

Lantraz Co. Ltd

Westfield Care Home

Inspection report

Devon Drive
Mansfield
Nottinghamshire
NG19 6SQ
Tel: 01623 427846
Website: N/A

Date of inspection visit: 29 to 30 October 2014
Date of publication: 18/03/2015

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?

Requires Improvement



Overall summary

We carried out an unannounced inspection of the service on 29 and 30 October 2014. Westfield Care Home provides accommodation, personal care and the treatment of disease, disorder or injury for up to 45 people. On the day of our inspection 26 people were using the service.

A registered manager was in post at the time of this inspection. 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.

During our inspections on 22 May 2014 and 13 June 2014 we identified three breaches of the regulations of the Health and Social Care Act 2008. These were in relation to obtaining people's consent to care and treatment, the care and welfare of people who used the service and the assessment and monitoring of the quality of service that people received.

Summary of findings

During our previous inspections we identified concerns that a person was at risk of becoming socially isolated due to the lack of opportunities given to them to interact with people. We also had concerns that this person's broken hearing aid had not been reported to and followed up with external professionals in a timely manner. During this inspection we saw improvements had been made. People were regularly encouraged to interact with people and referrals to external professionals were made and appropriately followed up.

We previously identified concerns that staff performance was not regularly assessed and that accidents and incidents were not appropriately recorded, acted on and reviewed by the home manager. During this inspection we saw improvements had been made to address this breach, but we have also identified a concern relating to the registered manager's auditing of medicines.

We had previously identified concerns that the provider had not always ensured that an assessment of a person's ability to make and understand the impact of their own decisions had been undertaken as required by the Mental Capacity Act 2005 (MCA). The MCA is legislation used to protect people who might not be able to make informed decisions on their own about the care and support they received. During this inspection we saw improvements had been made, assessments contained more detail relevant to the decision being assessed and in each of the care plans we looked at we saw assessments had now been completed for all decisions that required them.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The DoLS are part of the MCA. They aim to make sure that people are looked after in a way that does not restrict their freedom. The safeguards should ensure that a person is only deprived of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. The registered manager had applied the principles of the MCA and DoLS.

Staff were aware of people's individual preferences and people's consent was gained before care and support was provided.

There were enough staff with the knowledge and skills to provide safe and appropriate care and support. There were systems in place to protect people from the risk of abuse.

Personal emergency evacuation plans (PEEP) were in place for people should an emergency require the timely evacuation of people. However, these needed reviewing as some did not reflect people's current need for support.

People received their medicines as prescribed although the provider's policy of recording when 'as needed' medicines had been administered had not been followed by staff. 'As needed' medicines are an important part of the therapies that people take to manage different health conditions.

People spoke highly of the food; however when we observed lunch being served it was unorganised and some people had to wait up to 20 minutes before being offered a drink or to receive their meal.

People had access to external professionals when they required it and staff acted on the recommendations given to support people.

Staff showed a positive and caring approach when providing care and support for people. People interacted well with staff and there was a friendly atmosphere in the home.

There was no information available for people if they wished to access an independent advocate to discuss the care and support they received. An independent advocate helps people have a stronger voice and to have as much control as possible over their own lives.

We observed staff spend time with people, however people's personal hobbies and interests were not actively catered for.

People were not provided with a complaints procedure that was easily accessible or in a format that had been adapted to ensure people could easily understand the process.

Risk assessments had been completed which highlighted the potential risks to people's health and safety; however these did not always contain sufficient detail and guidance for staff to follow.

People's mental health needs such as people living with dementia were met by the home. The home has been

Summary of findings

awarded the Nottinghamshire County Council Dementia Quality Mark (DQM). The DQM is awarded to care homes in Nottinghamshire that have shown that they provide a high standard of care to people with dementia.

The registered manager carried out regular audits in areas such as the environment and people's care plans. However the audit to assess whether medicines have been administered appropriately had not been completed and they had not identified that staff had not adhered to the provider's medication policy when 'as needed' medicines were administered.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and this was in relation to assessing and monitoring the quality of service provision.

