2026

delphi care solutions

Tandridge Heights

Mock Inspection

Report and Improvement Plan

Date: 26th June 2026

Scope

Delphi Care Solutions was commissioned to complete an independent, evidence-based mock inspection of Tandridge Heights.

Delphi completed the mock inspection on 23rd-24th June 2026, with all work carried out on a face-to-face/on-site basis.

During the mock inspection, we identified good practices and potential areas for improvement. Throughout the day, we shared high-level feedback on these findings with the home manager.

This report provides comprehensive details of our findings and includes our recommendations. It is our opinion that if the Care Quality Commission (CQC) were to inspect on the days of our mock inspection, the ratings for Tandridge Heights would be as follows:

CQC KEY LINES OF ENQUIRY					
Safe 72/32 = 72%	**Effective** 18/24 = 75%	**Caring** 15/20 = 75%	**Responsive** 21/28= 75%	**Well-Led** 21/28 = 75%	**Overall Rating**
Good ●	**Good** ●	**Good** ●	**Good** ●	**Good** ●	**Good** ●

Rating

CQC Quality Statements scoring system:
4 = Evidence shows an exceptional standard.
3 = Evidence shows a good standard.
2 = Evidence shows some shortfalls.
1 = Evidence shows significant shortfalls.

We use these thresholds to convert percentages to scores:

- over 87% = **4**.
- 63% to 87% = **3**.
- 39% to 62% = **2**.
- 25% to 38% = **1**.

R/A/G Rating

The Red/Amber/Green (RAG) rating below provides a visual representation of the key areas to focus on in the improvement plan. This report sets out the findings of the mock inspection, using the Single Assessment Framework and Quality Statements methodology used by the CQC at the time of our mock inspection.

Complaints	Accidents Incidents	Fire Safety	Safeguarding	Supervision
●	●	●	●	●
Training	**Staff Files**	**Staff Rotas**	**Medication**	**Audits and Governance**
●	●	●	●	●
H&S Audits	**Medication Audits**	**Infection Control**	**Environment**	**Care Planning**
●	●	●	●	●
Specific Assessments	**General Risk Assessment**	**Daily Notes**	**Quality Monitoring**	**MCA**
●	●	●	●	●
Activities	**Policy and Procedures**	**Whistleblowing**	**Culture**	**Person Centred Care**
●	●	●	●	●

SAFE: Score Range 1 – 4 per area (maximum Score 32)								Total score
Learning Culture **SCORE: 3**	Safe Systems, Pathways and Transitions **SCORE: 3**	Safeguarding **SCORE: 3**	Involving People to Manage Risks **SCORE: 3**	Safe Environments **SCORE: 2**	Safe and Effective Staffing **SCORE: 3**	Infection Prevention and Control **SCORE: 3**	Medicines Optimisation **SCORE: 3**	**23/32** **72%**
EFFECTIVE: Score Range 1 – 4 per area (maximum Score 24)								
Assessing Need **SCORE: 3**	Delivering Evidence Based Care and Treatment **SCORE: 3**	How Staff Teams and Services Work Together **SCORE: 3**	Supporting People to Live Healthier Lives **SCORE: 3**	Monitoring and Improving Outcomes **SCORE: 3**	Consent to Care and Treatment **SCORE: 3**			**18/24** **75%**
CARING: Score Range 1 – 4 per area (maximum Score 20)								
Kindness Compassion and Dignity **SCORE: 3**	Treating People as Individuals **SCORE: 3**	Independence Choice and Control **SCORE: 3**	Responding to Peoples Immediate Needs **SCORE: 3**	Workforce Wellbeing and Enablement **SCORE: 3**				**15/20** **75%**
RESPONSIVE: Score Range 1 – 4 per area (maximum Score 28)								
Person Centred Care **SCORE: 3**	Care Provision Integration and Continuity **SCORE: 3**	Providing Information **SCORE: 3**	Listening to and Involving People **SCORE: 3**	Equity in Access **SCORE: 3**	Equity in Experience and Outcomes **SCORE: 3**	Planning for the future **SCORE: 3**		**21/28** **75%**
WELL-LED: Score Range 1 – 4 per area (maximum Score 28)								
Shared Direction and Culture **SCORE: 3**	Capable Compassionate and Inclusive Leaders **SCORE: 3**	Freedom to Speak Up **SCORE: 3**	Workforce Equality Diversity and Inclusion **SCORE: 3**	Governance Management and Sustainability **SCORE: 3**	Partnership and Communities **SCORE: 3**	Learning Improvement and Innovation **SCORE: 3**	Environmental Sustainability/ Sustainable Development **N/A**	**21/28** **75%**

Overview

We carried out an unannounced on-site mock inspection at Tandridge Heights.

The home was most recently inspected by the CQC in January 2026, with the report published on 9 February 2026, where it received a Requires Improvement rating overall; with Requires Improvement in Safe, Good in Effective, Requires Improvement in Caring, Good in Responsive, and Requires Improvement in Well-Led.

The home is registered with the CQC to carry out the following legally regulated service for a maximum of 75 people:

- Accommodation, nursing and personal care.

At the time of our mock inspection, 67 people were living at the home. The home's staff refer to those living at the home as "supported people," and this terminology is used throughout this report.

Safe

Learning culture: Score 3

People and staff experienced a positive culture in which safety was openly discussed, and staff told us they felt confident raising concerns, reporting incidents, and discussing mistakes without fear of blame. Staff described managers as approachable and said incidents were reviewed promptly, with learning shared across the home to reduce the likelihood of recurrence.

Accidents, incidents and complaints were recorded and reviewed by the management team to identify themes, trends and opportunities for improvement. We saw evidence that incidents were investigated and actions taken where required, with learning shared through daily stand-up meetings, staff huddles, clinical governance meetings and wider team communications. Staff consistently reported receiving feedback after incidents and understood how practice changes were communicated. One member of staff told us, "Incidents are investigated promptly by our manager. Our senior staff on shift will communicate any changes if there are any."

Leaders demonstrated that learning was used to improve people's safety. For example, following repeated falls involving a person who attempted to transfer independently from their wheelchair, a sensor was introduced to alert staff when the person attempted to stand, enabling staff to respond quickly whilst supporting the person's independence. Staff were able to describe similar examples in which risk assessments, observation levels, and care approaches were reviewed following incidents to reduce future risks.

