Mauricare Limited

Ashview House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Overall summary

We inspected this service on 23 April 2015. This was an unannounced inspection. This was the service's first inspection under their registration as a new provider.

The service was registered to provide accommodation and personal care for up to 22 people. People who use the service have physical health and/or mental health needs, such as dementia.

At the time of our inspection 18 people were using the service. Two of these people were using the service for an agreed short period of time. This is called respite care.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At this inspection we identified areas of unsafe, ineffective and unresponsive care. This was because the service was not well led. We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's health and wellbeing were not consistently identified, managed and reviewed and people did not always receive their planned care. People were also not always protected from potential abuse. This meant people were not always kept safe and their welfare and wellbeing was not consistently promoted.

There were insufficient numbers of staff to keep people safe and provide the right care at the right time. This also meant that people's individual care needs and preferences were not always met.

Records relating to people's care were not always accurate and up to date and medicines were not consistently managed safely. This meant people were at risk of receiving unsuitable or unsafe care.

The provider did not have effective systems in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

The registered manager did not always inform us of incidents that occurred at the service and pre-inspection information was not completed at our request. This meant we were not always aware of reportable incidents that had occurred within the home.

There were gaps in the staffs' knowledge and skills that meant some people's specialist needs were not met effectively.

People were not always supported to eat in a dignified manner and the staff could not always show that people's risk of malnutrition were being managed in accordance with professional advice.

People's feedback about care was not sought and people did not always feel empowered to complain about the quality of their care. This meant the registered manager and provider could not use people's feedback to make improvements to the quality of care.

When staff had the time they supported people with care, compassion and respect. However, we saw that the staff did not always have the time to consistently support people in this manner.

Some people who used the service were unable to make certain decisions about their care. Under these circumstances the registered manager followed the legal requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). The Mental Capacity Act 2005 and the DoLS set out the requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. This meant that decisions were being made in people's best interests when they were unable to make decisions for themselves.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe. Risks to people's health and wellbeing were not consistently identified, managed and reviewed, and people were not protected from potential abuse.

There were insufficient numbers of staff to meet people's individual needs and keep people safe. People's medicines were not always managed safely.

Inadequate

Is the service effective?
The service was not consistently effective. There were gaps in the staffs' knowledge and skills which meant some people's specialist needs were not met effectively.

People who were at risk of malnutrition did not always receive the support they needed to manage this risk effectively.

Requires Improvement

Is the service caring?
The service was not consistently caring. People were reluctant to ask for help because they felt the staff were too busy. People did not always receive care and support in a manner that promoted their dignity and independence.

Requires Improvement

Is the service responsive?
The service was not consistently responsive. People did not always receive care that reflected their individual preferences and needs. Some people told us they were reluctant to complain about the quality of care. This meant the registered manager was not always aware of people's concerns.

Requires Improvement

Is the service well-led?
Effective systems were not in place to assess, monitor and improve the quality of care. This meant that poor care was not being identified and rectified by the provider.

There was low staff morale as they felt improvements to care were not being made.

Inadequate

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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 was 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 23 April 2015 and was unannounced. Our inspection team consisted of two inspectors.

We checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan.

The registered manager was sent 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 improvements they plan to make. The registered manager did not receive or complete their PIR because they had not informed us that their contact details had changed.

We spoke with 11 people who used the service and two relatives, three members of care staff, the deputy manager and the registered manager. We did this to gain people's views about the care and to check that standards of care were being met.

We spent time observing how people received care and support in communal areas and we looked at 13 people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included a medicines audit, staff rotas and training records.

Following our inspection we made a referral to the local authority's safeguarding team. We did this because of a significant concern that we identified with a person's care.

Inadequate

Is the service safe?

Our findings

People told us there were not always enough staff to meet their individual needs in a timely manner. One person said, "I often have to wait because the staff are so busy. I've waited 30 minutes or longer to go to the toilet, and when you wait that long it gets uncomfortable" and, "I said I wanted the toilet just before dinner earlier this week and the staff told me I would have to wait until after dinner as they had to help people to eat". Another person said, "Last night I had to wait for someone to come and take me to bed, when they did come it was a bit rushed and when I was in bed I realised I still had my false teeth in". Staff confirmed that people's needs were not always met promptly. One staff member said, "There's not enough of us, It's hard and so busy".

Four people told us they wanted to go outside in the sunshine. One person said, "We want to go outside, but we are not allowed". We asked the registered manager why these people could not go outside. They said, "I feel it's unsafe, there is no safe area for people to sit" and, "We haven't got the staff to supervise people outside". This meant that these people, who could choose to spend time outdoors, were restricted from doing so because there were not enough staff to keep them safe.

