Care Quality Commission

Wingate Care Homes Ltd

Wingates Residential Home

Inspection report

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Westhoughton
Bolton
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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Good

Overall summary

The unannounced inspection took place on 09 November 2015. At the last inspection on the home had an overall rating of Requires Improvement. Wingates Residential Home is situated on a main road in the Westhoughton area of Bolton. It is on a bus route to the town centre, and is close to the motorway network. The home provides accommodation for 36 people, all in single rooms. There is a car park, a garden, and a patio area.

There was a manager at the home who was in the process of registering with the Care Quality 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.

On the day of the inspection there were 35 people residing at the home.

We looked at staffing levels on the day and at staff rotas and found they were of concern. Two apprentices were working on the day of the inspection and we questioned

Summary of findings

whether they should be performing the same tasks as care staff. The lounge was sometimes left unsupervised and we saw that people required assistance. Recruitment of staff at the home was robust.

Safeguarding and whistleblowing bullying policies were in place and staff demonstrated an understanding of the issues. The home had CCTV in communal areas and had a policy in place for this. There was a sticker in the window advertising that CCTV was in place but this should also have been referred to in the information given to people about the service to ensure they were aware of it.

Medicines policies were in place and we saw that medicines were ordered, stored, administered and returned safely.

We observed the meal time experience, which could have been improved with the addition of table mats, condiments and pictorial table menus. The environment could have been made more appropriate for people who live with dementia with the addition of better lighting, more signage and more appropriate pictures on the walls. There were a number of notices pinned to the walls in the home, which we asked the manager to remove as they were inappropriate.

The staff induction process was thorough and training had been undertaken by all staff. The new manager was in the process of collating information around staff training to ensure the new training programme was appropriate. Supervisions had not been undertaken for some time but the manager had begun to put these into place.

Consent for interventions was sought throughout the day. The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

We observed care in the home throughout the day and saw it was delivered with kindness and compassion by care staff. People's privacy and dignity was respected, there was a dedicated treatment room where people could receive treatment in privacy. If it was their wish people could receive treatment in their own bedrooms.

The home produced a quarterly newsletter and had a service user guide, which was in need of updating with details of new legislation and the new manager details.

Staff at the home had undertaken the Six Steps end of life training so that people could be cared for in the home environment at the end of their lives if this was their wish.

Care plans included some information about people's preferences, likes and dislikes but were in the process of being updated to make them more person centred.

Choices were given regarding what and when people chose to eat and whether people stayed in their rooms our spent time in communal areas. However, people had not been given the choice of having a key for their rooms, which would have afforded them more privacy.

A range of activities was on offer at the home, including arts and crafts, trips out, religious services and entertainment. However, a significant number of people spent most of the day sitting in the lounge with little stimulation.

There was a complaints policy in place and this was displayed in the reception area and outlined in the service user guide. We saw a number of compliments received by the service.

People who used the service, visitors and staff felt the manager was approachable. The manager was aware of what was needed at the service, had put an action plan into place and had already completed some actions.

The home maintained good links with the local community.

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 always safe.

Staffing levels were of concern as the lounge was sometimes left unsupervised and people required assistance. Recruitment of staff was robust.

Safeguarding and whistleblowing bullying policies were in place and staff demonstrated an understanding of the issues.

Medicines policies were in place and medicines were ordered, stored, administered and returned safely.

Requires improvement

Is the service effective?
The service was not effective in all areas.

The meal time experience could have been improved with the addition of table mats, condiments and pictorial table menus. The environment could have been made more appropriate for people who live with dementia.

The staff induction process was thorough and training had been undertaken. The new manager was in the process of collating information around staff training to ensure the new training programme was appropriate. Supervisions had not been undertaken for some time but the manager had begun to put these into place.

Consent for interventions was sought. The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Requires improvement

Is the service caring?
The service was caring.

We observed care in the home throughout the day and saw it was delivered with kindness and compassion. People's privacy and dignity was respected.