Daily clinical discussions and monthly governance meetings provided opportunities to review incidents, safeguarding concerns and complaints, helping leaders identify emerging themes and monitor whether improvements had been effective. This demonstrated a culture in which learning was part of everyday practice rather than limited to individual incidents.

Although there were clear arrangements for sharing learning, records of staff meetings did not always consistently evidence structured discussion of wider organisational themes or safeguarding learning. Further strengthening the recording of these discussions would provide additional assurance that learning continues to be embedded consistently across all staff groups.

Safe systems, pathways, and transitions: Score 3

People experienced safe and coordinated care because systems were in place to support effective communication, partnership working and continuity of care throughout their time at the service. Staff worked collaboratively with people, relatives and external healthcare professionals to ensure care was planned, reviewed and adapted as people's needs changed.

Pre-admission assessments were completed before people moved into the service to ensure their needs could be met safely. Information was gathered from people, relatives, hospitals and other professionals to develop an understanding of people's health, nursing needs, risks and equipment requirements before admission. This helped staff prepare for people's arrival and supported safe transitions into the home.

People's changing needs were discussed through daily clinical meetings, shift handovers and weekly GP ward rounds, ensuring information was shared promptly between staff and external professionals. Care plans and risk assessments were updated following changes to people's health or treatment, supporting continuity of care and reducing the risk of important information being lost during transitions between services.

The service maintained positive working relationships with GPs, community nursing teams, speech and language therapists, physiotherapists and other specialist services. Professional advice was reflected within care plans, and staff were able to explain how recommendations were implemented in practice to support people's safety and wellbeing.

Systems were also in place to manage complaints and gather feedback from people, relatives and professionals. Information from complaints, incidents, and safeguarding concerns was reviewed alongside feedback from meetings and surveys to identify opportunities for improvement, complementing the service's wider learning culture and supporting continuous safety improvements.

Safeguarding: Score 3

People were protected from the risk of abuse, neglect and discrimination because safeguarding arrangements were well established and understood by staff. People and relatives told us they felt safe living at the home and were confident they could raise concerns if needed. Staff demonstrated a good understanding of the different types of abuse, the signs that may indicate a safeguarding concern and the action they would take to protect people.

The provider had safeguarding policies and procedures which reflected local authority arrangements and national guidance. Training records confirmed staff had completed safeguarding training appropriate to their roles, and staff were able to explain the internal and external reporting processes, including when concerns should be referred to the local authority and other relevant agencies. Safeguarding concerns were appropriately recorded, investigated and escalated where required, with outcomes monitored by the management team.

Leaders worked effectively with partner organisations to protect people from harm. Records demonstrated that safeguarding referrals were made appropriately, actions were followed through, and learning was incorporated into care planning, risk assessments, and wider service improvements where required. This complemented the service's learning culture, ensuring that safeguarding concerns contributed to ongoing improvements in practice and people's safety.

The service worked in accordance with the principles of the Mental Capacity Act 2005. Deprivation of Liberty Safeguards authorisations had been applied for where required, and we saw evidence of decision-specific mental capacity assessments and best-interest decisions where people lacked capacity to make particular decisions. Staff understood their responsibilities under the Mental Capacity Act and were able to describe how they supported people to make their own decisions wherever possible, whilst protecting their rights.

Information was available to support people and visitors to understand how to raise safeguarding concerns, and people were supported to access advocacy where appropriate. These arrangements promoted an open culture in which people were encouraged to speak up, and concerns could be identified and addressed promptly.

Involving people to manage risks: Score 3.

People were involved in decisions about managing risks associated with their care and support, and told us they felt safe living at the home. People we spoke with explained how staff supported them to remain safe whilst maintaining their independence, and several showed us their pendant alarms and described how they used them to summon assistance when required. People told us that the staff responded promptly when they requested support.

We reviewed six people's care records and found that risk assessments were person-centred and reflected each person's individual needs, preferences and abilities. Risks relating to falls, mobility, nutrition and hydration, skin integrity, choking, diabetes, catheter care, and behaviours of distress were clearly identified where applicable, with corresponding care plans providing staff with guidance on how to manage these risks safely. Risk assessments were reviewed following changes in people's health, incidents and advice from healthcare professionals, demonstrating that risk management remained responsive to people's changing needs.

Records demonstrated that people were supported to manage ongoing health risks through appropriate monitoring where required. For example, people at risk of constipation had bowel monitoring records in place alongside clear guidance for staff, and catheter care records included monitoring of urine colour and output to support the early identification of potential deterioration. We also saw individual distress care plans, which provided staff with person-centred guidance to help reduce anxiety whilst protecting people's dignity and wellbeing.

Staff demonstrated a good understanding of people's individual risks and described how they balanced positive risk-taking with maintaining people's safety. People were encouraged to remain as independent as possible whilst appropriate control measures, such as mobility equipment, sensor technology and regular wellbeing observations, were implemented where required. This reflected the service's wider approach to involving people in decisions about their care whilst promoting choice and independence.

One person who retained capacity lacked a risk assessment regarding smoking, alongside the use of prescribed emollient creams.

Safe environments: Score 2

People received care in an environment that was generally safe and supported by a range of systems to monitor the premises and equipment. We reviewed health and safety documentation, including the Health and Safety Policy, fire risk assessment, environmental risk assessment, gas and electrical safety certification and servicing records. Routine environmental checks, health and safety audits and planned maintenance programmes were in place, demonstrating that leaders had established systems to support the safe management of the environment.

During our inspection, we observed the home to be clean, well-maintained and appropriately adapted to meet people's needs. Equipment had been serviced in accordance with statutory requirements, and records demonstrated regular testing of fire safety systems, emergency lighting, call bells and water temperatures. Staff understood how to report environmental concerns, and maintenance issues were responded to promptly.

Despite these positive findings, we identified several areas where environmental oversight could be strengthened. One fire extinguisher located within the ground-floor lounge was not secured to the wall; the COSHH cupboard did not fully lock due to the door catching on the floor; and the lounge refrigerator required further cleaning. Whilst these issues did not present an immediate risk to people, they indicated that routine environmental checks had not identified all areas requiring attention.

We also found items within the burns first aid kit had expired during 2024 and were not included in routine first aid equipment checks. In addition, there was no emergency eyewash station available within the laundry despite staff routinely handling hazardous cleaning chemicals.

