Life Style Care plc

Cedar Court Care Home

Inspection report

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Date of inspection visit: 8 July 2014
Date of publication: 31/10/2014

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
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

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service. This was an unannounced inspection.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

At our last inspection in October 2013 we found breaches of regulations relating to respecting and involving people, how people's care and welfare needs were met and infection control. Following that inspection the provider sent us an action plan to tell us what improvements they

Summary of findings

were going to make. During this inspection we looked to see if these improvements had been made. Improvements had been made and the breaches were now being met.

Cedar Court is a purpose built nursing home caring for up to 63 people who have care needs associated with physical needs, mental frailty and/or dementia. At the time of our visit 56 people were using the service, most of who were living with dementia. The home is owned and managed by Lifestyle Care.

People told us they were happy at the home. They said they felt well cared for and safe. However we saw one person's care regarding their personal hygiene was not always managed appropriately. We also saw that accurate records were not being maintained in relation to the care provided. However, this did not impact on people's care.

Some people were not appropriately supported to eat their meals and did not always receive the personalised support they needed. We observed some people were left alone at mealtimes when it was clear they needed support to eat and drink. However, other people were supported appropriately.

Throughout our visit we observed caring and supportive relationships between people and care staff. Most people were treated in a caring way that demonstrated a positive caring culture existed in the home.

The registered manager investigated and responded to people's complaints, according to the provider's complaints procedure. All of the people we spoke with knew how to make a complaint.

There were sufficient numbers of appropriately trained staff on duty to support people. The manager had taken steps to reduce staff sickness and we saw from the attendance rota that improvements had been made.

People told us they felt their privacy and dignity were respected and made positive comments about staff. Care staff were able to tell us, and we saw, how they respected people's privacy and promoted their dignity. Activities were enjoyed by people and we saw they were offered choices around activities and people who need it, were given the time to consider these choices.

Infection control concerns we raised at our last inspection had been addressed. The home was clean and free from malodours. Cleaning schedules were in place and were being followed and an infection control champion had been identified. An infection control champion is a member of care staff who receives additional training relating to infection control and acts as a source of information for other staff.

Care staff had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately. At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) application. This is where an application can be made to lawfully deprive a person of their liberties where it is deemed to be in their best interests or for their own safety. We spoke to the manager who told us that in light of the recent Supreme Court judgement they were assessing people with regard to future DoLS applications.

Care staff received training that enabled them to support people. They were also able to gain further training in specialist areas. For example, in dementia care, infection control and end of life care. 15 care workers had signed up to take further care qualifications.

People were supported to maintain good health. People had enough to eat and drink and appropriate referrals were made. For example, to GPs and Speech and Language Therapist (SALT) referrals were made where people were identified as being at risk of choking due to swallowing problems. People received support with regards to their tissue viability. Where people were at risk of pressure sores measures were put in place to reduce and manage the risk.

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?

Good

The service was safe. People we spoke with told us they felt safe. Care staff were aware of their responsibilities regarding reporting concerns.

People were safe from the risks of infection because the service had appropriate measures in place.

The manager was aware of their responsibilities regarding Deprivation of Liberties Safeguards (DoLS) and all staff had received training in the Mental Capacity Act 2005 (MCA). We saw care staff applied their training appropriately.

Is the service effective?

Requires Improvement

The service was not always effective. People who were at risk of pressure sores did not always have their records accurately maintained. However, we saw this did not impact on people's care.

We saw that risks regarding people's mobility were appropriately managed. Where risks to people's care and welfare were identified, appropriate risk assessments and management plans were in place.

People had enough to eat and drink. People were encouraged to eat and drink and snacks were available for people to have when they wanted them.

Is the service caring?

Good

The service was caring. People told us, and we observed, they were treated with kindness and compassion and their dignity was respected. People said, "staff are lovely." "It's nice here."

People were given time to make decisions about their care. We observed care staff talking with people throughout our visit. We saw people were given choices and time to respond to those choices.

We saw that people had been involved in the creation of their care plans. People's histories, preferences, likes and dislikes were recorded and considered.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always receive the support they required. One person did not receive appropriate support with their personal hygiene. This person did not always receive care and treatment in accordance with their needs.