The home produced a quarterly newsletter and had a service user guide, which was in need of updating.

Staff at the home had undertaken the Six Steps end of life training so that people could be cared for in the home environment at the end of their lives if this was their wish.

Good

Is the service responsive?
The service was not always responsive.

Care plans included some information about people's preferences, likes and dislikes but were in the process of being updated to make them more person centred.

Requires improvement

Summary of findings

Choices were given regarding what and when people chose to eat and whether people stayed in their rooms our spent time in communal areas. However, people had not been given the choice of having a key for their rooms. A range of activities was on offer at the home, but a significant number of people spent their time sitting in the lounge.

There was a complaints policy in place and this was displayed in the reception area and outlined in the service user guide. We saw a number of compliments received by the service.

Is the service well-led?

Good

The service was well-led.

There was no registered manager at the home, but the new manager was in the process of registering with the Care Quality Commission.

People who used the service, visitors and staff felt the manager was approachable. The manager was aware of what was needed at the service, had put an action plan into place and had already completed some actions.

The home maintained good links with the local community.

Wingates Residential 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 09 November 2015 and was unannounced. The inspection team consisted of two adult social care inspectors from the Care Quality Commission.

Before the inspection we reviewed information we held about this service. This included previous inspection reports and notifications we had received.

During the inspection we spoke with 5 people who used the service, 5 relatives. We also spoke with five staff members, including the manager. We looked around the home and observed how care and support was delivered to people who used the service. We used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We looked at records including five care plans, four staff files, minutes of meetings and audits held by the service.

Before our inspection we contacted Bolton local authority commissioning team to find out their experience of the service. We also spoke with three health and social care professionals who regularly visit the service to ascertain their views of the care and support offered.

Requires improvement

Is the service safe?

Our findings

We asked people who used the service if they felt safe at Wingates. One person told us, "Sometimes I feel safe but not always at the moment". This was because another person who used the service was in the habit of going in people's rooms sometimes when they were in bed. The home was in the process of addressing this.

We saw that there were policies in place with regard to safeguarding of vulnerable adults. Staff had received training in safeguarding and those we spoke with were able to demonstrate how they would identify a concern and how they would then report this. Safeguarding concerns had been notified to the Care Quality Commission as required.

There were also appropriate policies regarding whistle blowing and bullying. Whistle blowing is to guide, protect and support staff to be confident to report any poor practice they may witness. Staff were aware of the policies and knew where to find them to refer to if required. We discussed with the manager that the policies required reviewing and updating to ensure all information included was current. The manager was aware of the need to update all policies within the home.

The home had CCTV in place in communal areas, to help ensure people's safety. This was clearly outlined in the staff handbook and there was a notice on the window near the entrance to alert people visiting the service to the existence of the CCTV. However we discussed with the manager that an explanation of this should also be included in the information produced for people who used the service and their relatives to ensure they were aware of its use.

We looked at five care plans and saw that appropriate risk assessments were in place for individuals for issues such as use of equipment, mobility, falls, nutrition, continence and environmental risks. We observed staff using equipment safely and moving and handling people in an appropriate way. Each person had a Personal Emergency Evacuation Procedure (PEEP) document within their care file, to help ensure they would receive the appropriate level of assistance in an emergency situation. We spoke with the manager about creating a 'grab file' close to the entrance with all these documents in it for ease of use. The manager agreed to put this in place immediately.

We walked around the home and saw that it was clean, tidy, clutter free and free from any malodours. There were hand sanitizers, paper towels and liquid soap available. Staff used personal protective equipment (PPE) such as apron and gloves, when required People we spoke with who used or visited the service, told us the home was always clean and pleasant. Infection control policies were in place and there was guidance for staff about how to manage any outbreaks. The home had received an outstanding infection control report recently, scoring 92% and their food hygiene rating was five, which is the highest rating available.

The ground floor covered a large area, and we found that the conservatory area, where a number of people were sitting, was quite cold as the radiators were turned down low. People were sitting in this area with blankets around them. We asked for the radiators to be turned up and this was done. Suitable aids and adaptations, such as grab rails and raised toilet seats, were appropriately placed for people to use.