Overall, systems to maintain a safe environment were well established; however, greater attention to detail during routine environmental monitoring would strengthen assurance that all equipment, facilities and safety arrangements continue to support the delivery of safe care.

Safe and effective staffing: Score 3

People were supported by enough suitably skilled and competent staff to meet their needs safely. People and relatives told us staff were available when required, and during our inspection, we observed staff responding promptly to people's requests for assistance. Staffing levels were planned to use the provider's dependency tool and reviewed regularly to ensure staffing reflected people's assessed needs.

Recruitment processes were robust and supported safe recruitment practices. We reviewed staff recruitment records and found that appropriate pre-employment checks had been completed before staff commenced employment, including Disclosure and Barring Service (DBS) checks, proof of identity, right-to-work documentation, employment history, and suitable references.

Staff received an induction appropriate to their role and completed mandatory and role-specific training to support them in providing safe care. Training records demonstrated good compliance across mandatory subjects, and competency assessments had been completed for higher-risk tasks, including medicines administration, catheter care and the application of prescribed creams. Staff told us they

received regular supervision and annual appraisals, enabling them to reflect on their practice and identify further development needs.

Leaders monitored staffing levels through daily oversight and dependency reviews and had recently introduced an additional 9:00 am to 3:00 pm shift to strengthen support during the busiest periods of the day. The service also utilised an internal bank of staff to minimise agency use and maintain continuity of care. Leaders demonstrated ongoing review of staffing arrangements and had identified recruitment of an additional clinical nurse as part of their workforce planning.

Overall, staffing arrangements provided assurance that people received safe, timely and consistent care from staff who had the appropriate knowledge, skills and support to undertake their roles safely.

Infection prevention and control: Score 3

People were protected from the risk of infection because the provider had effective systems in place to prevent, identify and manage infection risks. Staff followed current infection prevention and control (IPC) guidance, and people told us the home was clean and well-maintained.

The provider had an up-to-date IPC policy supported by regular audits, cleaning schedules and staff training. Roles and responsibilities for infection prevention were clearly defined, and staff demonstrated a good understanding of standard infection control precautions, including the appropriate use of personal protective equipment (PPE), hand hygiene and the safe management of clinical waste and laundry.

We observed the home to be visibly clean throughout the inspection. Cleaning records were completed consistently, colour-coded cleaning equipment was used appropriately, and equipment was stored safely. Information on individual infection risks, including barrier nursing requirements where applicable, was documented in people's care records and communicated through daily handovers to ensure staff were aware of the precautions required to protect people.

The provider had arrangements in place to respond to infectious outbreaks, with guidance available to staff and clear communication processes with healthcare professionals and other agencies, as required. Regular IPC audits and environmental checks demonstrated ongoing oversight of infection prevention arrangements.

Although IPC systems were well established, we identified that the refrigerator located within the ground-floor lounge required further cleaning. Whilst this did not pose an immediate risk to people, it indicated that routine environmental monitoring had not identified this issue and that it should be strengthened to provide additional assurance that all areas of the home continue to meet expected hygiene standards.

Medicines optimisation: Score 3

Medicines management had improved significantly since the previous CQC inspection, during which concerns were identified regarding medicines administration, storage, documentation, and governance. During this inspection, we found the provider had taken appropriate action to strengthen medicines systems and embed safer practice across the service.

People received their medicines safely and in accordance with their assessed needs and preferences. We observed medicines being administered safely and found that staff followed the provider's

medicines policy and current best practice guidance. Medicines Administration Records (MARs) were completed accurately and fully, and reflected the prescribed treatment. We found no evidence of omitted signatures, inaccurate recording or delays in medicine administration.

Medicines requiring additional controls, including controlled drugs, were stored securely, with stock balances accurately reflecting the controlled drugs register. Storage temperatures were monitored appropriately, and records demonstrated prompt action where required. We also found that the medicine rooms, trolleys, and cupboards were secure throughout the inspection, addressing concerns identified during the previous inspection.

We reviewed 12 people's care records and found that the information on medicines was consistent with prescribing instructions and individual care needs. Where people received 'when required' (PRN) medicines, clear protocols were available to guide staff on when to administer them. Appropriate documentation was also in place for situations requiring covert administration or additional monitoring, ensuring decisions were made in line with current legislation and best practice. Pain assessment tools were available where people were unable to communicate pain verbally, enabling staff to monitor the effectiveness of prescribed treatment.

Staff responsible for administering medicines had completed medicines training and competency assessments before administering medicines independently. Medicine audits were conducted routinely and demonstrated effective oversight, with findings reviewed to identify learning opportunities and support continuous improvement.

Overall, we found the provider had responded positively to the concerns identified at the previous inspection. Governance arrangements had been strengthened, medicines were managed safely and consistently, and improvements appeared to be embedded into day-to-day practice, providing assurance that people received their medicines safely and as prescribed.

Effective

Assessing need: Score 3

People's health, care, wellbeing and communication needs were assessed before they moved into the service to ensure the home could meet their individual needs safely and effectively. Pre-admission assessments were comprehensive and considered people's physical health, nursing needs, risks, communication, mobility, nutrition, mental health and personal preferences. Information was obtained from people, relatives, hospitals and other healthcare professionals to support safe admission and continuity of care.

We reviewed six people's care records and found assessments had informed person-centred care plans and associated risk assessments. Care records reflected people's current needs and demonstrated that assessments were regularly reviewed and updated in response to changes in health, treatment, or advice from healthcare professionals. This provided staff with accurate information to deliver safe and effective care.

People's communication needs, protected characteristics, cultural preferences and wishes regarding their care were considered during the assessment process and reflected throughout care planning. Where appropriate, relatives and advocates were involved in assessments and ongoing reviews to ensure decisions reflected people's wishes and best interests.

Staff demonstrated a good understanding of people's assessed needs and were able to describe how care was adapted as people's circumstances changed. Daily handovers, clinical meetings and weekly GP ward rounds supported the timely sharing of information, ensuring assessments remained current and care continued to reflect people's individual needs.

Overall, assessment processes were well established and provided assurance that people's needs were identified, reviewed and used to inform safe, person-centred care throughout their time at the service.

Delivering evidence-based care and treatment: Score 3

People received care and treatment that reflected current legislation, recognised good practice guidance, and adhered to evidence-based standards. We reviewed six people's care records and found that care plans and risk assessments reflected people's assessed needs and incorporated guidance from healthcare professionals where appropriate. Care plans were personalised, regularly reviewed, and provided staff with clear information to support consistent care delivery.