We saw that there were not enough staff to keep people safe. At lunch time we saw one person who used the service attempt to support another person who used the service to eat on four occasions. A member of staff intervened on two of these occasions and told the person it was the staff's responsibility to help people. Supporting someone to eat without the understanding or skills to do so could result in harm, such as choking. Another person who used the service attempted to help another person to stand from their chair by moving the chair away from the table. Supporting someone to move without having completed the required training could result in injury to both parties.

People and staff told us that the provider's minimum staffing levels were not always met. One person said, "They say they are fully staffed but they are not. There's often only two staff on and there should be three. When there is only two staff on I have to wait longer for everything". The registered manager and staff told us that three staff members should be on the late shift due to people's support needs. However, they said this was rarely the case. The staff rota showed that three staff members had been on duty on only five of the 22 days prior to our inspection.

The above evidence shows that the lack of sufficient numbers of staff meant that people's individual needs were not met and people's safety and welfare were compromised. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not always protected from the risks of potential abuse. This included financial and physical abuse. One person asked us if they could see their financial records so they could check their money was safe and understand how much money they had available. We informed the registered manager of this, but they told us the records were unavailable. The registered manager told us the person's financial records were at their home address as they had taken them home to audit. This meant the person could not view their financial records and could not be assured that their finances were being managed safely.

Prior to our inspection, a person who visited the service shared concerns with us about how incidents of alleged abuse were managed. We found that incidents of alleged abuse were not always reported in accordance with the local authorities safeguarding procedures. The agreed local safeguarding procedure is that staff should immediately report safeguarding concerns and incidents to them so they can consider if any action is required to manage or minimise further incidents from occurring. We saw that there was a two day delay in reporting an incident of alleged abuse that had resulted in one person needing emergency medical treatment. When we contacted the registered manager to discuss the concerns they told us they had not completed the safeguarding referral because they were busy with other work.

Two maintenance workers were working at the home on the day of our inspection. One of these workers had undergone checks to ensure they were suitable to work with the people who used the service. The second worker had not, which meant the provider did not know if the person was suitable to work at the home unsupervised. The provider told us that the maintenance workers would always work together, so the unchecked worker would always be supervised by the person who had been deemed

Inadequate

Is the service safe?

as suitable to work with people who used the service. We saw the second worker who had not had suitability checks completed entering people's bedrooms when they were in bed and working in communal areas with no supervision from the other worker or other staff. The registered manager told us she did not know the suitability of either of the maintenance workers. They confirmed they had not assessed or planned for the potential risks associated with this.

The above evidence demonstrates that people were not consistently protected from potential abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people's safety were not always assessed and planned for. For example, one person who used the service displayed episodes of aggression towards people and staff. Staff told us and we saw that there were no risk assessments or management plans in place to give staff the information they needed to manage this risk safely and consistently. One staff member who told us they were unsure of how to manage the person's aggression said, "You have to stay calm, but inside you're scared that you might get hurt".

Where risks to people's safety had been recognised and planned for, we found that care was not always delivered in accordance with their planned care. For example, one person required thickener in their drinks to help reduce their risk of choking. We saw a member of staff place an un-thickened drink in front of this person who then picked up the drink in an attempt to drink it. We intervened to prevent the person from drinking this unsafe drink and informed the staff. The staff member then added thickener to the person's drink, but did not comment as to why the person's care plan was not originally followed.

We found that where risks had been identified, they were not always reviewed and updated to reflect their changing needs. For example, one person had fallen seven times over a 44 day period. Their risk of falling had not been reviewed following any of these falls, and no changes had been made to their care to prevent further falls. For example, the registered manager confirmed that the use of assistive technology to help manage the person's risk of falling had not been considered. The registered manager told us, "We have no time to complete risk assessments". This meant that the person could not be assured that their risk of falling was being managed effectively.

People were not confident that they were safe while maintenance work was being completed. One person said, "You could break your neck on all that" whilst they pointed to a variety of work tools and an extension lead that had been left blocking a corridor that led to the toilets. We saw one person who was visually impaired walk to the toilet using their walking frame unsupervised. We saw their walking frame catch a saw that was on the ground, so we intervened by moving the saw. The person then caught the extension lead with their walking frame and at that point the workman moved the lead to the side of the corridor. We asked the registered manager if they had completed a risk assessment in relation to the maintenance work. They told us they had not. This showed that the registered manager had not taken action to ensure people were safe while the maintenance work was being completed.