You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe

Staff did not follow the provider's medicines' policy which required them to record the reasons why 'as needed' medicines had been administered.

Personal emergency evacuation plans did not always reflect each person's current need and could mean people were not evacuated safely by staff.

There were an appropriate number of staff to meet people's needs.

Requires Improvement



Is the service effective?

The service was not consistently effective.

People were protected under the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards.

People spoke highly of the quality of the food although the lunch time experience was disorganised.

Recommendations by external health care professionals had been implemented, but their effect had not been discussed with all people.

Requires Improvement



Is the service caring?

The service was caring.

People were supported by staff who were kind and caring.

People were encouraged to be independent and to do as much for themselves as possible.

People's privacy was maintained at all times.

Good



Is the service responsive?

The service was not consistently responsive.

People were not always able to engage in the hobbies and interests that were important to them. There was limited opportunity for people go to outside of the home.

Staff were aware of people's personal preferences however guidance for staff within care plans for how to address people's agitation was not always completed.

Staff responded in a timely manner, when call bells were pressed.

Requires Improvement



Is the service well-led?

The service was not consistently well-led.

Requires Improvement



Summary of findings

People's views were not obtained in order to assist the provider with driving improvement at the home.

The registered manager's audits were not always effective in identifying risks to the service provided.

Staff received assessment of their work although the frequency of these assessments was not in line with the provider's policy.

Westfield Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 29 and 30 October and was unannounced.

The inspection team consisted of three inspectors, an Expert by Experience and specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a registered nurse with experience of working in an older person's care home.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to

make. In addition to this, to help us plan our inspection we reviewed previous inspection reports, information received from external stakeholders and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted Commissioners (who fund the care for some people) of the service and asked them for their views.

Many of the people who used the service had difficulty communicating as many were living with dementia or other mental health conditions. We spoke with four people who used the service, three relatives, five members of the care staff, the maintenance person, a registered nurse, a community support worker, two registered managers, one of which was also the provider.

We looked at the care records of seven people who used the service, as well as a range of records relating to the running of the service including quality audits carried out by the home manager.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

The people we spoke with told us they felt safe at the home. One person told us, "I feel safe living here, but there's no place like home. There's nothing to worry about here, it's such a super place." Another person told us; "As places go it's fair here, the staff are nice, no problems there. I do feel safe here."

Two people who use the service told us they would speak to a member of staff if they had any concerns that they or somebody else had been the victim of abuse. We spoke with care staff and asked them what they would do if they believed someone was being abused. The staff we spoke with could explain who they would report their concerns to both internally and to external agencies such as the local authority multi agency safeguarding hub (MASH).

Investigations into whistleblowing, staff concerns and accidents or incidents were thorough and dealt with in a timely manner. The registered manager ensured that notifiable incidents, such as when a person had sustained a serious injury, were forwarded to the relevant regulatory bodies such as the CQC and the multi-agency safeguarding hub (MASH). The home manager told us they had an open and transparent approach to investigating these matters that ensured people's concerns were dealt with appropriately.

We were told by the provider that personal evacuation plans (PEEP) were in place for each person who used the service. We were told by the provider that some of them were out of date and required reviewing. The staff we spoke with were aware of how to evacuate people safely and what assistance each person required. However due to the provider's admission that some of the PEEPs required updating we could not be assured that the current arrangements for evacuating people in an emergency were up to date and reflected their current needs.

We spoke with the maintenance person who told us they ensured that people were kept safe by the regular assessment of the safety of the premises and the equipment used within it. We saw the process they had in place where staff identified concerns with equipment or

the environment that needed to be addressed urgently. Throughout our inspection we found the home to be well maintained and free from potential hazards which ensured that people who use the service and visitors were safe.

The provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider requested criminal records checks through the Government Disclosure and Barring Service (DBS) as part of its recruitment process. These checks are to assist employers in making safer recruitment decisions.

Throughout the inspection we saw there were sufficient staff to meet people's needs. The registered manager had a mixture of staff in place with the right mix of skills including; nurses, care workers and domestic staff. We observed staff working together to provide care and support for people in a way that ensured their safety. The registered manager told us that if they believed the safety of people was placed at risk due to an inappropriate number of staff or by staff not having the relevant skills, then they would address this immediately.