Some people did not receive personalised care. We saw two people who were not supported in a personalised way at mealtimes. One was left asleep throughout the meal, although they were supported to eat when they were awake, and another did not receive the support they needed with their cutlery.

Summary of findings

Complaints were dealt with appropriately and in a timely fashion. People were happy with the outcomes and learning was shared with nursing and care staff.

Regular residents' and relatives' meeting were held. Meetings were recorded and actions from meetings carried forward and completed.

Is the service well-led?

Good

The service was well led. The service had a registered manager who was available to people, relatives and staff. We were told by people and staff the manager was popular with everyone and very approachable. They had been in post since March 2014 and had made many positive changes to the culture and service at the home.

The manager had helped to develop a learning environment by appointing champions. Staff were identified to lead on, and be a point of reference for other staff on specialist areas. Staff specialised and promoted improvements across the service by supporting their colleagues through their specialist knowledge.

Accidents and incidents were recorded and investigated. We saw that any learning from these events was shared to improve the service.

Cedar Court Care Home

Detailed findings

Background to this inspection

We visited this home on 8 July 2014. During the visit we spoke with three people who used the service and four relatives. Most of the people using the service were living with dementia and we were not able to speak with them. We spoke with 11 members of care staff, the activities co-ordinator and the manager. We observed care and support and looked at the kitchen and some people's bedrooms. We looked at a range of records about people's care and how the home was managed.

The inspection team consisted of a lead inspector, one other inspector, a dementia specialist and an expert by experience who had experience of older people's care services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

We used the 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.

Before our inspection, we reviewed the information we held about the home and contacted the commissioners of the service to obtain their views. We also looked at the Provider Information return (PIR). The PIR is a form that asks the provider to give some key information about its service, how it is meeting the five questions, and what improvements they plan to make.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

At our last inspection in October 2013, we were concerned about cleanliness and hygiene at the home. We asked the provider to send us an action plan outlining how they would make improvements. These were to be completed by the end of February 2014. At this visit we found our concerns had been appropriately addressed.

The home was clean, tidy and free from malodours. One relative said "The home is always nice and clean, the [their relative's] room is always clean and tidy, they come in to clean it every day. I have never seen any of the rooms in the home untidy or dirty." One person said "the home is always so clean." The provider had an infection control policy in place that was available to all care workers and domestic staff. Care staff were aware of this policy. Care workers followed hand washing regimes and used protective gloves and aprons when assisting people with personal care. Hand sanitizers were available around the home and hand washing instructions were displayed in toilets. The house keeper had cleaning schedules that domestic staff followed to clean the home and an "infection control champion" had been appointed. An infection control champion is a member of care staff who is appointed as a point of reference for other care workers with regards to matters concerning infection control. Care and domestic staff knew who the infection control champion was.

People told us they felt safe and did not have any concerns. One person said "I feel very safe here; they treat me very respectfully, particularly with personal care." Relatives we spoke with told us they had no concerns about safety at the home. One told us "My relative is quite safe, never any reason to think otherwise. My relative is looked after very well." Another said "definitely quite safe."

Staff told us, and records confirmed, they had received training in safeguarding vulnerable adults. Care staff knew who they should report any concerns or suspicions of abuse to. They were confident senior staff would take action. Senior staff we spoke with were aware of their responsibilities regarding reporting safeguarding.

There were sufficient staff on duty to provide care and support to people to meet their needs. The manager told us staffing levels were based on people's needs and the skills of the staff group. We observed that call buzzers were answered promptly and care staff were not rushed in their duties. We looked at the duty roster and saw that planned staffing levels were maintained. However, we saw from the roster that staff sickness at weekends had historically been a regular occurrence. The manager told us they had taken action to address this and staff sickness had reduced. The staff attendance roster confirmed this.