The above evidence demonstrates that effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. One person was prescribed an 'as required' medicine to help reduce their agitation and aggression. We asked a member of staff who was responsible for medicines administration when they would give this person this medicine. They said, "I don't know, I wouldn't be able to make this decision. I haven't had the training". No written guidance was available to help the staff make the decision to administer this medicine in a consistent or effective manner. Therefore, this person was at risk of not receiving their prescribed medicine when they needed it.

We found that the quantities of medicines listed on people's MAR did not match the numbers of medicines stored at the home. All of the six medicines we counted did not match the numbers recorded on the MAR. A staff member confirmed that medicines were difficult to manage. The said, "I'm not surprised they don't match up" and, "The boxes are not organised properly, I have to search for them". These discrepancies meant people could not be assured they were receiving their medicines as prescribed by their doctor.

Requires Improvement

Is the service effective?

Our findings

We observed how people were supported during lunch and found that people's mealtimes were not always positive experiences because there were not enough staff available to support people to eat. For example, one person sat at the table watching other people eating for a lengthy period of time before staff brought them their meal and supported them to eat. This person could not tell us how this made them feel, but we observed them displaying signs of being restless, such as, fidgeting and sighing. Staff confirmed this person regularly had to wait long periods before they received the support they needed. One staff member said, "They have theirs last as we have people in bed who need feeding and were busy". Another person did not receive the support they required in a timely manner when their hot meal was placed in front of them, so they resorted to using their fingers to eat. This person's meal was not suitable to eat using their fingers as it was covered in warm gravy and the person struggled to pick up the food. Not ensuring there were enough staff to ensure people had positive mealtime experiences was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Effective systems were not in place to ensure people's risk of malnutrition was managed in accordance with professional advice. Some people who used the service were prescribed nutritional supplements to help manage this risk. We did not see people receiving their prescribed supplements and people's MAR were also not signed to show they had been given as prescribed. We saw that one person who was prescribed nutritional supplements had lost weight. The staff we spoke with could not confirm if this person had received their prescribed supplements. This meant the person could not be assured that staff had managed their risk of malnutrition effectively.

We saw that one person who was at risk of malnutrition was not being weighed in accordance with professional advice. A visiting health care professional had recommended they needed to be weighed every two weeks. However, despite having lost over five percent of their body weight over a short period of time, they had not been weighed recently. The registered manager told us, "They are not being weighed as they are too fragile" and, "We need to implement a MUST but we've never done this before so we are waiting for training from the district nurses". The Malnutrition Universal Screening Tool (MUST) is a tool that can be used to assess and monitor people's risks of malnutrition. Not implementing the use of another form of monitoring the person's risk of malnutrition meant the person's risk of malnutrition was not being effectively monitored.

The registered manager told us that people's weight was monitored as part of people's general health monitoring. The most recent weights check showed that three people had lost weight since January 2015. The registered manager had recorded that the three people required a referral to their GP as a result of their weight loss. We asked the registered manager if these referrals had been made. They told us they had not as they were waiting for everyone who used the service to be weighed so that any required referrals could be made in one go. This meant that when a health concern had been identified, prompt action was not always taken to share this information with health care professionals.

Staff told us and we saw there were gaps in their knowledge and skills that resulted in some people's needs not always being met effectively. For example, staff told us they had not received training to enable them to work with people with learning disabilities. We observed how staff managed a person's behaviours who had a learning disability and visual impairment. We saw that this person had difficulties understanding and processing changes to their environment because of their learning disabilities and sensory impairment. We saw that this person became distressed, by shouting when they were subjected to sitting in a room where maintenance workers were drilling loudly. None of the staff independently identified that this was causing the person to become distressed, therefore we intervened and requested that staff offered the person the reassurance they required. The person then stopped shouting once reassurance was given.

People confirmed that staff sought their consent before they provided care and support. Systems were in place to protect people's rights if their ability to make important decisions about their health and wellbeing changed. Most staff understood the legal requirements they had to work within to do this. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out these requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. The staff demonstrated they

Requires Improvement

Is the service effective?

understood the principles of the Act and they gave examples of how they would work with people to make decisions in their best interests if required. One person was being restricted under the DoLS and the registered manager was in the process of referring two other people for DoLS authorisations.

People told us they were given food choices that met their individual preferences. One person said, "We all have different things for breakfast. I have cereal with warm milk and sugar, two pieces of brown bread with marmalade and two cups of tea". Another person said, "There is always a choice at mealtimes, the staff write it on the board and tell us what the choices are. There hasn't been anything I haven't liked so far".