Where people required specialist support, recommendations from external professionals were incorporated into care planning and implemented in practice. We saw evidence of guidance from speech and language therapists being reflected within care records for people requiring modified diets or support to reduce the risk of choking. Nutritional risk assessments, food and fluid monitoring and weight management plans were used where clinically indicated, enabling staff to identify changes in people's health and seek timely intervention when required.

Staff used recognised assessment tools to monitor people's health and wellbeing, including assessments of nutrition, pressure area care, and falls risk. Clinical observations and monitoring records supported early identification of deterioration, and care plans were updated in response to changes in people's needs or professional advice. This demonstrated that care remained responsive and reflected current evidence-based practice.

People's healthcare needs were regularly reviewed through multidisciplinary working with GPs, community nursing teams, and other healthcare professionals. Weekly GP ward rounds and daily clinical discussions supported timely clinical decision-making, ensuring treatment plans remained appropriate and any changes to people's care were communicated promptly to staff.

The provider promoted evidence-based practice beyond clinical care. Meaningful activities, nutritional support, and dementia care approaches were part of people's care planning, recognising the importance of maintaining their physical, emotional, and psychological wellbeing alongside their healthcare needs.

Overall, we found people received care and treatment that reflected current guidance and recognised best practice, providing assurance that care was planned and delivered in a safe, effective and person-centred way.

How staff teams and services work together: Score 3

People benefited from coordinated care because staff worked effectively with each other and with external healthcare professionals to plan, deliver and review care. Information was shared promptly between teams, helping to ensure people received consistent care and did not have to repeat their needs when moving between services or accessing healthcare.

We reviewed six people's care records and found evidence that care planning reflected input from a range of healthcare professionals, including GPs, speech and language therapists, physiotherapists and community nursing teams where appropriate. Professional recommendations were incorporated into care plans and risk assessments, providing staff with clear guidance for consistent care.

The provider had established systems to support communication across the multidisciplinary team. Daily clinical discussions, shift handovers, and weekly GP ward rounds were used to review people's changing needs, share important information, and agree on actions when concerns had been identified. Care records were updated in response to changes in people's health, ensuring staff had access to the most up-to-date information to support effective decision-making.

Where people required input from external services, referrals were made appropriately, and outcomes were reflected within care planning. Information accompanied people when they attended hospital or healthcare appointments, supporting continuity of care and reducing the risk of important information being lost during transitions between services.

Overall, staff, teams and partner organisations worked collaboratively to deliver coordinated care, providing assurance that people experienced joined-up support that reflected their assessed needs and promoted positive outcomes.

Supporting people to live healthier lives: Score 3

People were supported to maintain their health, well-being, and independence through timely access to healthcare services and person-centred care. We found staff recognised changes in people's health and responded appropriately, ensuring people received support from relevant healthcare professionals when required.

We reviewed six people's care records and found evidence that they had access to a range of healthcare professionals, including GPs, community nursing teams, speech and language therapists, dietitians, physiotherapists, and other specialist services, where appropriate. Professional advice was incorporated into care plans and risk assessments, providing staff with clear guidance to support people's ongoing health needs.

People's physical health was monitored through a range of clinical observations and monitoring tools, where required. Records demonstrated effective monitoring of nutrition and hydration, weight, bowel function, catheter care, skin integrity and other identified health needs. Where changes or concerns were identified, referrals were made promptly, and care plans were reviewed to reflect updated clinical advice.

The provider promoted people's health through preventative approaches as well as responding to illness. People's nutritional needs and dietary preferences were assessed, with monitoring implemented where clinically indicated. Staff had access to guidance to support people at risk of malnutrition, dehydration, pressure damage and choking, helping to reduce avoidable deterioration and promote positive health outcomes.

Healthcare information was communicated effectively between staff through daily clinical discussions, shift handovers and weekly GP ward rounds, ensuring changes in people's health were recognised and acted upon promptly. These arrangements supported continuity of care and helped people receive coordinated support that reflected their individual needs.

Overall, people were supported to live healthier lives through proactive monitoring, timely access to healthcare professionals and care that promoted their independence, wellbeing and quality of life.

Monitoring and improving outcomes: Score 3

The provider had effective systems in place to monitor people's care, treatment and outcomes and used this information to support continuous improvement. We found a range of clinical and governance audits were completed routinely, including audits relating to medicines, infection prevention and control, care documentation, falls, accidents and incidents, health and safety and the environment. Audit findings were reviewed by the management team, with actions identified and monitored through to completion.

We reviewed six people's care records and found that clinical monitoring records were completed consistently where required. Monitoring of areas such as nutrition and hydration, weight, bowel function, catheter care, skin integrity and repositioning enabled staff to identify changes in people's health and respond appropriately. Care plans and risk assessments had been reviewed following changes in people's needs, supporting the delivery of effective, person-centred care.

Leaders monitored key service performance areas through regular governance and clinical meetings. Information from audits, incidents, complaints, safeguarding concerns and feedback from people, relatives and professionals was reviewed to identify emerging themes and opportunities for improvement. This demonstrated that governance systems supported learning and contributed to improvements in the quality and safety of care.

The provider had established systems to monitor the implementation of recommendations made by healthcare professionals. We found evidence that changes to treatment, equipment, and care interventions were reflected in care records and communicated to staff through handovers and daily clinical discussions, supporting the consistent delivery of care.

Overall, we found the provider had strengthened oversight of people's outcomes and service quality. Monitoring systems provided leaders with assurance that risks were identified, actions were implemented, and improvements were sustained, supporting positive outcomes for people living at the service.

Consent to care and treatment: Score 3

People were supported to make decisions about their care and treatment wherever possible. The provider worked within the principles of the Mental Capacity Act 2005 (MCA), ensuring people were supported to make their own decisions and that any restrictions placed upon them were lawful, proportionate and in their best interests.

We reviewed six people's care records and found consent had been sought and recorded appropriately. Where people had the capacity to make decisions, their choices and preferences were respected. Where people lacked capacity to make specific decisions, decision-specific mental capacity assessments had been completed, and best interest decision-making was evidenced, involving relatives and relevant healthcare professionals where appropriate.