When 'as needed' medicines such as Lorazepam, which is used to control anxiety disorders, were administered, staff had not recorded the reasons why as per the provider's medication policy. A registered nurse and a staff member trained in the administration of medicines could not explain what process they followed when administering this type of medicine. The inconsistent approach by staff when administering these medicines could place people's safety at risk.

The care plans we looked at showed that people's ability to administer their own medicines had been assessed in line with the requirements of the Mental Capacity Act 2005. We observed staff administer medicines safely, in a calm and patient way that ensured, where appropriate, people were supported to take their own medicines in a way that they wanted to. The room where medicines were stored was locked when not in use and all medicines and controlled drugs were stored safely.

Is the service effective?

Our findings

During our previous inspection on 22 May 2014 we identified a breach of Regulation 18 of the Health and Social Care Act 2008. The provider had not always ensured that an assessment of a person's capacity was undertaken as required by the Mental Capacity Act 2005 (MCA). The MCA is legislation used to protect people who might not be able to make informed decisions on their own about the care and support they received. During this inspection we found improvements had been made in relation to the level of detail recorded when decisions were made in a person's best interest, people's ability to administer their own medicines and manage their own finances had also now been assessed.

We saw that one person had been supported to make major decisions by an Independent Mental Capacity Act Advocate (IMCA). IMCAs support and represent people who do not have family or friends to advocate for them at times when important decisions are being made about their health or social care.

The registered manager told us they had the processes in place that ensured they did not unlawfully restrict the freedom of people. They told us they had recently applied for Deprivation of Liberty Safeguards (DoLS) to be put in place for one person whose safety would be at risk if they accessed the community alone. This had been authorised by Nottinghamshire County Council. We reviewed the documentation and saw that the terms of the agreement were being adhered to.

People told us they were supported to make their own decisions. One person we spoke with told us, "I get a choice, I am free to get up and go to bed when I want to, I choose my own meal and can see my GP whenever I want to." Each member of staff we spoke with could explain how they obtained people's consent and we observed staff doing so throughout the inspection.

A relative of a person who used the service told us, "The staff seem well trained, there are some new staff but they know [family member's] needs well." The staff we spoke with told us they felt supported in their role and they had received appropriate induction and training before they started work. The induction was carried out in line with the

Skills for Care's Common Induction Standards. These standards are designed for people working in adult social care and need to be met before they can safely work unsupervised.

We observed staff working together to assist people when moving around the home. However, when we observed staff assist people with moving from their wheelchair to the chair they wished to sit on, they did not always explain to people what they were doing. This compromised people's dignity by staff not engaging with them in a respectful way.

People spoke positively about the quality food. One person told us; "The food is fantastic", and another told us; "The food is excellent, I like the food, I never go hungry." A relative we spoke with told us, "The food is lovely, it is better than what I cook."

The lunch time meal was not effectively organised. We observed lunch being served and saw one person wait 20 minutes before a member of staff asked them if they wanted a drink. Another person had finished their main meal and waited for their dessert; due to the time they were waiting they left the table before it was served without the knowledge of the staff. This meant the person may not have had a sufficient amount to eat and staff may not have been aware.

During lunch we saw one person was asleep at the table. We saw staff encourage the person to wake up as their meal had arrived, however they became agitated and wanted to leave the table. We observed staff encourage the person to sit at the table and eat, however they only ate a small amount of their main meal before they left. We noted the same person had got up late that morning and had only eaten breakfast at 10:45. The staff did not seem aware that the person had not long eaten their breakfast and we did not see them offer the person the opportunity to eat their lunch at a later time.

We saw people were weighed regularly and where required their food and fluid intake was recorded. We spoke with a dietician prior to the inspection, they told us, "I have no concerns with the patients at this home. The documentation relating to nutrition is always very good and they take on board all recommendations that I have made to them. People seem well cared and well looked after."

The registered manager ensured staff were aware of people's daily health needs by carrying out a

Is the service effective?

comprehensive handover between shifts. They discussed each person who used the service and gave instructions for staff to follow. We spoke with a member of staff to check whether they had completed one of the tasks the registered manager has assigned to them who told us they had.

