We do all the usual, manual handling, fire, food hygiene. We also have workbooks we can do on some topics." Another staff member said they enjoyed their training but had not done anything on 'end of life' care. The manager explained this training was provided by the local hospice and specifically related to the person being supported at the time. One member of staff told us training on how to manage some people's sexual

advances would benefit the staff team. Registered nurses had completed training to maintain their professional qualification. A health and social care professional told us more wound care training would be beneficial.

Courses, such as the management of challenging behaviour had been introduced. This was intended to be a baseline, in preparation for supporting those people who were new to the service. The manager had developed a training package regarding pressure ulcer prevention. They said they were developing 'champions' in different areas of provision. All 'champions' would complete additional training to enhance their chosen specialism.

Staff had meetings with their line manager to discuss their work. Records showed most of the meetings were "ad hoc" sessions, to address practice rather than on-going development. A senior manager told us this approach was planned. They said staff needed to be accountable for their actions and were being taken "back to basics" with all aspects of care. The manager told us some sessions were to recognise the good work staff had completed.

People were complimentary about the food. Meals, including pureed food looked well presented. There was a choice and people were offered alternatives if they did not like what was on the menu. People were offered drinks with their meal and these were served from a trolley, mid-morning and afternoon. Snacks such as biscuits, cake and crisps were available but there were no healthier snacks on the trolley, such as fresh fruit. A senior manager told us the amount of money spent on fresh produce demonstrated that people had fresh fruit on a regular basis.

People's weight was monitored and any concerns were discussed with the GP and dietician. A member of staff told us those people who had lost or were losing weight were encouraged to have milkshakes twice a day. They said food was also fortified with cream and butter. A health and social care professional told us these interventions had worked well, as weight gain or sustained weight was evident. However, fortifying all food did not consider those people who needed to be careful with their weight. The support plan of one person, who was overweight stated, "Encourage [person] to eat food that [they] enjoy and is nutritionally healthy for [them]." There was no further clarity or any reference to their weight gain. The manager did not agree with the staff's view that all food was fortified. They told us all meals were conducive to people's needs and preferences.

The environment was bright, comfortable and well maintained. The corridors had been decorated with wall paper to create a warm and homely feel. There was a communal lounge and dining room on each floor. One area had been made into a coffee shop. People had en-suite facilities and there were communal bathrooms. A bathroom had a mural on the wall to enhance relaxation. People could personalise their room and bring furniture and personal possessions with them on their admission. One person told us they liked their room. They told us, "My room is very small but I like it and it suits me". Another person said, "Some days it doesn't even feel like a Care Home to me."

There was a comprehensive range of safety checks involving equipment and the environment. All checks were up to date and records were methodically kept. CCTV was operated in the corridors and communal areas, and on-going footage could be seen in the office. The manager told us people were informed of the CCTV on their admission but there was no signage around the home as a reminder.

People told us they could access a range of services, to meet their healthcare needs. This included regular visits from GPs and specialist services such as speech and language therapists, dieticians and tissue viability nurse. One person had recently had some bereavement counselling. Staff told us there were strong links

with the local hospice. They said three hospice nurses regularly visited the home and were available on the telephone to offer advice when needed. Any consultations were documented within people's care records.

Good

Is the service caring?

Our findings

People told us they were happy with their care. Specific comments included, "All my personal care is done for me, no problems" and, "If you want a cup of tea at 2 in the morning, or if you can't sleep they [staff] come and talk to you". One person told us, "It has been lovely for me moving here, it has been extraordinary and transformed my life. The worry, all the anxiety and pressure has all gone". Relatives were also complimentary about the care their family member received. One relative told us, "I cannot emphasize enough how pleased I am with the care here."

People were complimentary about the staff team and said they were kind and caring. Specific comments were, "The carers are lovely girls", "I cannot get over how happy and cheerful the staff are" and, "Nothing is too much trouble for them". One person told us, "They can't do enough for you here, sometimes I think it is better than a hotel."

Management told us there were various ways in which they ensured staff treated people with kindness and compassion. They said they were regularly "on the floor", which meant they observed staff practice and acted as role models. They said they were very "visible" and would identify and address any interaction or attitude, they were not happy with. The new manager confirmed this. They said they were getting to know people and building relationships, which enabled an open approach. They said they considered themselves a "care giver" as well as a manager. This meant they often supported people with their personal care and worked alongside staff. The new manager told us this work enabled them to demonstrate key values, they felt so passionate about.

The manager told us staff cared about people and often went the "extra mile". They said one member of staff had supported a person to buy and wrap a birthday present for their family member, as a surprise. They said other staff had sensitively sat with various people at the end of their lives. They said staff had given comfort and reassurance in a sensitive manner. There was a "memory" tree in the entrance hall. Small wooden shapes, with details of those who had recently passed, were hung on the tree as a form of respect and remembrance.