Applications for Deprivation of Liberty Safeguards (DoLS) had been submitted where required, and records demonstrated good oversight of authorised and pending applications. Conditions attached to

authorisations were reflected within care planning, providing staff with clear guidance to ensure restrictions remained lawful and proportionate.

Staff demonstrated an understanding of the principles of the Mental Capacity Act 2005 and the importance of supporting people to make decisions for themselves wherever possible. Care records reflected the least restrictive approach, balancing people's rights, independence and safety when planning and delivering care.

Overall, we found people were involved in decisions about their care and treatment wherever possible, and where this was not possible, decisions were made in accordance with legislation and recognised best practice, promoting people's rights and protecting them from unlawful restrictions.

Caring

Kindness, compassion, and dignity: Score 3

People were treated with kindness, compassion and respect by staff who knew them well and understood their individual needs and preferences. During our inspection, we observed warm, relaxed and respectful interactions throughout the home. Staff consistently took time to engage with people, offering reassurance, encouragement, and meaningful conversation whilst supporting them in ways that promoted their dignity and independence.

We spoke with five people living at the home, including the Resident Ambassador, who spoke positively about the care and support they received. The Resident Ambassador described enjoying their role in representing the views of other people at the home and said they felt listened to by the management team. People consistently described staff as caring, approachable and responsive to their needs, and the relative we spoke with told us they were happy with the care their family member received.

We observed the lunchtime experience across the home and found it to be calm, well organised and person-centred. Staff supported people patiently, offering choice, encouraging independence where appropriate and spending time engaging in conversation rather than simply completing tasks. People's preferences were respected, and staff responded promptly to requests for assistance whilst maintaining people's privacy and dignity.

We spoke with eight members of staff who demonstrated a detailed knowledge of the people they supported, including their life histories, communication preferences, routines and what was important to them. Staff spoke to people with warmth and respect, consistently referring to them as individuals rather than tasks. The provider had also developed several functional lead roles, with staff receiving additional training and responsibilities to champion areas of practice and support colleagues. This promoted consistent standards of care and strengthened staff knowledge across the service.

The provider had responded positively to previous cultural concerns within the service. Leaders had taken steps to reinforce the provider's values and expectations through leadership, supervision and staff development. Throughout our inspection, we observed a positive, respectful culture where staff worked collaboratively, and interactions between staff and people living at the home were consistently caring and compassionate.

Compliments received by the service for demonstrating positive experiences were consistently recognised by people, relatives, and visiting professionals. Feedback regularly described staff as caring,

kind and respectful, providing additional assurance that the positive culture we observed was embedded throughout the service.

Treating people as individuals: Score 3

People received care that reflected their individual needs, preferences and life experiences. Throughout our inspection, we observed staff consistently treating people as individuals, adapting their approach to each person's communication needs, preferred routines, and personal wishes. This demonstrated a significant improvement in the culture of care.

We reviewed six people's care records and found care plans were personalised, regularly reviewed and reflected what mattered most to them. Records included information about people's backgrounds, preferred routines, communication needs, relationships, hobbies, and personal preferences, enabling staff to provide care tailored to the individual rather than following a standardised approach.

We observed that each person's bedroom displayed a personalised "Cloud Profile". These provided staff with an accessible summary of the person's life history, interests, preferred routines, communication needs, likes and dislikes, and what was important to them. This enabled new, temporary and unfamiliar staff to quickly understand the individual, initiate meaningful conversations and adapt their approach from the first interaction, promoting continuity of care and helping people feel recognised as individuals regardless of which member of staff was supporting them.

We spoke with eight members of staff who demonstrated detailed knowledge of the people they supported. Staff confidently described people's personal histories, preferred daily routines, communication styles, interests and the approaches that helped people feel reassured and comfortable. This knowledge was consistently reflected in the interactions we observed throughout the inspection and demonstrated that staff had developed positive and meaningful relationships with the people they supported.

The provider had strengthened its approach to person-centred care by introducing a number of functional lead roles across the home. Staff undertaking these roles had received additional training to champion areas of practice, support colleagues and promote consistent standards of care. This had contributed to improving staff knowledge and ensuring people's individual needs continued to be recognised and met.

We also spoke with the Resident Ambassador, who described feeling valued in their role and enjoyed representing the views of other people living at the home. They explained how they regularly shared feedback with the management team and encouraged other residents to voice their opinions, demonstrating the provider's commitment to involving people in shaping both their own care and the wider service.

Overall, we found people were consistently treated as individuals. Staff demonstrated compassion, understanding, and respect for people's personal preferences, and the systems introduced by the provider supported the consistent delivery of personalised care across the home.

Independence Choice and Control: Score 3

People were supported in making decisions about their care and encouraged to maintain as much independence as possible. Throughout our inspection, we observed staff offering people choices about

their daily routines, meals and activities, respecting their preferences and supporting them to remain in control of decisions affecting their lives.

We spoke with five people living at the home who told us they felt involved in planning and reviewing their care. People said staff listened to their views and respected their choices, adapting support to reflect their wishes and changing needs. The provider offered regular resident meetings and newsletters. The relative we spoke with also confirmed they were involved in care planning discussions and were kept informed of changes to their family member's care, enabling them to contribute to decisions where appropriate.

We reviewed six people's care records and found evidence that people, and where appropriate their relatives, had contributed to the development and review of care plans. Care records reflected people's preferences, routines, goals and the support they wished to receive, demonstrating a person-centred approach to care planning. The electronic care planning system also provided an audit trail of care plan reviews and updates, enabling leaders to monitor when records were amended and ensuring staff had access to the most up-to-date information.

During our observations, staff consistently encouraged people to do as much as they were able for themselves, providing support only where required. At lunchtime, people were offered choices of food and drink, encouraged to make their own decisions, and supported in ways that promoted dignity and independence. Staff recognised when people required reassurance or additional support whilst ensuring they remained involved in decisions about their care.

The Resident Ambassador described feeling empowered to represent the views of other people living at the home and explained how feedback from residents was shared with the management team. This demonstrated the provider's commitment to involving people in decisions about the development of the service and their individual care.

Whilst people described being involved in planning and reviewing their care, one person told us they had not been offered a copy of their care plan. Although this had not impacted their involvement in decision-making, routinely offering people, or their representative where appropriate, a copy of their care plan following significant reviews would further promote transparency and strengthen people's involvement in managing their care.