The registered manager told us if needed, they referred people to the relevant external health services to obtain professional guidance on how to support them. Prior to the inspection we spoke an external health professional who told us, "I have no concerns with this home. I have been in once to the home when it was reported to us that a person was choking on their food. The home had already put plans in place to immediately help the person and also welcomed our input into other ways they could help the person."

Prior to the inspection we spoke with another external health professional. They told us; "They [registered manager] have always taken my advice on board and do follow my recommendations." They gave an example where they had recently advised the home manager to place stair gates at the top and the bottom of the stairs to reduce the risk of people falling down the stairs. We saw this advice had been followed and the gates were in place. However, the registered manager had not discussed the potential restrictive nature of the stair gates with people who used the service and therefore the result of this action could be a restriction on people's ability to move freely around their home.

Is the service caring?

Our findings

All of the people we spoke with spoke positively about the staff. A person who used the service told us, "I'm well cared for here. I think the staff are always here to help me. If I was worried about anything I would speak to any of the staff." Another told us, "The staff know me well and they are definitely kind to me; they are human." Another person told us, "They [staff] are very kind. They are very very good." A relative we spoke with told us, "I watch the staff sometimes; they are very caring and kind."

We observed many positive interactions between staff and people who use the service. For example, we saw a person had become visibly upset. The staff member spoke calmly and with kindness to reassure the person. They listened to the person's concerns and had a good understanding of the person's personal circumstances which enabled them to help the person and to calm them down. The staff member clearly understood how to assist this person and the person responded well to the staff member's caring approach.

We observed people receive support from staff to complete tasks independently. For example, we saw one person was assisted by staff when returning from the toilet and they were encouraged to walk back to their seat independently. The staff member gave clear direction and ensured the person turned and sat down at the relevant time. They also supported them to ensure they were comfortable when seated in the chair. This was done in a caring and supportive way and the person responded positively to the staff member's approach.

The staff we spoke with could explain how they would safely assist people whose behaviours challenged and we observed staff interact with people in a patient and caring way. One member of staff explained to us how they would ensure people and others were safe when a challenging situation arose. They told us; "I would speak calmly to the person and ask them to calm down and encourage them to come with me and sit down on a one to one basis and have a talk." Throughout the inspection we saw staff regularly used these techniques and people responded positively to them.

People were able to express their opinions and make decisions for themselves, which were respected by staff. We saw people say where they wanted to eat their meals, where they wanted to sit and what they wanted to do.

People were able to access independent advice about their care. Whilst there was no information available in the home for people to gain access to this advice independently of staff or their family and friends, the registered manager had ensured that where needed, people had access to the advocacy service.

Throughout the inspection we observed staff support people in a respectful way that maintained their dignity. A person who used the service told us, "The staff are very kind to me; I am totally comfortable with them." We asked a staff member how they ensured they maintained people's dignity. One staff member told us; "I always close doors and curtains. I will explain what I am going to do and always encourage the person to be independent. For example, I let them do things for themselves like wash their face with a flannel."

When external professionals attended the home people were taken to their bedroom or other parts of the home in order for their privacy to be maintained. There were areas of the home that could be used should a person wish to sit alone or speak privately with family or friends.

The registered manager told us that when a person passed away they had specific protocol for staff to follow that ensured that the person's body was cared for sensitively. They also told us that once the person's body was removed from the home they ensured the person's room was not assigned to any new admissions to the home for a month. They told us they did this as of a mark of respect for the family of the person who had passed away; but also for the people at the home who may have been directly affected by the person's death. This showed the registered manager had a caring and sensitive approach in dealing with a person's death and the effect it could have on the person's relatives and people at the home.

Is the service responsive?

Our findings

During our previous inspection on 22 May 2014 we identified a breach of Regulation 9 of the Health and Social Care Act 2008. We identified concerns that a person was at risk of becoming socially isolated due to the lack of opportunities given to them to interact with people. We also had concerns that this person's broken hearing aid had not been reported to and followed up with external professionals in a timely manner. During this inspection we saw improvements had been made. Staff regularly encouraged people to leave their rooms and interact with other people at the home and referrals to external professionals were now made in good time and appropriately followed up.