We looked at staffing levels at the home and checked the rotas and we had some concerns. On the day of the inspection there was the manager, two senior carers, two carers and two apprentices on shift. The manager explained that there was usually one senior on duty, but an extra one was in as the new cycle of medicines were being delivered and the senior was needed to help check them in. We were told that the apprentices were expected to do the same job as the carers, which we questioned. We felt this may not be entirely appropriate due to their lack of experience and status as apprentices or trainees at the service. During the day there was also a cook, two cleaners and a laundress. There was one senior and two carers on the night shifts.

We observed the lounge area and found that it was unsupervised for periods of time, approximately 10 minutes. Staff were aware of a problem with one person who used the service who was inclined to invade other people's space and needed constant supervision. Another person who was living with dementia was sitting on a chair and constantly leaning forward. We felt there was a risk that they could have fallen face first from the chair if the inspector had not intervened.

Recruitment at the home was robust and we saw in the four staff files we looked at that there were application forms, interview notes and proof of identity. Two references

Requires improvement

Is the service safe?

were required from each potential employee and Disclosure and Barring Service (DBS) checks were carried out prior to them commencing work. DBS checks help ensure staff are suitable to work with vulnerable people.

Appropriate environmental and health and safety risk assessments and policies and procedures were in place. We saw that fire drills were carried out regularly and equipment was maintained appropriately. A number of checks, such as water temperatures, were undertaken on a monthly basis by the handyman. The home had a robust contingency plan in place in case of emergency evacuation. The home had a wheelchair store area which meant that there was no clutter around the home, making the environment safer for people who used the service to walk around.

Accidents and incidents were logged within people's files and those we looked at had been followed up appropriately. Analysis and learning from accidents had not been carried out whilst there was no manager in place, but the new manager assured us this was something that would recommence in the immediate future.

There was an appropriate medicines policy in place and there was a dedicated treatment room in which district nurses could provide people with treatment in privacy and store their notes securely.

We were at the home when the new cycle of medicines was to begin and the new medication was delivered. Two seniors checked in the medication and explained the process of disposal and return of surplus medicines, which were due for collection that day. We looked for the safe administration and storage of medicines. The home used a system called Biodose. This is where medicines are contained in a 'pod'. Each pod can contain tablets or liquid medication. Photographic identification was on the front of each tray which helped to minimise medication errors. All staff had completed medication training. There was a small amount of controlled drugs stored at the home. These were in a controlled drugs cupboard and a controlled drugs register had been accurately completed following administration.

We saw that medicines were securely stored, however the home would benefit from having the correct Biodose drug trolleys to store the Biodose trays. Medication was currently stored in large cupboards with the cassettes on top on one another. During the inspection the manager drafted a form for when medication was taking out of the building by family when a person who used the service was going out for the day. This was to be signed by the person who was then responsible for the administration of tablets.

Fridge temperatures were taken daily to ensure any medication kept this way was stored safely and we saw that the temperature was within manufacturers' recommended range. Staff wore a tabard when giving out medicines to help ensure they were not disturbed. One person was prescribed 'thick and easy' which is used in drinks to ensure they are at the required consistency. These were prescribed in individual sachets.

One person spoke with told us, "I always get my tablets on time, they [staff] are very good at that". We observed some poor practice at lunch time when a member of staff was giving out medicine to a person whilst they were eating their meal. This took a considerable length of time, as the person struggled to get their tablets down and their meal was going cold in the meantime. The member of staff was kind and patient but it was inappropriate and unnecessary to administer the medicines at that time. We spoke with the manager about this, who agreed to address the matter immediately.

Requires improvement

Is the service effective?

Our findings

We asked people about the food at the home. One relative told us their loved one required a substantial amount of encouragement to eat. This was being given in a kind and appropriate manner and they were pleased that this issue was being addressed. One person who used the service told us, "The food is OK"; another said "Could do with more variety". A relative told us, "We bring some of our food, not luxuries, basic stuff and the food is basic". Another relative told us, "The food is OK but why can't they [people who use the service] have proper fruit juice at breakfast instead of cheap cordial".