Whilst there was positive feedback about the delivery of care, some interactions were task orientated and not always person centred. For example, one member of staff was assisting a person to eat but mid-way through, they left and another staff member replaced them. This did not ensure consistency or give value to the person. Another member of staff delivered a person's meal to their room. The person needed assistance, but it was five minutes before a member of staff arrived to support them. One person was anxious about the late arrival of a visitor. Whilst this was brought to the attention of staff, they did not offer the person any reassurance or assistance. The manager told us these examples were not reflective of their observations, which were seen on a day to day basis.

Other interactions were more positive. One member of staff was attentive and reassuring when helping a person to be seated, ready for their lunch. Another person had just returned from a hospital stay. A member of staff saw the person and called out, "[Person's name]. It's lovely to see you. Welcome back. We've missed

you." The person smiled and said they were glad to be back. Some people enjoyed light hearted banter about Halloween and the activities that had been arranged to celebrate this.

People's rights to privacy and dignity were promoted. Staff knocked on people's doors and called out before entering. Care was delivered behind closed doors and staff used screens in communal areas. This was to promote privacy when people were assisted with using the hoist. Staff used the screens when one person chose to see the GP in the lounge, rather than in their room.

Within conversation, staff spoke about people fondly. One member of staff told us, "We have lovely people here." They continued to explain how they wanted to ensure people received the best possible care, as this is what they deserved. One member of staff told us, the best thing about the home was the people who lived at the service. They said, "I'm here for them".

People were encouraged to give their views about the service. This was informally on a day to day basis, within "Resident" meetings or by using surveys. The manager told us surveys were sent to people annually and to their relatives, twice a year. The feedback received for this year was in the process of being collated. The manager told us relative's meetings were held but attendance was often poor. They said some relatives kept in contact via email and shared their views this way. However, records showed the timing of the evening meal, for people on the first floor, had been changed. This was because the original time conflicted with people's repositioning regimes. Records did not show people had been consulted with or consented to the change.

Requires Improvement

Is the service responsive?

Our findings

Between August 2018 and this inspection, the Care Quality Commission had received 16 anonymous concerns about people's care. The information generally stated people were not being repositioned to minimise their risk of pressure ulceration or receiving sufficient food and fluids. We informed senior managers of the concerns and investigations took place. The concerns were not fully substantiated.

During the inspection, we received another concern, of similar content, which gave a specific date the shortfalls occurred. The manager was aware of this and had completed an investigation. The findings showed staff had not completed the care intervention charts. This did not give assurances that people had received the care they required. The investigation identified two people had not been given their evening meal. Senior managers told us once the shortfalls were recognised, meals were given and a welfare check of each person was carried out. No ill effects or harm, were identified. They said the shortfalls were addressed with the staff concerned.

The home's complaint log showed a person had asked a member of staff to assist them to use the bathroom. The staff member had refused, as they said they were assisting with lunch. The person had to use their continence pad, which was uncomfortable and undignified. Senior managers told us action had been taken against the member of staff and they were no longer employed at the home.

People looked well supported. They were well-groomed and dressed appropriately. Those people who were nursed in bed looked comfortable and had clean bedding. People had their call bells and other items they needed, within easy reach. Some people liked to smoke and did so in the garden. Staff encouraged people to 'wrap up warm' with coats and gloves before going out.

People had an electronic care plan in place. Information was generally well written and had been regularly reviewed. For example, one plan informed staff how best to communicate with a person. This included standing to the person's left, in line of their sight, so they could see who was talking to them. Another plan showed the person should be given time to respond to any questions asked of them. One plan showed the person enjoyed caravanning, detective stories, 60's music, tennis, hockey and fencing. This gave staff "talking points" to enhance conversation and the development of relationships.

Some areas of people's health care needs were not reported on in their care plans. For example, one person had a Percutaneous endoscopic gastrostomy (PEG) but there was not a specific care plan for the PEG tube. A PEG is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the abdominal wall and into the stomach. As the site of the PEG tube posed an increased risk of infection, the skin needed to be monitored for signs of inflammation. This was not stated in the person's skin integrity care plan. Another person had a care plan in relation to their diabetes. Whilst the information showed the person needed to have their blood sugar levels checked twice daily, their normal ranges were not stated. This did not identify a clear baseline, to determine if any further action was needed. The manager told us they would address these areas.

Some information within care plans lacked specific detail. For example, one plan stated, "Staff to check resident hourly to maintain dignity, comfort, and safety." It was not clear what this meant in practice. Another person used a thickener in their drinks but an assessment showed they did not have any swallowing difficulties. Information did not explain this conflict. Staff told us the GP had confirmed they did not need to record some people's daily recommended fluid intake. The reason for this and details of the discussions, had not been documented.

Treatment plans were in place regarding any wounds. The plans were clear, up to date and showed any changes to treatment which had been recommended by the Tissue Viability Nurse Specialist. A health and social care professional told us wound care was well managed. They said staff gained advice where needed and followed any treatment plans well. They said because of these interventions, any wounds were healing or had not deteriorated further.

