London Residential Healthcare Limited

Cedar View Care Centre

Inspection report

1 Stanhope Road
Croydon
Surrey
CR0 5NS

Tel: 02086810668
Website: www.lrh-homes.com

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Cedar View Care Centre is a residential care home providing personal and nursing care to 41 people at the time of the inspection. The service can normally support up to 65 people over three floors in one purpose-built building, with one floor specialising in providing care to people living with dementia. However, at the time of our inspection the home had temporarily reduced its capacity to a maximum of 46 people due to building work.

People's experience of using this service and what we found
People did not always feel staff had time to talk and listen to them. Staff often carried out routine care tasks without engaging people in conversation or telling them what they were doing. This may have compromised people's dignity. However, when staff spoke to people they were kind and respectful and staff were good at understanding how to support people who were distressed. People did not always feel involved in planning their care, but there was evidence their relatives were involved. Staff gave people choices about their day to day care such as meal choices and personal care routines, and supported people to do as much for themselves as possible.

The provider carried out regular checks of the quality of the service. While some of these were effective, this was not consistent as they had not identified issues we found with care records, care interactions and staff supervision. The registered manager monitored the culture of the service to make sure staff provided care in a person-centred way. They were open and honest and understood their regulatory responsibilities. Staff worked well together and shared information efficiently. The provider invited people, their relatives and staff to give feedback about the service and used this to help them improve the service. The provider worked well with other agencies such as local authorities.

There were enough staff to care for people safely and safe recruitment checks helped ensure they were suitable for the role. Medicines were managed safely. Staff did regular checks to make sure the environment was safe and hygienic. The provider made sure they learned lessons when things went wrong. There were systems to protect people from abuse and foreseeable harm. People had risk assessments about risks that were specific to them. However, some of the risk management plans associated with these did not contain enough detail.

We have made a recommendation about personalising risk assessments.

People's needs were assessed and their care was delivered in line with best practice. Staff received the training they needed. Although nurses did not receive regular one to one meetings to support them, the provider immediately put plans in place to do this. Other staff were well supported. People had the support they needed to access healthcare services and had enough to eat and drink, although feedback about the food was mixed. The home environment was suitably adapted for people's needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way

possible and in their best interests; the policies and systems in the service supported this practice.

People received personalised care based on detailed care plans. Staff knew about people's needs, preferences, likes and dislikes. Although some information in care plans was potentially confusing or out of date the provider was aware this needed improvement and was in the process of resolving the issue. The care people received at the end of their lives took into account their comfort, dignity and previously expressed wishes. People received information in a format they understood. People had opportunities to engage in meaningful activities, socialise and have support with religious needs. The provider was responsive to people's complaints and concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 24 May 2017).

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was well-led.

Details are in our Well-led findings below.

Cedar View Care Centre

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Cedar View Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We looked at the information we held about the service. This included previous inspection reports, records of discussions with the local authority and statutory notifications. Statutory notifications contain information about incidents the provider is required to report to us, such as serious injuries and deaths of people who use the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
During the inspection, we spoke with 16 people who used the service, two people's relatives and eight members of staff including nursing, domestic, care and administrative staff. We also spoke with the registered manager and regional manager. We carried out observations of staff providing care and 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. We reviewed five people's care plans, six people's medicine records and we checked other documentation including staff training and recruitment records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

● Staff regularly checked to make sure the home was safe. For example, they checked call bells worked properly, so people would be able to call for help if they needed it. Fire safety equipment was regularly serviced and in working order. Staff knew what equipment people needed and how to support them safely to use it.

● The provider assessed individual risks to people and put appropriate management plans in place. This included risks associated with falls, developing pressure ulcers or infections, and malnutrition. Staff understood how some health conditions could interact and present a higher risk, such as diabetes increasing the risk of skin breakdown. However, some risk assessments lacked detail. We looked at moving and handling risk assessments for two people who had health issues that may have presented risks around moving and handling. Their moving and handling plans did not take these issues into consideration. This meant risks specific to people were not always taken into account in moving and handling risk management plans.

We recommend that the provider consults appropriate guidance about creating personalised risk management plans.

● The provider considered how to balance managing risks with enhancing people's autonomy and quality of life. For example, they looked at whether it would be safe for one person to use a new piece of furniture that would improve their day to day comfort, and how to reduce the risks they identified.