Care staff were recruited and selected appropriately. We looked at four care staff files and saw that they contained their work histories. Where there were gaps in work histories we saw that this was investigated. References had been sought, one being from the most recent previous employer. Criminal Records Bureau (CRB) and Disclosure and Barring Service (DBS) checks had been conducted. These are agencies who maintain criminal records and allows providers to check staffs previous histories. Care staff had received training that allowed them to support people safely. For example, in infection control, moving and handling and dementia care. We observed care staff supporting people appropriately and putting their training into practice. For example, two care staff hoisted a person into an armchair from a wheelchair. This was completed in a safe, caring and appropriate fashion. This meant care staff were suitable and trained to keep people safe and meet their needs.

Risks were appropriately managed. Where risks were identified appropriate risk assessments and management plans were in place. For example, risks to people's skin from pressure damage and to people's mobility. Risks were identified and measures were put in place to reduce the risk. All risk assessments were reviewed every month or as circumstances changed. We saw that appropriate actions in relation to the evaluations had been taken.

People were not being deprived of their liberties. At the time of our visit no one was subject to a Deprivation of Liberty Safeguards (DoLS) application. This is where a person can be lawfully deprived of their liberties where it is deemed to be in their best interests or their own safety. We spoke to the manager who told us they were considering the new guidance in relation to DoLS to determine if applications were needed. Care and nursing staff had knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Care staff told us that they had received training in these areas. We saw people were supported to make decisions for themselves. For example, in one care plan it was noted the person did not like to wear their dentures. Care staff were advised to

Good

Is the service safe?

encourage the person to wear them at mealtimes but they were reminded it was the person's decision. We looked at the training records and confirmed care staff had been trained in DoLS and the MCA.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we found concerns regarding how people's care and welfare needs were met and how people were involved in their care. We asked the provider to send us an action plan outlining how they would make improvements. At this visit we found those concerns had been addressed.

At this visit we found that care staff were not consistently recording information in people's care plans. We looked at the care plans for all three people who had pressure ulcers. Care workers were able to tell us the support these people needed and we saw pressure relieving equipment was in place. However, the documents for recording when people were repositioned to help prevent skin damage were not maintained consistently. We spoke with three care staff who knew which people needed assistance to reposition. They told us this happened, but it wasn't always documented. One member of the care staff said, "we do turn them, but records don't always get kept." Another said, "I'm not confident it always gets recorded." Whilst we saw this did not impact on people's care and their condition was improving, this showed us an accurate record of their care was not always maintained as it should be.

Risks regarding people's mobility were appropriately managed. People were assessed prior to any care being provided and, where risks were identified, risk assessments were in place. We looked at one risk assessment for a person who required hoisting for all transfers as they were immobile. Clear instructions on moving and handling procedures for this person were listed along with photographs to show how the person was to be safely positioned. We saw two care workers were required to assist this person and the training records confirmed that all care workers had been appropriately trained. Care staff confirmed they were aware of this and were following the instructions.

The GP visited the service twice a week and appropriate referrals to healthcare specialists were made. For example, we saw referrals to the tissue viability specialists. Tissue viability specialists provide advice and guidance in relation to the risks associated with pressure ulcers and their treatment. We contacted an Oxfordshire Health tissue viability specialist and asked them about the service and how they managed risks. They said "at one point we had a lot of referrals which were not complex. We discussed this with the home and this has now reduced". This meant referrals were being made appropriately for people when they needed assessing and support with pressure care.

People had enough to eat and drink throughout the day. Snacks were available between meals and finger foods such as biscuits and crisps were left in accessible places in the dining rooms for people to help themselves. Menus were displayed and people were given choices about what they wanted to eat at every meal. People were given a choice of drinks and salt and pepper was available to be used if they wanted. When people had finished their meal we saw care staff asked people if they wanted more.

People were observed by staff for signs of difficulty in swallowing. This can accompany some medical conditions. One person was at risk of choking. Care staff had made referrals to the GP and the Speech and Language Therapist (SALT) who provided assessment, advice and guidance in relation to people's swallowing. The SALT had made recommendations to support this person to swallow safely. We saw care staff following these recommendations. For example, thickened fluids and pureed foods were given as prescribed by the SALT. Pureed meals were prepared in a way that was appealing to the person and each portion was presented separately on the plate. The chef was aware of this person's needs and their diet sheet in the kitchen reflected the SALT recommendations.