Responding to people’s immediate needs: Score 3

People received timely and responsive care that reflected their immediate health and well-being needs. Throughout the inspection, we observed staff responding promptly to requests for assistance and adapting their support to people's changing needs and preferences. Staff interactions were calm, reassuring and unhurried, ensuring people received support when they needed it.

We observed the lunchtime experience and found staff anticipated people's needs, offering reassurance, encouragement and assistance where required whilst continuing to promote independence. Staff recognised when people required additional support, responded promptly and adjusted the level of care provided without compromising people's dignity or choice. The dining experience was relaxed, with staff taking time to engage with people rather than focusing solely on tasks.

People's changing healthcare needs were managed proactively through effective partnership working with healthcare professionals. During the inspection, we observed the weekly GP ward round, where

the clinical nurse accompanied the GP throughout the visit. This enabled discussions regarding people's health, treatment plans and clinical concerns to take place in real time, ensuring agreed actions were implemented promptly and reflected within care records where required. This collaborative approach supported timely clinical decision-making and continuity of care.

Records demonstrated that people had regular access to a range of healthcare professionals to support their ongoing health needs. We saw evidence of scheduled four-weekly chiropody visits, physiotherapy involvement and access to other specialist services where appropriate. Recommendations made by healthcare professionals were incorporated into people's care plans and communicated effectively to staff, ensuring care remained responsive to people's changing needs.

We spoke with eight members of staff who demonstrated a good understanding of how to recognise deterioration in people's physical or emotional well-being and described the actions they would take to promptly escalate concerns. This was reflected in the care records we reviewed and supported by the provider's daily clinical discussions, shift handovers and established communication processes.

Compliments received by the service consistently recognised staff's responsiveness and the support provided when people's needs changed. The positive feedback received from people, relatives and professionals was consistent with our observations throughout the inspection and demonstrated that responsive, person-centred care had become embedded within the service.

Workforce wellbeing and enablement: Score 3

The provider continued to develop an inclusive and respectful culture in which people and staff were treated with dignity and respect. Since the previous CQC inspection, leaders had taken positive steps to strengthen the culture within the home. Throughout our inspection, we observed a welcoming and inclusive environment in which people, relatives, and staff interacted positively.

People were supported by staff who respected their individual backgrounds, beliefs, preferences and protected characteristics. We reviewed six people's care records and found personal information relating to culture, religion, communication needs and individual preferences had been considered during assessment and care planning where appropriate. Staff demonstrated an understanding of the importance of respecting people's choices and ensuring care reflected what was important to each individual.

We spoke with eight members of staff from a diverse workforce who described a supportive working environment and demonstrated respect towards one another throughout the inspection. Staff worked collaboratively across departments and shared a common focus on achieving positive outcomes for people living at the home. The introduction of functional lead roles and additional development opportunities had further supported staff engagement and promoted a culture of shared responsibility and continuous improvement.

People and relatives spoke positively about the staff supporting them, and we observed respectful interactions throughout the inspection. The Resident Ambassador also described feeling listened to and valued within the home, demonstrating that people were encouraged to contribute to the service's development regardless of their background or personal circumstances.

Overall, we found an open and inclusive culture where diversity was respected, people were treated as individuals, and staff worked together to deliver compassionate, person-centred care. These

findings demonstrated that improvements made following the previous inspection had become embedded within day-to-day practice.

Responsive

People received care that was planned and delivered around their individual needs, preferences and aspirations. Throughout the inspection, we observed staff providing personalised care and adapting their approach to reflect each person's wishes, communication needs and level of independence. Care was flexible and responsive to changes in people's needs, enabling people to maintain choice and control over their daily lives.

We reviewed the care records of 6 people and found that care plans reflected their personal histories, preferences, routines, interests, and goals. Care plans were regularly reviewed and updated in response to changes in people's health or personal circumstances, ensuring staff had access to accurate, up-to-date information to deliver personalised care.

We observed that each person's bedroom displayed a personalised "Cloud Profile", providing staff with an accessible summary of what was important to the individual, including their interests, preferred routines, communication needs and personal preferences. These profiles supported continuity of care by enabling new, temporary and unfamiliar staff to quickly understand the person, build meaningful conversations and tailor their approach from the outset.

People told us they were able to make choices about how they spent their day, their routines and the support they received. The Resident Ambassador explained they enjoyed representing the views of other residents and felt their feedback contributed to ongoing improvements within the home. The relative we spoke with also confirmed they were involved in care planning and regular reviews, helping to ensure care continued to reflect their family member's wishes.

The provider had continued to strengthen person-centred practice following the previous CQC inspection. Staff demonstrated a detailed knowledge of the people they supported and consistently delivered care that respected people's individuality, promoted independence and responded to their changing needs.

Care provision, integration, and continuity: Score 3

People experienced coordinated care because the provider worked effectively with healthcare professionals to ensure care remained responsive to people's changing needs. Information was shared appropriately between staff and partner organisations, helping to maintain continuity of care and ensuring people received the right support at the right time.

We reviewed the care records of six people and found evidence of effective multidisciplinary working. Care records demonstrated regular involvement from GPs, community nursing teams, physiotherapists, speech and language therapists, dietitians and other specialist services where appropriate. Recommendations made by healthcare professionals were reflected in care plans and associated risk assessments, providing staff with clear guidance to support consistent care delivery.

During our inspection, we observed the weekly GP ward round, where the clinical nurse accompanied the GP throughout the visit. This enabled collaborative discussions about people's health, treatment

plans, and ongoing care, with agreed actions implemented promptly and communicated to the wider staff team. This supported timely clinical decision-making and reduced the risk of delays in responding to people's changing healthcare needs.

Records demonstrated that people also benefited from routine access to other healthcare professionals. We saw evidence of scheduled four-weekly chiropody visits and physiotherapy involvement where required, supporting people to maintain their health, mobility and independence. These arrangements demonstrated the provider's proactive approach to coordinating care and ensuring people received ongoing support from the appropriate professionals.

People and relatives told us they were kept informed about changes in health and care needs and felt involved in discussions regarding ongoing care. Information was communicated effectively through daily clinical discussions, shift handovers, and care plan reviews, helping ensure staff had access to accurate, up-to-date information to provide consistent care.

Overall, we found effective systems were in place to coordinate care, maintain continuity and ensure people experienced joined-up care that reflected their individual needs and changing circumstances.