Using medicines safely

● We observed a nurse giving medicines to people, generally in line with best practice and the provider's policy. This helped to ensure medicines were administered safely. However, on one occasion we observed a nurse giving a person a tablet and leaving before the person had swallowed it. We discussed this with senior staff who agreed there was a risk of people not taking their medicines as prescribed and said they would speak with nurses about this.

● The provider carried out regular checks to make sure people received their medicines as prescribed. We checked medicines stock and administration records, which showed people received the medicines they needed.

● The provider was due to start using electronic medicines records shortly after our inspection, a system which was designed to reduce the probability of human error during medicines administration and recording.

Systems and processes to safeguard people from the risk of abuse

● There were systems to protect people from abuse and ill-treatment. This included a robust system to report and record any allegations or suspicions of abuse. Records showed the provider dealt with such allegations appropriately. Although people gave us mixed feedback about whether they felt safe using the service, nobody expressed any concerns relating to safeguarding.

● Where people presented behaviour that might make them vulnerable to abuse from others, staff took action to protect people. For example, they made sure other people knew certain behaviours were not directed at them.

Staffing and recruitment

● There were enough staff to care for people safely. However, people felt staffing levels meant staff did not have time to spend with them beyond carrying out essential care tasks. One person told us, "They tell you to ring the bell but it doesn't go down well."

● The provider used a standardised tool to measure how many staff were needed based on people's level of dependency. This was reviewed at least monthly to ensure staffing levels were based on current needs. The administrator made sure there were always enough staff on the rota and that those staff were in the home when they needed to be.

● The provider made sure staff were suitable to care for people. There was a robust recruitment process where the provider carried out a number of checks on potential new staff, including criminal record checks and collecting references.

Preventing and controlling infection

● Staff understood their duties in relation to infection control, including the disposal of waste, hand washing and use of personal protective equipment at appropriate times to prevent the spread of infection.

● Staff made sure people understood how to avoid spreading infections. We observed staff supporting people to wash their hands before lunch and explaining to people why this was important.

● The home was visually clean and was free from unpleasant odours. Staff carried out regular checks of cleanliness in the home, including furniture and other items that might harbour dirt or bacteria.

Learning lessons when things go wrong

● The provider had a robust system for recording accidents, incidents and near misses. This allowed them to identify any trends and take appropriate action to prevent things from going wrong again.

● We saw examples of changes the provider had made to the service as a result of learning lessons from when things went wrong. For instance, they had introduced a new system to make sure nurses were aware of which people they should and should not attempt to resuscitate in case of medical emergency.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People had an assessment of their needs before starting to use the service. This included their needs around communication, health and nursing needs, personal care support needs and any behaviour that might challenge the service. This assessment allowed the provider to make a decision on whether the service was able to provide effective care to each person.
- Staff knew how to support people in line with best practice. The registered manager used staff meetings to share updates about current best practice guidance with staff and they had opportunities to discuss how this related to their work.

Staff support: induction, training, skills and experience

- Not all staff received regular supervision. Although most staff had regular one-to-one meetings with their line managers to discuss their work, nurses did not. There was a risk that people were not always cared for by staff who were adequately supported to do their jobs well, although nurses did attend a six-weekly meeting to discuss their practice. We discussed this with the registered manager and deputy manager, who immediately put a plan in place to address the issue.
- Staff had the knowledge and skills they needed to provide safe and appropriate care to people. Most staff were happy with the training they received although some felt further training on dementia would benefit them, and one member of staff told us it was the most thorough training they had had at any workplace. The provider arranged for extra training to take place where they or other agencies identified any gaps in staff knowledge. A domiciliary dentist had recently provided staff with training on oral care and the local authority provided specialist training to meet specific needs of people currently using the service.
- New staff received a thorough induction to make sure they were properly equipped to provide care to people.
- The service had two employees who were assigned as Dementia Champions. They used their additional knowledge and training to support staff to deliver care to people living with dementia, in line with current best practice.

Supporting people to eat and drink enough to maintain a balanced diet

- We received mixed feedback about the quality of food at the service, although most people told us they enjoyed it. One person said, "The food is not good at the moment" but others told us, "The food is good. Everything is good" and "I wish I had soup with lunch. I like soup. Food is otherwise good." The kitchen staff were working with the management team to make meals more enjoyable by regularly consulting with people about what they would like.
- The provider assessed people's needs around eating and drinking and monitored what people ate and

drank to make sure they had enough. Where this identified a cause for concern, staff referred people to appropriate services to support their nutritional needs. If people had specific needs relating to eating and drinking, they had care plans about these to make sure staff had the information they needed.
● Drinks and snacks were available to people throughout the day. People with specific needs around eating and drinking received their meals and drinks in a way that met their needs, such as pureed foods and thickened drinks for people with swallowing difficulties. Staff had a good knowledge of people's food preferences.