Where people were at risk of weight loss they were assessed using a Malnutrition Universal Screening Tool (MUST). This tool enabled nursing staff to assess the risk to the person and monitor and manage their weight and condition. One person had been at risk of losing weight and a referral was made to the GP. Their recommendations were being followed and the person was weighed every month. We saw the person had gained weight.

Care workers received an induction before starting work at the home. This included training in safeguarding vulnerable adults, medication, infection control, moving and handling, dementia care and the Mental Capacity Act (MCA). Where people are living with dementia the act provides protection in relation to choices and decisions about the person, their best interests and whether they are able to make those choices for themselves. The induction programme was linked to "Skills for Care". This meant care workers were trained to nationally recognised common induction standards.

Requires Improvement

Is the service effective?

Further training was also available to care workers such as end of life care and National Vocational Qualifications (NVQ) in care and Diploma In Health and Social Care. The training records showed 15 care workers had signed up to take further care qualifications. Care staff said they had access to the training they needed to meet people's needs. One said, "there is lots of training and you can request additional training. I've just finished my NVQ 3." The newly appointed manager had a plan for sharing best practice between staff. For example, one care worker had been appointed as "dementia lead" and had received specialist training in dementia. This member of staff was also planning to start a teachers training course. There were plans to make connections with the Alzheimer's Society. They told us this would allow them to provide extra dementia training for care staff in addition to the training currently provided. This was part of the manager's plans for further training for staff.

The home was decorated in soft calming colours. This gave the home a warm and calm atmosphere that was of benefit to people living with dementia. Corridors were free from clutter to help reduce the risk of people falling. The doors to people's rooms were painted in different colours so that doorways stood out to help people recognise and use the doorway. Lounges and communal rooms were furnished with pictures, paintings and prints on the walls. This gave the home a homely feel. Some lounges on the dementia unit had sensory stimulating mobile's hanging from lights. The mobiles reflected light and we saw people touching them which changed the reflected light patterns. This showed us people's sensory stimulation needs were considered.

People's rooms were personalised with photographs, ornaments and other personal items. We saw "reminiscence rooms" at the home. These rooms were decorated and furnished in period style. For example, with old style sideboards and chairs with dial telephones, typewriters and gramophones on display. These objects presented opportunities for people to touch or use if they wished. The objects might be familiar to people and could stimulate memories from their past, or help people to have conversations. Music from the 40s and 50s was played in the rooms and we saw one person sitting in the room. They were listening to the music and looking at an old picture book. We asked the person if they knew the song being played and they smiled and nodded. Care staff told us the room was regularly used and popular with people.

Good

Is the service caring?

Our findings

At our last inspection in October 2013, we were concerned about how people were respected and were not involved in their care. We also found concerns around interactions between people and care staff, particularly on the dementia unit relating to dignity and involvement. We asked the provider to send us an action plan outlining how they would make improvements. At this visit we found our concerns had been addressed and care on the dementia unit had improved considerably.

People said they felt well cared for. One person said "If you have any concerns they listen to you and take on board what you say. When I ring my bell at night they come very quickly within minutes. They are very respectful; they don't disturb you if you don't want to be disturbed. "Another said "they are very good, very kind. Whatever I ask, they do. They talk to me about how I'm getting on. I can be as private as I want". A relative said "from what I've seen they treat people with dignity and respect". A healthcare professional said "I find we have good communications with the home and people are treated well". We saw one person required assistance with personal care. We observed that care staff went to assist this person. As they went into the person's room we saw that they shut the door. We spoke with the care staff who said, "when I provide personal care, I ensure the person's door is shut and curtains are closed. I also make sure that people are covered up when we provide personal care." We saw that "Do not disturb" signs were available for people to use. This meant privacy could be controlled and maintained.

People told us they were treated with kindness and compassion and their dignity was respected. They said, "staff are lovely, It's nice here." We observed that care workers knocked on people's doors before entering rooms. We saw that care staff took time to talk. For example, we observed care staff spent time talking to one person and then gave them assistance with a drink. They talked with the person about their life and where they had lived. The person appeared happy talking with care staff. This interaction was typical of the many positive interactions we saw through the day. Some people needed hoisting. Care staff ensured this was carried out with regard to people's dignity and in a thoughtful and reassuring manner.