We spoke with the chef and he was able to tell us about people who were on special diets or had particular dietary requirements. We observed a meal time at the home. There were no condiments on the table and people had been given coloured plastic tumblers to drink from, which were not age appropriate. There were paper rolls being used as mats. There was a whiteboard in the dining room with the menu written on it, but this was difficult to read. There were no table menus or pictorial menus which would have been easier for people living with dementia to understand.

We saw that specialised cutlery and plate guards were used for some people. However one person was having difficulty with their plate, which kept moving as they tried to eat. They would have benefited from a rubber mat to secure the plate. We saw that staff were wearing plastic gloves to serve the food, which was unnecessary and inappropriate. We discussed improvements to the dining experience with the manager and she began at once to look into pictorial menus, bud vases and place mats for the table and agreed to address the other issues raised.

We looked at the visitors' comments book, which included a very positive comment from a visiting professional. This stated, "I'm so impressed by the staff's efforts following up care advice. My patient's improvement and outlook on life has been a joy to see. Keep up the good work".

We saw that all staff had a thorough induction prior to commencing work, which included orientation to the home, introduction to people who used the service and other staff and mandatory training. Staff we spoke with were able to explain their role and responsibilities clearly.

There was a staff supervision policy in place. We saw that supervisions had not been undertaken routinely whilst there was no permanent manager in place. However, the new manager had already commenced supervision sessions with staff and this process was on-going. We looked at some of the supervisions already undertaken and found they were thorough and included a review of the person's work performance, review of training, support and development needs and future work targets. There was also a topic relevant to the person's role discussed and their knowledge of the issue checked.

The four staff files we looked at demonstrated that staff had undertaken a range of training and staff we spoke with confirmed the training they had participated in. One senior member of staff we spoke with had undertaken advanced training in the area of dementia care. The new manager told us they were unsure of the specifics of when training was due for renewal so they were collating information about staff qualifications and planned to begin a training programme immediately to ensure all staff were trained to the required standard. All mandatory training, such as moving and handling, had been undertaken and was up to date.

The manager told us that handovers, at the end of each shift, had been improved. These now included visual, verbal and written information to ensure any tasks not completed should be done by the relevant staff member prior to leaving the premises. The handovers also helped ensure people's care was as seamless as possible and any potential issues, such as a person being unwell, were followed up appropriately.

We looked at five care plans and saw that they included relevant health and personal information about the individual. Monitoring charts, such as monthly weights, were complete and up to date. There were records of professional visits from agencies such as district nurses and GPs. The care plans were updated on a monthly basis to ensure the information remained current.

We observed care delivery throughout the day and saw that staff ensured they sought consent prior to giving support or assistance.

The Mental Capacity Act 2005 (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

Requires improvement

Is the service effective?

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.

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 and hospitals 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 saw that staff had undertaken training in Mental Capacity Act (2005) (MCA) and those we spoke with demonstrated a good understanding of the issues surrounding this. At the time of the inspection there was one person subject to a DoLS authorisation but others were in the process of being applied for. Some staff we spoke with demonstrated limited knowledge of the DoLS process and the manager assured us this would be rectified via training and supervisions in the near future.

The environment could have been adapted better to meet the needs of older people, some of whom were living with confusion or dementia. There were a large number of notices pinned to the walls all around the home. We spoke with the manager about the inappropriateness of these notices and asked that they be removed, which they were.

There was a lack of signage around the home and the lighting in some areas was very poor. This could be detrimental to people living with dementia or confusion. There were no tactile items around the walls for people living with dementia to touch. The use of brighter colours, and more meaningful pictures that people could relate to, such as reminiscence photos of the area, could be of benefit to people living with dementia.