Adapting service, design, decoration to meet people's needs
● At the time of our visit the provider was in the process of carrying out renovations to the building and there was a clear improvement plan to make the environment more suitable for people living with dementia. The registered manager told us they were not admitting any new people to the part of the home where the work was being carried out until this was complete. This was to avoid causing distress to people who may be disoriented or upset by the noise of the building work.
● The décor was pleasant and took people's cultural needs into consideration. For example, our inspection took place close to Remembrance Day and the home had a display of poppies. There were also permanent displays reflecting the shops people would have visited, products they may have used and films they may have seen when they were young. This helped promote a feeling of nostalgia and provided prompts for people to talk about their memories.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Staff understood people's health needs and made referrals to healthcare services when needed. They monitored people's health closely, for example by recording people's blood pressure and blood sugar levels, so they would become aware of a deterioration in a person's health early on. Staff were starting to use a new electronic care records system, which flagged up the need for oral health checks when they were due.
● People had the healthcare support they needed. Senior staff reviewed people's involvement with healthcare professionals at regular intervals to make sure appointments were being made and kept when needed and that staff kept up good communication with medical professionals. This helped ensure people received consistent care in line with professional guidance.
● People's care plans also contained advice and guidance people received from other agencies such as healthcare providers. This allowed staff to provide consistent care to people.

Ensuring consent to care and treatment in line with law and guidance
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 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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● The provider followed the principles of the MCA when making decisions about people's care. This included

assessing people's capacity to make or consent to those decisions. Where people did not have capacity, the people who knew them best were involved in the process to help ensure decisions were made in people's best interests.

● When assessments had identified the need to deprive people of their liberty as part of their care, the provider applied for and obtained the appropriate authorisations. These were up to date and the registered manager kept a log of their expiry dates so they could apply for renewal in time.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel they were listened to or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity

- People did not always feel staff took time to talk and listen to them. One person said, "[Staff] talk too much to each other." Another person told us, "They are too busy." A third person said, "I have no-one to talk to" and another person's relative said, "No-one has got time for talking to [my relative]." Throughout the day we observed staff carrying out care tasks without engaging people in conversation, although some staff did this more than others. We fed back these observations to the registered manager, who had been looking at ways to monitor the quality of caring interactions.
- However, staff made an effort to ensure people felt comfortable and at home. We observed staff checking people were comfortable throughout the day. The registered manager told us they had introduced a new policy for staff to wear pyjamas while working at night time, which promoted a homely atmosphere and helped people who experienced disorientation around time of day. The registered manager also encouraged staff to eat with people at mealtimes.
- Staff understood how to meet people's emotional support needs. For example, for people who experienced distress or agitation due to mental health problems, staff knew how to reassure and support them through these difficult experiences.
- Care plans contained detailed information about people's life history, family relationships, personal achievements and interests. This helped staff get to know people and what was important to them. For some people there was information about how long term health conditions had affected them over the years, to help staff better understand them and the support they needed.
- People felt staff were kind and respectful. One person told us, "They are alright here. Nice. Yes, they are kind" and another person said, "They are very kind." We observed staff speaking to people in a calm, friendly and respectful manner. They clearly knew people well and were patient when people took a long time to complete a task.

Supporting people to express their views and be involved in making decisions about their care

- People we spoke with did not feel they were fully involved in planning their care or were not sure if they had been. However, there was evidence staff involved some people and families in planning people's care. They regularly contacted family members, where appropriate, to discuss any changes to people's care plans.
- Staff gave people choices about their day to day care. We observed staff discussing the day's menu choices with people, making sure they understood what their choices were and describing each dish if needed. People were provided with written food and drink menus to choose from if they were able to use these. We also observed staff asking people what they wanted to do and supporting them with their choices.

● People had input into decisions about their healthcare and medical interventions, if they were able to. Staff told us they never assumed people were unable to make decisions just because they were living with dementia or another cognitive impairment. They said they always made an attempt to involve people in decision making despite their level of ability.

Respecting and promoting people's privacy, dignity and independence

● We observed some staff caring for people in ways that promoted dignity, although this was inconsistent. For example, they offered people moist wipes at lunchtime to clean their hands and faces. People told us staff supported them with personal care in a dignified way. However, staff did not always tell people what they were about to do when performing care tasks, such as moving their wheelchairs to a different part of the room or putting protective covers over them so they did not get food on their clothes. Because staff did not always speak to people about what they were doing, people may not have felt included in the process and this compromised their dignity.