Providing information: Score 3

People were provided with information in a way that supported their understanding and participation in decisions about their care and the home's operations. Information was shared through a variety of methods to meet people's individual communication needs, helping people remain informed about their care, activities and life within the service.

We reviewed six people's care records and found care plans were written in a person-centred manner and reflected people's preferences, routines and individual needs. Information was updated in response to changes in people's health and wellbeing, ensuring staff had access to accurate, up-to-date information when providing care.

We observed that each person's bedroom displayed a personalised "Cloud Profile", providing staff with an accessible summary of important information about the individual, including their communication needs, interests, preferred routines and what mattered most to them. These profiles supported consistent communication, particularly for new, temporary and unfamiliar staff, helping to ensure conversations and care remained personalised from the outset.

People told us they felt involved in discussions about their care and were kept informed when changes occurred. The Resident Ambassador explained they regularly shared information with other residents and encouraged people to raise suggestions and concerns through resident meetings and discussions with the management team. The relative we spoke with also confirmed they received regular updates and felt well informed about their family member's care.

Whilst people described being involved in planning and reviewing their care, one person told us they had not been offered a copy of their care plan. The electronic care planning system demonstrated that, when care plans had been reviewed and updated, there was no consistent record to show that people, or, where appropriate, their representatives, had routinely been offered a copy following significant reviews. Strengthening this process would further promote openness and support people to remain fully informed about their care.

Listening to and involving people: Score 3

People were encouraged to share their views on the care they received and the service's development. We found an open culture where feedback was actively sought from people, relatives and professionals and used to support continuous improvement.

We spoke with five people living at the home, who told us they felt listened to and were confident raising concerns or making suggestions. People described staff and leaders as approachable and said they were comfortable discussing any issues that should arise. The relative we spoke with also confirmed that they felt involved in decisions regarding their family member's care and knew how to raise concerns if required.

We met with the Resident Ambassador, who spoke positively about their role in representing the views of other people living at the home. They explained that they regularly encouraged residents to share their opinions and worked closely with the management team to ensure feedback was taken into account when improving the service. This demonstrated the provider's commitment to involving people in shaping the delivery and development of care.

The provider had established a range of opportunities for people and relatives to provide feedback, including resident meetings, relative meetings, satisfaction surveys, compliments and complaints. We reviewed records and found that feedback was appropriately monitored and responded to. Compliments consistently recognised the caring and responsive approach of staff, whilst complaints were investigated, responded to and used as opportunities for learning and service improvement where appropriate.

Throughout the inspection, we observed positive interactions between people, staff and leaders. The improvements made to the home's culture since the previous CQC inspection were evident, with people appearing relaxed in the company of staff and comfortable approaching managers and senior staff to discuss their views and experiences. This assured that people were not only listened to but were actively involved in shaping the quality of care and support provided.

Overall, the provider had created a culture where people, relatives and professionals were encouraged to provide feedback, with systems in place to demonstrate that comments, concerns and suggestions were valued and used to drive continuous improvement.

Equity in access: Score 3

People experienced equitable care and support that reflected their individual needs, preferences and protected characteristics. The provider demonstrated a person-centred approach to care, ensuring people had fair access to healthcare services, activities and opportunities regardless of their age, disability, cultural background, religion or communication needs.

We reviewed six people's care records and found that individual needs relating to communication, culture, religion, and personal preferences had been considered during assessment and care planning, where appropriate. Care plans reflected the reasonable adjustments required to support people safely and effectively, enabling staff to provide care that respected people's individual identities and promoted positive outcomes.

Throughout the inspection, we observed staff adapting their communication and approach according to each person's needs and abilities. People were supported to participate in daily life, activities and decision-making in ways that reflected their preferences and promoted inclusion. Staff demonstrated

a good understanding of people's individual communication needs and were able to explain how care was adapted to achieve the best possible outcomes for each person.

People had equitable access to healthcare professionals and specialist services based on their assessed needs. We saw evidence of regular GP ward rounds, physiotherapy input, four-weekly chiropody visits and involvement from other healthcare professionals where appropriate. Recommendations from external professionals were incorporated into care planning to ensure people received consistent and coordinated care regardless of the complexity of their needs.

The provider had taken positive steps to strengthen the culture within the home since the previous CQC inspection. Throughout our inspection, we observed an inclusive environment where people were treated with dignity and respect, staff worked collaboratively, and individual differences were valued. The Resident Ambassador also provided an additional opportunity for people to ensure their views and experiences were represented within the service.

Overall, we found people experienced equitable care and support, with systems in place to promote inclusion, reduce inequalities and ensure people achieved positive outcomes based upon their individual needs rather than a one-size-fits-all approach.

Equity in experience and outcomes: Score 3

People experienced care and support that reflected their individual needs, abilities and protected characteristics. We found the provider had established systems and practices to ensure people had equitable access to care, healthcare, activities and opportunities regardless of their level of dependency, disability, communication needs or religious beliefs.

We reviewed six people's care records and found appropriate reasonable adjustments had been identified to support people's individual needs. This included care planning for people living with dementia, hearing impairment, religious beliefs and communication needs, enabling staff to adapt their approach and provide personalised care. During the inspection, we observed staff using adapted approaches to support communication and independence, including the use of aided crockery to assist people living with dementia during mealtimes.

People had equitable access to meaningful occupation and social engagement. Records showed that people who remained in their bedrooms or were unable to participate in group activities were offered regular one-to-one engagement tailored to their interests and preferences. We also saw evidence that external services, including pet therapy visits, were provided within people's bedrooms where required, ensuring people with reduced mobility were not disadvantaged by their health needs.

People had timely access to healthcare services based on their assessed needs rather than their level of dependency. During the inspection, we observed the weekly GP ward round, during which the clinical nurse accompanied the GP to discuss people's health needs and to ensure agreed actions were implemented promptly. Records also demonstrated ongoing involvement from physiotherapists, scheduled four-weekly chiropody visits, and other healthcare professionals, including for people cared for in bed, ensuring equitable access to healthcare across the home.

The provider recognised and respected people's cultural, spiritual and religious needs. We found evidence of personalised care planning, people wishing to practise their faith, regular visits from faith representatives, and weekly religious services held within the home. Leaders also promoted inclusion

through cultural awareness events, providing opportunities for people and staff to celebrate and learn about different cultures and backgrounds.