We spoke with the manager about this. She told us she planned to convert one of the small rooms into a reminiscence lounge. She agreed to look at current information around best practice in this area to look at what other additions or adaptations could be made to enhance the environment.

Good

Is the service caring?

Our findings

One person who used the service said, “Staff are very nice, they look after your privacy and dignity”. Another told us, “The staff are lovely, I treat them like my family”. One member of staff we spoke with told us, “Everyone seems happy”. One family member told us they were happy with most of the carers but that some had an ‘attitude’. They said that clothes went missing and white washing was never white.

The service had a policy on equality and diversity relating to staff issues. There was also a policy on rights, covering equality and diversity relating to people who used the service and policies on religion and beliefs, social contact and sexuality with regard to people who used the service.

There was a policy on the values of privacy and dignity. People who used the service told us their privacy and dignity was respected by staff. There was a dedicated treatment room where people could be seen by visiting health professionals, such as district nurses, in order to receive consultations in private and without interruptions. People were also given the choice to be treated in their own rooms if this was their preference.

Visitors could see people in the lounge, conservatory or, if they wanted more privacy, the day room or the person’s own bedroom. The visitors we spoke with told us they were always made very welcome at the home. One visitor commented, “Staff are really good and welcoming with visitors, we [the family] think the home is great”.

We observed care throughout the day and saw that people were treated with compassion and kindness. Staff and people who used the service demonstrated good relationships and the home had a friendly and relaxed atmosphere.

No residents and relatives meetings had been held since the previous registered manager left their post. However, the new manager had plans to hold a meeting in the very near future. She told us she would write to each relative to ensure they were aware of the meeting and could ensure they were free to attend if they wished to do so. This would provide a forum for people who used the service and their loved ones to put forward suggestions, raise concerns and discuss any issues they felt were relevant.

A newsletter had been produced for Autumn 2015 which included information about staff changes, refurbishments taking place, fund raising, recent events and entertainment and forthcoming events. There was also some information and advice about safety and security, reminding people to ensure outside doors were closed on entering and leaving.

There was a service user guide, which included information for people who used the service and their relatives about the service. The complaints procedure was outlined within this guide. However the guide was a little out of date and the manager agreed to ensure it was updated immediately.

Staff at Wingates had completed the Six Steps end of life training. This programme helps ensure that people reaching the end of their life have an experience that takes into account their wishes and is as pain free and dignified as possible. There was a room available in the home for relatives to stay in if they wished to be on hand when their loved one was nearing the end of their life. This helped ensure people who used the service had their loved ones around them at this important time and that relatives felt involved at the end of life.

Requires improvement

Is the service responsive?

Our findings

We asked people about the choices they were given. One person told us, "You have the choice to stay in your room if you want to." We asked if people were given the option of having a key for their bedroom door, but people told us this was not the case. Offering a key to people who used the service, who were able to manage this, would afford them more privacy and dignity and give them a little more independence in their life. There was also a concern raised by some people who were experiencing difficulties with another person who used the service who repeatedly came into their rooms. Having a key may have helped to alleviate this problem.

We saw that people could choose if they had a picture on their door or another item to help them recognise and relate to their room more easily. Many had brought some of their own furniture and had been involved in the decoration of their own room.

We saw that some people chose to remain in their own rooms, whilst others spent time in the lounge, socialising with others. We saw that people could choose what time they had their meal and where they ate it. One person was eating breakfast in the dining room in the late morning; a small number ate their meals in their rooms as was their preference.

People were well groomed but not all had socks or stockings on. We asked one person if their feet were cold but they were unable to comment whether they wanted socks on or not. Staff spoken with did not know if this was their preference.

Care plans included a range of health and personal information. There was information about people's likes and dislikes, family history, hobbies and interests in order to ensure the care delivered was appropriate to each individual who used the service. All care plans were being reviewed by the new manager in order to ensure they were more person centred. The manager told us the care plans would include an 'All about me' section. The home would need to involve the person who used the service in this process and, where appropriate, family and friends to supply further information.