● People had personalised continence plans with attention paid to the details of how they wished to be supported with intimate care. This helped staff provide this type of care in a way that promoted dignity.

● Staff provided care that promoted independence. We observed staff encouraging people to do things for themselves, only intervening when people were unable to complete tasks independently. They gave people prompts when needed to help them remember what to do next.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.. This meant there was a risk that people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Staff had the information they needed to provide personalised care that met people's needs. Care plans contained detailed information about how people liked to receive personal care, their preferred routines and how they liked to spend their time. There were also care plans detailing how to use any special equipment people needed. We observed staff supporting people in line with their care plans.
- However, the information in care plans was not always recorded in a way that made it clear when people's needs had changed. Some out of date information was left in care plans after they were updated making it potentially confusing which information was current. For one person, the decision had been made to change the way a care task was performed to avoid causing the person discomfort as their illness progressed, but this was not reflected in their care plan. We discussed this with the clinical lead, who acknowledged the documentation required some improvements. We judged there was no significant risk to people because staff discussed people's changing needs daily at handover meetings and the provider was in the process of introducing a new electronic care records system which would make it clearer which care plans were current. We will check this again at our next inspection.
- The provider considered how best to meet people's needs in terms of comfort and wellbeing. For example, one person was prone to having a dry mouth and their care plan took into consideration the oral care they needed to remain healthy and comfortable. Another person sometimes struggled with psychological discomfort due to mental health needs and the provider had considered how to support them with this, for example looking at how staff could tell when was a good or bad time to ask the person to make a decision about something.
- People's care plans were reviewed regularly, involving those who were familiar with people's individual needs such as healthcare professionals. This helped to ensure the information staff had about people's needs was complete and up to date. One example we saw was for a person whose regular care reviews had identified they seemed to be experiencing more confusion over time and this flagged up the need for further assessments.
- People received support with their cultural and religious needs. This included attending religious services.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Staff knew how to communicate with people in ways they understood. Care plans for people who had

impairments or disabilities affecting their ability to communicate contained details about how they communicated. This looked at both the person's ability to express themselves and their ability to understand what was said to them.

● People received information in suitable formats. Information such as activity plans had pictures so it was easy to understand. The registered manager told us one person, who was blind, liked to read and so staff would read to them.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● The provider considered people's religious and cultural needs as part of their care. This included support for people who no longer had the capacity to communicate what they wanted, and was based on what they had done previously and what their families told staff.

● People told us they enjoyed activities, and we received positive feedback about the activities coordinator whom we observed supporting people in a person centred way. One person told us, "I have enjoyed activities here" and another said, "There is plenty to do. I participate in some [activities]."

● Care plans contained information on people's preferred activities, hobbies and interests to help staff engage them in ways that were meaningful to them. This also took into consideration people's cultural background and life history. The home had a varied activities programme and we saw people engaging in different individual and group activities, such as doing a quiz, reading newspapers and painting nails. We observed staff starting a group discussion by asking people to share their experience of the places they had travelled to in their lives. Staff spoke to us about supporting people to feel they still had a purpose in life.

● The home had adequate space and facilities to allow a range of activities to take place. This included a cinema with a range of films available for people to watch, a pool table and other activity equipment. People confirmed they had opportunities to use these. There were plans for a local theatre group to do a performance at the home soon after our inspection.

● People had the support they needed to maintain relationships. Staff regularly supported people to contact their family members and encouraged relatives to visit the home. Communal areas were set up to facilitate social interaction and we observed staff encouraging people they knew got on well to sit together.

Improving care quality in response to complaints or concerns

● The service was responsive to complaints and concerns. Staff documented any minor concerns raised by people and their families, took action to address the concern and fed back to the person who raised the concern about what they had done. Although one person told us nothing had changed after they complained, the majority of people we spoke with were happy with how the service responded to their concerns and complaints.

● There were robust systems to address complaints and concerns. Where people raised concerns or complaints, senior staff investigated what led to the problem arising and addressed this. For example, one person complained about being disturbed at night by another person, so staff looked at reasons why the person who disturbed them may not have been sleeping well.

End of life care and support

● The provider supported people and their families to consider the care they would wish to receive at the end of their life. This meant they would be able to provide care in a personalised and dignified manner as people approached the end of their lives. End of life care plans contained details such as whom the person wished to be involved, religious and cultural needs and preferences around how and where their care was delivered.