People could join in with a range of social activity, which was arranged by designated staff. A staff member said the activity programme was designed according to people's individual preferences. During the inspection there was bingo, a musical entertainer and a range of Halloween themed activities. These included pumpkin carving, biscuit icing and face painting. Staff had dressed up in Halloween costumes as part of the celebrations. Some people had satellite television, which they enjoyed. One person told us, "I pay for it but it is good to have". They said other people often gathered in their room to watch television and have a drink. Another person told us, "I am very much into playing chess on line. I played for three and a half hours with a chap in Brazil the other day."

People had 'end of life' care plans in place. The plans showed information about active treatment, resuscitation and funeral plans. There was limited information however, about people's preferences regarding their care as their health deteriorated. Staff told us they could directly refer people to the nurses from the local hospice. They said they did this to gain advice about the management of a person's symptoms.

Staff spoke sensitively when talking about those people they had supported at the end of their lives. They told us they aimed to ensure people were comfortable, pain free and surrounded by those who were important to them. One member of staff told us, "We always try to let relatives know, even if it's only a small deterioration, so they can get here in time." Another staff member told us, "Once a person has passed, we always make sure they look nice and their room is tidy." They told us of a person whose appearance was important to them. They said, "We applied their makeup but struggled with their hair, so we gave the undertaker a photo of them, so they could make them look as they usually did."

People knew how to make a complaint. Contact details of senior managers were displayed around the home. This enabled them to be easily contacted if required.

Requires Improvement

Is the service well-led?

Our findings

The service has a poor history of non-compliance. In 2015, the service was rated inadequate and placed into special measures. Subsequent inspections rated the service requires improvement as improvements were not always sufficient or sustained, to ensure a consistently good service. Shortfalls particularly related to the planning of people's care, medicine management and decision making in line with the Mental Capacity Act 2005.

A new manager started employment at the home in September 2018. They were being supported by a manager, who was the registered manager of another service within the organisation. Both were planning to become registered managers of Church View Nursing Home. The managers said they were in the process of doing this but at the time of the inspection, applications had not been submitted.

There had been inconsistent management and leadership, since the resignation of the last registered manager. This was because there had been three other managers in quick succession. All had left before registering to become to the registered manager. Senior managers told us the changes in manager had impacted on the development of the service. Staff told us the changes had been unsettling, as all managers had shown different ideas and leadership styles. They confirmed one of the managers currently at the home had given some consistency during the changes. They said they were hoping this would continue.

Before the inspection, we received concerns about management approaches being used. Some records, such as staff meeting minutes, gave evidence to support these concerns. This was because they were written in a very direct manner with terminology such as, "Let me make it crystal clear…" Senior managers told us they were aware staff might be unhappy with the management approaches being used. They said this was because a very strong, clear message was being given to staff. This formally stated poor practice would not be tolerated. The management team told us they expected staff to be accountable for their actions and engage with any changes being made. If staff did not do this, senior managers said they needed to be aware of the consequences. The new manager explained they had very strong values and would not accept poor practice in any form.

Staff told us they were looking forward to the further development of the home. One staff member said they liked the direct approach being used. Another member of staff said, "There has been some lack of consistency in care standards but the managers are getting to grips with it." Another staff member said, "It's steady. I would say it's steadily improving. We'll get there."

The managers told us they had a clear vision for the development of the service. They said they wanted to achieve an outstanding rating and offer high quality care, which made a real difference to people's lives. The managers said they wanted to build on the warm, homely feel of the service and develop its culture. They said they were planning to do this through staff training and supervision, regular monitoring and clear communication. A member of the management team told us, "Whilst developing the service we offer, I'd also like to develop our profile and our reputation. We need to let everyone know we're here."

Regular meetings were held to share information and aid communication. This included a daily meeting at 10:00 to discuss the events of the day. The meetings were held with each head of department. Any ill health or appointments were discussed and staff were given reminders, such as remembering to promote people's fluid intake.

Senior managers told us an initiative to assist 'winter pressures' was in its early stages of operation. This involved offering places to up to seven people who were medically fit to be discharged from hospital, but not well enough to go home. Senior managers told us staffing levels would increase in accordance to people's needs, once the project was implemented. One manager told us they were looking forward to the 'winter pressures' initiative. They said they had established good relationships with many health and social care professionals during their previous work roles. The manager told us they planned to utilise these within the initiative and to help with the overall development of the service.

There were a range of audits to assess the quality of the service. These included checks of systems such as the safe administration of medicines and other areas such as the environment, equipment and meal time experiences. Records showed any shortfalls identified, were being addressed. In addition to the audits, a monthly management report was completed and submitted to senior managers. This information was further analysed and compared to that of other services within the organisation. However, shortfalls identified during this inspection, such as those which compromised infection control and the management of risk, had not been identified within the auditing processes.