People had been involved in writing their care plans. People's personal history and preferences were listed and their preferred names were noted at the front of each plan. Care workers used people's preferred names in a respectful manner. In one person's care plan we noted they had a preference for scotch eggs. We spoke with this person who told us "I asked for more scotch eggs at meal times, they did it for me."

Care plans recorded people's end of life care wishes. For example, one person had stated "I would like to live a normal life as possible. I do not want to be alone." Another had stated "I want to be cremated". Where people lacked capacity we saw evidence their best interests had been considered and a relative or an advocate had been involved in the decision making.

People could make decisions about their care. One person had been actively involved in decisions about their care and support. The person had requested bedrails were fitted to their bed as it helped them feel safe and secure. Bedrails are usually fitted where there is a risk the person may roll out of bed. In this instance this was not the case. In certain circumstances, bedrails can pose their own risks. For example, people can trap their limbs or injure themselves on the rails. An appropriate risk assessment was in place and had been regularly reviewed. This ensured the risk was minimised and the person was safe. The person had signed their plan to give consent to bedrails being fitted.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive the personalised support they needed. We saw one person was given their lunch but was asleep. Staff told us this person usually slept through lunch and had their meal later in the day. We were not concerned that this person was not getting enough to eat. However, bringing the person to the dining room to eat when they were not ready to eat showed that staff had not provided a type of support that was centred around the person, and not the routines of the home. Another person did not receive personalised care. The person did not recognise that they had cutlery because the knife, fork and spoon were wrapped in a paper towel. We saw that this person struggled to understand that the cutlery was inside the paper towel, and were therefore unable to use their cutlery. They received no support from care workers. The paper towel eventually broke and the person used the fork and spoon and was happy eating their meal. This person needed their cutlery individually laid out in a more traditional manner. We saw in the other dining areas people were being supported appropriately.

Care staff told us about one person who refused assistance with their personal hygiene. They told us one care worker had easily been able to support this person but they had been moved to a different part of the home. Other staff struggled to support this person because they resisted them. Their relative was unhappy with this aspect of their support. The way the care was organised for this person was not personalised. We spoke to the manager about this. They said they would return the care worker who effectively supported the person to their floor. Following our visit we received an email from the manager stating that the care worker who used to support this person effectively had been moved back to support them and the person was receiving and accepting personal care.

There were two activities co-ordinators who organised and led activities in the home. Notice boards around the home displayed forthcoming activities and events. People and relative's told us about the activities. One relative said "There are plenty of activities, bingo as well. There are as much activities here that they can cope with". One person said "They advise about activities through the newsletter and it's on the board. I take part in dominoes, crosswords and bingo, that's at least once a month. We put forward ideas for the Gardening Club. A lady singer comes once a month. We also have a library service once a fortnight". The activities co-ordinator told us activities were popular in the home. They said "I try to fit activities to suit people. Whatever is popular at the time. Because of the nice weather flower arranging in the garden has been popular so we try to organise that as often as we can." Another activities co-ordinator told us about activities for people living with dementia. They said "we tend to do more one to one activities with people with dementia. This holds their attention better." We observed the activities co-ordinator with one person. They were reading a picture book with them. The person was fully engaged in the activity and appeared to be enjoying the experience.

Regular religious services were held and we were told by the activities co-ordinator that where people could not attend the visiting cleric would go to the person's room if they wanted. One person's care plan stated that they liked to attend group services but could not always attend because they could become anxious. A care worker told us, "they have always followed religion. They can get anxious in groups. So we monitor each time. If they can't go to the service then we ensure they have a one to one service in their room. This is important to them and they are happy when they see the vicar." Religious services were advertised in the monthly newsletter. We saw the July newsletter which stated "Services are held in the Woodland lounge at 2.30 pm. All are welcome." One person we spoke with said "I never miss the church services, I really enjoy them."

People said they knew how to complain. One person said "I have complained in the past but things are much better now." Another said "I made a complaint about two girls leaving me sitting in bed all morning. They did sort it out. I was much happier afterwards." The provider had a complaints policy that was displayed in public areas around the home and was contained in the "service user's guide" given to all people who used the service. We looked at the complaints file and saw that there had been 14 complaints recorded since January 2014. All complaints had been resolved in line with the policy. Care staff told us that they were aware of the policy and could help people, particularly those living with dementia, to raise a concern.