We saw within the care plans that transitions between services had been coordinated and managed effectively. Hospital appointments were clearly recorded and people were supported to receive care and treatment from other agencies and services as required.

Staff told us that various activities took place at the home, such as arts and crafts, pampering, sing-alongs, quizzes, entertainers, seasonal and festive celebrations. A visit to the home was planned from 'Ye Olde Toffee Shop', an old fashioned toffee shop in the local area. In the afternoon of the inspection day an arts and crafts session took place in the dining room, facilitated by a volunteer, at which five people enjoyed making Christmas decorations. However, the vast majority of people who used the service spent their time sitting in the lounge area with little stimulation taking place. With the numbers of staff on duty and the tasks to be completed, the staff would have been unable to facilitate activities or one to one conversation had the volunteer not been at the home. There were no items around the home, such as rummage drawers and tactile objects, which people living with dementia often find stimulating and interesting. Doll therapy was used at the home for some people who used the service, where appropriate. The dolls represent babies and can result in positive effects in alleviating stress and anxiety in people who are living with dementia.

A fortnightly communion service took place at the home and staff told us that two people were taken to church on a weekly basis, by staff. Members of the church brought the people back to the home after the service. The home had a number of links with the wider community and was visited regularly by children from the local school and volunteers from the local churches.

The service had an appropriate complaints policy in place. The complaints procedure was displayed in the reception area and outlined within the service user guide. People we spoke with were aware of the complaints policy and were confident to raise concerns with any of the care staff or with the manager.

We saw a number of compliments received by the service including, "Thank you for the care and attention you afforded to our [relative]"; "We really appreciate all you did for [relative], a big thank you to you all"; "Thanks for taking such good care of our [relative]". There was also a report from a consultant at hospital saying, "The staff at Wingates Residential Home need to be commended for their great

Requires improvement

Is the service responsive?

effort in ensuring that [patient] is receiving adequate nutrition". This person's weight had been maintained despite them having achalasia, a condition in which the muscles of the lower part of the oesophagus fail to relax, preventing food from passing into the stomach.

Good

Is the service well-led?

Our findings

There was a new manager in place who was in the process of registering with the Care Quality 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.

We asked people if they felt the manager of the home was approachable. One family member told us they felt that standards had fallen since the registered manager left 12 months ago. However, their relative, who used the service, became upset with the comment and told us they did not want to move.

Although the new manager had only been in post for a number of weeks, people who used the service, visitors and staff felt she was approachable. One staff member told us, "We are being listened to by the new manager; I think she is doing a good job."

Some concerns were raised by one family about how the fees were worked out, which was later explained to them. They also raised the concern that they had paid for taxis for hospital appointments and only for the last visit was community transport arranged. We asked the manager to look in to these concerns and she agreed to do this immediately. The manager had already addressed some financial issues, such as people who used the service not receiving individual receipts for items such as hairdressing and the purchase of newspapers. This had already been rectified and individual receipts were now being obtained.

The manager was well supported by the director of the home, who visited regularly. The new manager was aware of what needed to be done at the home and had already put an action plan in place. She was working through this and some of the actions had already been completed. For example, the manager was in the process of implementing some quality audits and had implemented visual and verbal handovers at the start of shift. She was also carrying out spot checks at the home, including some at the weekends.

We saw that fire equipment was tested and serviced regularly and health and appropriate safety certificates were in place at the home. There was a kitchen cleaning schedule in place in which tasks were ticked off when completed.

Supervisions and appraisals had not been undertaken during the time there was no permanent manager in place. However, these had now commenced and were of a good standard. Staff meetings had also not been held regularly but the manager planned to begin to hold regular staff meetings in the future.

The home could demonstrate good links with the local community, such as the local churches and schools. The manager told us she planned to continue to strengthen these links in the future.

We spoke with the managers of two of the local social work teams prior to the inspection. They had visited the home recently and carried out some reviews of care. Both were positive about the new management arrangements and felt that, although there had been some issues of concern over the past few months, the service was now beginning to be delivered more effectively.