Requires Improvement

Is the service caring?

Our findings

People told us that the staff were kind and caring. However, people told us and we saw that they were reluctant to ask the staff for the help they needed because they knew the staff were busy. One person said, "They are very nice, polite and helpful, but they never seem to have a free minute" and, "I don't want to ask the workers for help as they seem so busy". During lunch one person told us, "I feel uncomfortable". We asked if they wanted us to tell the staff and they replied, "No, don't bother them".

People told us that because the staff were busy, it affected how their care was provided. For example, one person said, "How I used to look after people and how they look after me is totally different. They haven't got the time to do the ordinary, everyday things, like chatting".

We saw that when the staff had the time to interact with people this was done with kindness and compassion. For example, we saw one staff member gently rouse one person from a sleep by stroking their arm and talking quietly to them to wake them in a calm manner. However, we saw that the staff did not always have the time to support people with care and compassion. For example, we saw one staff member ignore one person on two occasions when they shouted, "I want to go, its killing me" and, "I think I want to go to the toilet". At times this person looked distressed as they held their head in hands and were shaking their head. Another person was sharply told by staff, "Don't put your fingers in it" when they were attempting to eat their meal using their fingers. This showed that people were not consistently treated with kindness and compassion.

We saw that people did not consistently receive care and support in a respectful manner because the staff did not always have the time to facilitate this. For example, we saw one staff member supporting two people to eat their lunch by assisting one person, then turning to assist the other and vice versa. We saw that these people were not given an explanation or apology for the disruption this caused to their meal time experience.

We saw that when staff directly supported people they promoted their privacy and dignity. For example, people were taken to private areas to receive personal care. However, we saw that the staff did not always have the time to ensure that every person's dignity was maintained. For example, we saw one female resident who staff described as disorientated at times, go to the toilet and leave the door open whilst maintenance workers were working in the corridor where the toilets were located.

People's independence was not consistently promoted. At meal times people's mobility aids were removed from the dining room. People then had to ask for their mobility aid so they could leave the room when they had finished eating. Because staff were busy at mealtimes, this meant that people could not always get up and leave the dining room when they wanted to do so. One person's care records showed they required glasses, but we saw that this person did not have their glasses on. This person was visually disorientated and could not reach for their drink. Staff told us they were not wearing their glasses because, "They won't keep them on". We asked a staff member if the person's glasses could be fetched. When the person was supported to wear their glasses, we noted an immediate change in how they interacted with the staff and environment. They started to focus on objects, such as their cup and they began to speak to staff. This person then kept their glasses on for the duration of the inspection. This meant that at times people were restricted and disabled by the actions of the staff.

Requires Improvement

Is the service responsive?

Our findings

People told us they were involved in the planning of some aspects of their care. For example, people said they were asked what time they wanted to go to bed and get up in the morning. However, some people told us that they were not enabled to manage and control the care and support they received. For example people who had the ability to make decisions about their care told us they had restrictions placed upon them that meant some of their individual needs were not met. One person who told us they wanted to go outside said, "We are not allowed outside, it's the rules". Another person told us they were not able to access a phone every time they wanted to do so. Neither of these people knew why these restrictions were placed upon them and care records did not show why these restrictions were in place. The registered manager confirmed that these people had not been involved in planning these aspects of their care.

Some people told us they did not receive their personal care in accordance with their preferences. For example, one person's preference was to have a shower, but they told us, "I can't have a shower as they can't use the hoist in there". We asked the registered manager if they had considered the use of assistive equipment to enable this person to access the shower, such as a wheeled shower chair, but they told us they had not. Another person told us they would like a bath more regularly than their current routine of one bath a week. They told us this was because bathing helped to ease their joint pain. We asked the registered manager why this person could not have regular baths. They told us they were offered more baths, but the person refused them. The person and their care records were unable to confirm that additional opportunities to bathe had been offered. This meant the provider could not demonstrate they were meeting people's individual care preferences.

The specialist needs of some people were not being met. For example, one person who had a learning disability did not have their specific needs relating to their learning disability assessed or managed. For example, their social needs were not assessed and planned for and staff confirmed this person was not enabled to visit and be part of their local community. The home environment did not enable people who were living with dementia to orientate themselves to the different areas within the home, such as the toilets and dining room. We observed one person spend time trying to locate the toilet on two occasions, and at lunch time we observed the person walking up and down the corridor asking, "Where do I go now?". There were no pictorial signs to help people to orientate themselves within the home's environment.