● Senior staff regularly met to discuss and review the care of people who were approaching the end of their lives. This helped to ensure people's needs and preferences were being met and that any additional needs

that arose were considered. For example, when one person was admitted to a hospice staff considered which of their personal belongings would be most important to them so these could be sent in.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager regularly discussed the culture and values of the service with staff. This included issues such as promoting independence, data protection and promoting good care for people living with dementia. The registered manager told us they had been reviewing the culture since they came into post and had made some changes to the staff team as a result.
- People and staff felt the registered manager was open, approachable and caring. One person told us, "I think [the manager] does a good job." Despite this, not all the people we spoke with knew who the manager was. One person said, "I have not spoken to the manager yet. I would like to speak to her." However, the registered manager held regular meetings which people were encouraged to attend, and we observed them during the inspection walking around the home and speaking to people."
- The vision and values of the service were clear. These were reflected in information that was on display for people, staff and visitors to see, helping the provider to promote a cohesive culture.
- Leaders monitored the culture of the service on a regular basis. Staff used the electronic care records system to record the interactions they had with people and the senior staff team regularly checked this and carried out observations in the home to make sure staff were spending time with people. However, the results of these did not agree with what we observed and heard from people during our inspection. People did not feel staff were spending quality time with them, although they fed back that staff performed care tasks well.

Continuous learning and improving care

- The provider had a quality assurance system that allowed them to have a good level of oversight of the service in general. The electronic system sent information about people's care records, incidents and significant events to the provider's compliance team every week. However, the provider's checks did not identify the issues we found with care records, including the lack of personalisation of risk management plans and the out of date information in care plans. This could be a barrier to accurate and efficient sharing of information with other agencies when needed. The provider had also not identified that nurses were not receiving regular supervision.
- Although the service required improvement at the time of our inspection, the provider did have plans in place to make the improvements we saw were needed to care plans. The new electronic care planning and records system the service was trialling was designed to minimise the risk of errors caused by unclear or out of date information and staff fed back that this had been very useful for reliably sharing information among the staff team.

● Senior staff met three times a week with the registered manager to discuss any accidents, incidents, complaints and issues relating to people's care such as pressure ulcers, food and fluid monitoring and making sure people who needed medical appointments had support to attend them. This helped the registered manager continually monitor the quality of care people received and quickly identify any trends in data that might indicate a problem, such as an increase in falls.
● The management team carried out regular checks to make sure the service was meeting essential standards of quality and safety. These included directly checking the quality of care people received, such as looking at people's dining experience and the quality of activities. The provider also looked at how well they were complying with best practice around caring for people living with dementia and had a clear plan for improvement in this area. However, the checks had not identified that people did not always feel they had much meaningful interaction with staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager understood the duty of candour and when they needed to comply with it.
● There was evidence the registered manager spoke with people after things went wrong and was open and honest with them.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● There were clear lines of accountability and staff were clear about their roles. Managers and staff discussed teamwork and how best to work together at staff meetings. The provider also held regular managers' meetings to discuss their services including any ongoing risks and to share good practice ideas.
● Senior staff met three times per week with the registered manager to discuss any new or increased risks to people and how they were managing these risks. Staff also attended daily handover meetings, which they told us were very helpful and helped them understand what they needed to do.
● There were systems to make sure staff were up to date with any information they needed to carry out their roles. The service had introduced an electronic care records system to enable staff to share information quickly and store it securely.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and staff had opportunities to feed back their opinions of the service. Managers consulted staff about planned changes to the service, such as the refurbishment work and their dementia care strategy.
● People were invited to feed back about the quality of care, food, housekeeping, activities and the attitudes of staff at regular residents' meetings. Records showed the provider made changes in response to people's feedback and people were able to feed back about the changes afterwards. Staff also gave examples of changes made in response to their own feedback.
● The service had links with the local community. Local groups were invited into the home to provide activities and religious support.

Working in partnership with others
● The registered manager told us they had a generally good relationship with the local authorities they worked with and were able to work well in partnership with them.
● The local authority's compliance team carried out audits of the service and the registered manager told us they had a good relationship with the compliance team as they found it useful to have an outside perspective on care quality.
● The service worked in partnership with organisations that had expertise in research and best practice in

care for people living with dementia. This included the Alzheimer's Society and a university with a prominent dementia research programme. This helped the provider have a better understanding of how to provide high quality care to people living with dementia.