We observed people's requests for assistance to go to the toilet, to have a drink or to go back to their room were met in a timely manner. We observed staff respond quickly when call bells were pressed which ensured that people were not left alone for long periods of time which could place their safety at risk. A person who used the service told us, "They [staff] are there if I have a problem and I can talk to them on a one to one basis. They are very good to me; they don't mind doing anything for me at all."

People received consistent care and treatment that was personalised to them. Staff spoke knowledgeably about the people they supported and explained how they identified and responded to people's needs. For example, a staff member told us a person had recently been on bed rest due to an injury. They told us they encouraged the person to walk and take small steps for them to become independent and walk unaided and the person responded well to this support.

We saw care plans were individualised and contained life history and personal preferences for each person who used the service. Where able, people had contributed to their care plans and if required, family had been consulted. We spoke with staff and they showed a good knowledge of people's like and dislikes. One member of staff member told us a person enjoyed playing cards and they played with them.

We spoke with people who told us they did activities such as crosswords, chatting to people and watching television. One person told us that staff gave them jobs to do and also they had their hair and nails done. However, throughout

the inspection we saw limited attempts by staff to engage with people in line with the interest and hobbies. During the inspection we saw people spend the majority of their time either in the lounge or dining room areas with little stimulation other than background music or television. During the inspection we spoke with a Community Support Worker who visited the home on a regular basis. They told us that they did not see activities provided for the people used the service.

The registered manager told us that they had plans to recruit a member of staff who would work with people to explore their hobbies and interests, however they acknowledged that at the moment people were not encouraged enough by staff to explore the things that were important to them and also that people were not given enough opportunity to leave the home and visit the local community.

We saw there was an inconsistent approach to the assessment and review of people's needs. The care plans we looked at showed regular reviews were conducted however the detail of these reviews, and who was involved, was limited. We saw risk assessments had been carried out in a variety of areas; however some risk assessments did not contain sufficient information and guidance for staff to follow. For example, in one care plan we looked at we saw a person's 'mental ability' had been assessed, which stated the person may become agitated if they wished to go to bed early. However, there was no guidance for staff advising how they could respond to and help reduce the person's agitation.

Westfield Care Home has been awarded the Nottinghamshire County Council Dementia Quality Mark (DQM). The DQM is awarded to care homes in Nottinghamshire that have shown that they provide a high standard of care for people living with dementia. We saw the provider had implemented a variety of tools to support people living with dementia. For example, we saw different items were attached to the wall areas around the home such as; flower baskets and sport items, such as boxing gloves and bats for ball games. We saw pictures and photographs of famous people and historical events had been placed throughout the home to help people remember past events or things they may interest them. We saw some soft toys for people who may have wished to use them as a comfort object, and observed people use

Is the service responsive?

these throughout the inspection. We also saw the Provider had placed blue tape around all light switches throughout the home to ensure that light switches were easily identifiable to people.

The registered manager had ensured that staff were aware of people's religious requirements and ensured that these needs were met. For example, the registered manager had discussions with a person about their religious beliefs

when they first came to the home. The person's wishes were recorded in their care plan for staff to follow. Recently the person had been unable to read their own religious books and friends had visited the home to assist them with this. They had given the person some books to be left in their room for the staff to read to them. The home manager has ensured that staff were aware of these books and they were read to this person.

Is the service well-led?

Our findings

During our previous inspection on 22 May 2014 we identified a breach of Regulation 10 of the Health and Social Care Act 2008. We saw the provider had not ensured that accurate records of staff training were maintained, regular supervision and appraisal of staff performance had not been conducted, recommendations made by the registered manager with regards to people's health and safety had not been reviewed and the recording of accidents and incidents that had occurred throughout the home were not completed and maintained in sufficient detail. We also identified that people's views were not formally obtained to assist the home manager in making the necessary improvements to improve the service that people received.