"Residents and Relative's" meetings were regularly held and minutes were recorded. Records showed these were attended by both people and their relatives. An agenda was provided for the meeting and one item was entitled

Requires Improvement

Is the service responsive?

"Improvements you would like to see". One relative had asked for a GP to visit and give a talk about dementia and short term memory loss. The manager told us that this talk had been arranged for September 2014.

We spoke with community professionals who worked in partnership with the service. We asked them if the service was responsive to people's needs. One told us about an incident where a person who used the service became very distressed during an interview with a social worker. Following this, discussions were held to see how this could be avoided in the future. The community professional said "we had a debrief and shared learning from it. I found them [the manager] frank and open and we were able to take learning from both sides". They went on to say the service "was fully on board on working really closely with us and building good working relationships and mutual support". This showed us the service worked openly and honestly with community professionals and took learning from people's experiences.

Good

Is the service well-led?

Our findings

The service had a registered manager who was available to people, relatives and staff. We were told by people who used the service and staff, the manager was popular with everyone and very approachable. They had been in post since March 2014 and had made many positive changes to the culture and service at the home. One relative said "I have complained in the past but not with the new manager. Things are much better now". One member of care staff said things had improved at the home. They said "the manager has made a big difference. They are very supportive. Staff sickness is going down and we are better informed than we were before". Another care staff member said "I feel confident to go to the manager if needed; things have really improved here since the manager came. They are really improving things, like training and staffing."

Accidents and incidents were recorded and investigated. We looked at one accident where the person was found, uninjured, on the floor of their room. The fall was not witnessed. They were referred to the care home support team. The care home support team specialise in falls prevention and offer advice to care homes in the Oxfordshire area. The investigation concluded that as the person was independent and the fall unforeseen, no changes to their care were necessary. However we noted that the person's care plan was reviewed and updated. A monthly analysis of all accidents and incidents was collated and sent to the head office. The manager told us the information was analysed to identify patterns and trends across the service. We saw the results were fed back to the manager who passed on learning to care staff through the nurse's and the health and safety meetings.

There were systems in place to audit the quality of care provided and to identify risks. These included audits of medicines, care plans, risk assessments, infection control and dignity. The manager told us that the process for creating action plans from audit results was not yet in place. They were planning to introduce a new "quality audit system" that would capture information and allow improved analysis of the results by the manager and head office. This would improve both internal and external governance of the service.

The manager had helped to develop a learning environment by appointing champions. Staff were identified to lead on, and be a point of reference for other staff on specialist areas. For example, infection control, dementia, dignity and safeguarding. Where necessary these staff received specialist training in their area and were able to pass on knowledge and advice to other staff. Staff were empowered to specialise and promote improvements across the service by supporting their colleagues through their specialist knowledge. For example, since our last visit, interactions between people living with dementia and care staff had improved.

The manager enabled open and transparent communication. Regular meetings were held with people who used the service, their relative's and staff. Staff meetings were held every three months. The manager said these were designed to share learning with the staff. Care staff were encouraged to reflect on events, such as safeguarding alerts and areas for improvement were highlighted. Recently staff discussed introducing an infection control champion to act as a point of reference and knowledge for care staff on matters relating to infection control. A member of care staff told us about the staff meetings and how information is shared and discussed. They said "we talked about the infection control champion at the last meeting." Another said "I think this service is open and honest. There is an open door policy with the manager which is great."

We saw a whistle blowing policy that was available to all staff and details of how to whistle blow were posted on staff notice boards. Care staff we spoke with were aware of the policy. One said "I know I can report anything I have concerns about." The policy contained contact details for the local authorities and the Care Quality Commission."

We saw there were plans for dealing with emergencies, such as an outbreak of fire. The home suffered a recent fire in the boiler room and the evacuation plan was followed. Reports from community professionals and the fire service praised the home for its prompt action in dealing with the fire. The incident was dealt with quickly and the home shortly returned to normal operations.