People told us and we saw that they were not enabled to participate in their preferred social and leisure based activities. No activities were promoted on the day of our inspection and people told us that the staff member who previously promoted activities had retired. One person said, "We used to have someone who did activities, but she's left now. Someone else [another member of care staff] is meant to be in charge of that now, but she's ever so busy". Another person said, "Now there are no activities we are all just tired all the time". This showed that not having activities promoted had resulted in people becoming less active which was detrimental to their health and wellbeing.

The above evidence shows that care was not always provided in accordance with people's preferences and people's individual needs were not always met. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had mixed responses from people when we asked them if they would feel comfortable complaining about their care. Some people told us they would happily approach the registered manager or deputy manager to complain. Positive comments supporting this included, "I would go to the manager with a complaint" and, "I would tell any of the managers". However some people told us they would be reluctant to make a complaint. One person said, "They would think I was being a nuisance so I wouldn't complain". Another person said, "I wouldn't go to the boss, she's frightening". This showed some people did not feel able to share concerns about their care.

Is the service well-led?

Our findings

People told us their feedback about the quality of care was not sought. The registered manager confirmed that no meetings had been held and no satisfaction questionnaires had been completed since they registered with us. They said, "We've tried them before. Relatives don't come in for meetings and they don't send questionnaires back". We asked if they had looked at alternative methods of gaining feedback but they told us they hadn't. This meant that people were not encouraged and enabled to provide feedback about their care so that improvements could be made.

Effective systems were not in place to assess, monitor and improve the quality of care. For example, regular medicines audits were not being completed, so the concerns we identified with unsafe medicines management had not been identified by the registered manager. The registered manager told us the last medicines audit was completed in January 2015. They said, "They are a waste of time as it doesn't correspond to what's going on in the home. We need a better audit form". We saw that some problems with medicines management had been identified from this audit, but no action had been taken make the required improvements. For example, the audit showed that staff needed to be reminded to sign people's MAR, but the registered manager confirmed that they had not yet met with staff to tell them this.

Other quality checks, such as checks of; care records and health and safety were not being completed. For example, the registered manager had not identified that some people's risk assessments had not been updated to reflect changes in their needs. This meant up to date information about people's risks were not available for the staff to follow. The registered manager told us they had the paperwork to start completing quality checks and they would start them next week. However, the provider's improvement plan had stated that these checks would be introduced by 31 December 2014. This meant we could not be assured that these checks would be implemented when the registered manager said they would.

The provider had failed to identify that there were insufficient numbers of staff to provide safe care and support. We saw that this had led to people's safety and wellbeing needs not being met. For example, we saw that one person who fell frequently, had more unwitnessed falls when there were only two staff on duty. This was confirmed by the registered manager and the staff records. We also saw that people who required support to eat did not always get the support they needed when they needed it because staff were not available to do this. One staff member at lunchtime said, "It's a one man band in here [the dining room] at the moment, I'd like to say this is a one off, but this is a good day. We never have enough staff".

Registered managers are required to notify us of certain notifiable safety events such as alleged abuse. We found that the registered manager did not consistently inform us of notifiable events. For example, we had not been notified of a safeguarding incident that had occurred at the service. This meant the registered manager did not meet the requirements of their registration with us.

Registered managers also have to tell us about changes that affect their registration, such as a change in contact details. The registered manager failed to return their Provider Information Return (PIR) as requested by the Commission. This was because they had not notified us that they had changed their contact details, so the PIR was sent to an inaccurate address.

When the provider registered with us in December 2014, they submitted an action plan outlining how they were going to make improvements to the quality of the care. We found that many of the listed actions had not been completed within their agreed timescales. Actions not completed included introducing dignity champions, implementing a quality audit system and introducing an induction pack for new starters. This showed that the provider had not followed their plans to make improvements to the quality of care.

The above evidence shows that the service was not well-led. Effective systems were not in place to assess, monitor and improve quality and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were hopeful that improvements to care would be made. One person said, "The new owners have said there will be changes, but I haven't really seen any yet. I am hopeful that things will happen". However, there was an atmosphere of apathy at the service amongst the staff. The registered manager told us they couldn't change the current quality of care. They said, "It's the

Is the service well-led?

culture out there, you can't change it". Staff told us they were frustrated that improvements to care were not being made. One staff member said, I keep thinking it's going to get better, but it's not. It's going nowhere". Another staff member said, "I dread CQC coming to inspect as it's just embarrassing". This shows that although people were hopeful that improvements in care would be made, the staff were not confident that these improvements would happen.