During this inspection we found that some improvements had been made but further improvement was required in some areas. The staff training records were now more comprehensively completed. We could see who had attended training, when training was due to expire and who was booked to attend future training courses. The registered manager told us they had recently had an increase in the number of people who fallen and booked further training for staff to enable them to support people and maintain their safety. This showed the registered manager had identified a risk and addressed that risk quickly to ensure that people were protected by well trained staff.

Staff told us they felt supported by the management team. The registered manager told us that improvements had been made in the way that staff performance was assessed, however further work was still required to ensure staff received regular assessment in line with the providers' policy of assessing staff performance every two months. Some staff not having received an assessment of their work for six months.

The registered manager had completed a range of audits of the service. These were completed to ensure different aspects of the service were meeting the required standards. The audits covered a number of areas such as care plan reviews and medication. However the home manager's 'medication audit' had failed to identify that staff had not been adhering to the Provider's medication policy which stated that when 'as required' medicines had been administered, staff must record the reasons why. The

registered manager had also failed to conduct a review of when staff had administered these medicines and whether they had done so appropriately. This increased the risk of an inconsistent approach by staff when administering 'as needed' medicines to people.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Since the last inspection little improvement had been made in the way the views of people who used the service, their relatives and external stakeholders were gained in relation to the quality of the service provided. Four of the people we spoke with told us they were not aware of a residents' meeting taking place. We raised this with the registered manager and they acknowledged that they hadn't planned a residents' meeting for a long period of time and they would introduce one.

The registered manager provided us with a questionnaire that had recently been sent to the relatives of people who used the service. However there was no process in place to review the feedback and to address the points raised. People who used the service had not been given a questionnaire or other opportunity to provide formal feedback. We were shown a questionnaire that was currently being devised, however this had not been finalised at the time of the inspection. There was also no process in place to obtain the views of external stakeholders.

During this inspection we saw limited information was available for people throughout the home which explained how they could make a complaint to the members of staff or how that complaint would be investigated. A complaints procedure was available in the conservatory at the front of the home, but where it was placed would prove difficult for some people to access. The complaints procedure was produced in small font and may prove difficult for some people to read. There was no facility in place for family, friends or visitors to make an anonymous suggestion or complaint.

We saw improvements had been made in the way accidents and incidents were recorded and reviewed by the registered manager. The registered manager ensured that recommendations they had made were now implemented and their effectiveness reviewed. The registered manager told us they started to conduct statistical analysis of the incidents that had occurred at the home and planned to

Is the service well-led?

use the information to assist them in identifying potential risks to the people who used the service. However at the time of this inspection the registered manager could not show how the information was currently being used to reduce risk and drive improvement at the home.

Prior to this inspection we checked the statutory notifications that we had received regarding incidents that had occurred at the home and then cross referenced these with records held by the home manager. It was clear that the registered manager was aware of their responsibilities to notify the relevant authorities when incidents had occurred and these were investigated and acted on fully. This meant people who used the service could be assured that the registered manager acted in an open and transparent way with the external regulatory bodies.

The registered manager told us that they had recently put plans in place to improve links with the local community.

Plans were in place to invite the local school to the home's annual Christmas party/fayre and they had also asked the local Scouts group to visit the home and to sing Christmas carols with people.

The staff we spoke with were confident that if they raised a concern with the registered manager that their views would be welcomed and investigated thoroughly.

The management team had a clear understanding of their roles and the responsibilities and how they contributed to the service provided. However, they were unclear of how they would contribute to the future development of the home and to drive improvement. The Provider did not have a business plan in place that enabled the home manager to regularly assess whether agreed goals for the home were being met. The home operated on a day to day basis rather than planning ahead to continually drive improvement.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision
Diagnostic and screening procedures	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.</p> <p>The registered person did not have suitable arrangements in place to identify, assess and manage risks relating to the health, welfare and safety of service users and others.</p> <p>The registered person did not regularly seek the views of service users, person's acting on their behalf and persons who are employed for the purposes of the carrying on of the regulated activity, to enable the registered person to come to an informed view in relation to the standard of care and treatment provided to service users.</p> <p>Regulation 10 (1) (b) (2) (e)</p>