The provider had systems in place to ensure the views of all people were considered. Advocacy services were accessed where appropriate, families were invited to attend resident meetings and were involved in decision-making where people lacked the capacity to make specific decisions. Clinical governance meetings also reviewed themes and trends relating to falls, complaints and other quality indicators, with learning shared with staff to help ensure improvements benefited all people using the service.

Overall, we found the provider had established inclusive systems that promoted equitable experiences and outcomes for people living in the home. Care was tailored to individual needs, reasonable adjustments were made where required, and people had equitable access to healthcare, meaningful engagement and opportunities to participate in decisions about their lives.

Planning for the future: Score 3

The provider had effective arrangements in place to support people in planning for their future care and to ensure their wishes, preferences and values were understood and respected. Records demonstrated that advance care planning formed part of people's ongoing care, with discussions taking place with people and, where appropriate, those important to them.

We reviewed the care records of 6 people. We found evidence of personalised advance care plans, including preferences for future care, end-of-life wishes, spiritual needs, and cardiopulmonary resuscitation decisions, where appropriate. ReSPECT documentation and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were clearly recorded and reflected within care planning, providing staff with clear guidance to ensure people's choices were respected.

A coordinated multidisciplinary team supported people approaching the end of their lives. Records demonstrated effective partnership working with palliative care services and other healthcare professionals to ensure people received care that reflected their wishes and changing needs.

We found evidence that people's documented wishes had been followed in practice, assuring that advance care planning informed the care people received. Families and representatives were involved in future care planning where appropriate, particularly where people lacked the mental capacity to make specific decisions, ensuring care remained person-centred, and decisions were made in people's best interests.

The provider recognised the importance of supporting both people and those important to them during and after the end of life. Memory boxes outside people's bedrooms celebrated their lives and supported meaningful conversations with staff and visitors. Families were offered bereavement support and an after-death service, recognising that compassionate care continues beyond the person's death and providing relatives with practical and emotional support during a difficult time.

Overall, we found that the provider had established compassionate, well-coordinated arrangements to support future care planning. People's wishes were discussed, documented and respected, assuring that care continued to reflect what was important to the individual throughout the later stages of life.

Well-led

Shared direction and culture: Score 3

Leaders had established a clear vision for the service, focused on delivering safe, person-centred care, continuous improvement and positive outcomes for people. The registered manager and leadership team clearly described the home's priorities. They demonstrated how these had been translated into day-to-day practice through effective communication, staff engagement and governance.

A comprehensive service improvement plan was in place, supported by a detailed action plan developed following the previous CQC inspection. We reviewed the provider's internal clinical governance system and found that actions were clearly allocated, monitored, and reviewed, providing assurance that improvements were progressing and embedded in practice.

Staff consistently demonstrated an understanding of the home's priorities and their individual responsibilities in achieving them. We spoke with eight members of staff who were able to describe current improvement objectives and explained how these were communicated through team meetings, daily stand-up meetings, shift handovers, supervisions and annual appraisals. This demonstrated that staff understood the service's direction and how their roles contributed to achieving positive outcomes for people.

Leaders had developed a range of communication methods to ensure information was shared consistently across the workforce. We saw evidence of daily stand-up meetings, structured handovers, staff meetings, newsletters, noticeboards and electronic communications through the provider's staff application. To ensure night staff remained engaged, the deputy manager routinely attended the home early each morning to meet directly with the night team, providing opportunities to share updates, discuss concerns and maintain consistent communication across all shifts.

The provider recognised and celebrated staff contributions through initiatives, including Employee of the Month awards across different departments. Functional lead and champion roles had also been established, with staff receiving additional training and responsibilities to support service development and share good practice with colleagues. These arrangements promoted ownership, accountability and continuous professional development across the workforce.

Throughout the inspection, staff consistently described leaders as visible, approachable and supportive. Residents and relatives also spoke positively about the accessibility of the management team. Our observations demonstrated that leaders maintained a regular presence in the home and actively engaged with people, relatives, and staff, assuring that the provider's values and expectations were embedded throughout the service.

Capable, compassionate, and inclusive leaders: Score 3

The service was led by a visible, approachable leadership team that demonstrated a commitment to delivering high-quality, person-centred care. Throughout the inspection, we observed the registered manager and deputy managers engaging positively with people living at the home, relatives and staff. Leaders maintained a regular presence across the home, providing support, responding to questions, and overseeing the quality of care being delivered.

We spoke with eight members of staff, who consistently described the registered manager as supportive, approachable, and as providing clear direction for the service. Staff told us they felt comfortable seeking advice, discussing concerns and contributing ideas for improvement. The leadership team had established an open environment where staff felt valued and supported in their roles.

Leaders demonstrated a commitment to developing the workforce. We found evidence of internal promotion opportunities, leadership development programmes, nurse development and support for staff undertaking professional qualifications. Functional lead and champion roles had been introduced across the home, enabling staff to develop specialist knowledge, share good practice and provide additional support to colleagues. These arrangements promoted succession planning and helped build leadership capacity within the service.

The provider recognised staff contributions through a range of initiatives, including Employee of the Month awards across departments, birthday celebrations, recognition of professional achievements, and acknowledgement of long service. These arrangements demonstrated that leaders valued staff contributions and promoted a positive working environment.

During the inspection, we observed leaders responding promptly to staff and resident questions, providing guidance when required, and remaining actively involved in the day-to-day operations of the home. This visible leadership approach enabled managers to maintain oversight of practice, support staff development and promote consistent standards of care across the service.

Overall, leaders demonstrated the skills, experience and values required to lead the service effectively. Their visible presence, commitment to staff development, and approachable leadership style provided assurance that people, relatives, and staff were supported by capable, compassionate, and inclusive leaders.

Freedom to Speak Up: Score 3

The provider had established a culture in which staff, patients and relatives were encouraged to raise concerns, share feedback and contribute to continuous service improvement. Multiple routes were available for raising concerns, ensuring people could choose the most appropriate method for them.

We spoke with eight members of staff who demonstrated a good understanding of the provider's Freedom to Speak Up and whistleblowing arrangements. Staff were able to identify the Freedom to Speak Up Guardian, understood the different routes for raising concerns, and were confident that concerns would be listened to, investigated, and responded to appropriately. Staff described feeling able to challenge poor practice and seek advice without fear of negative consequences.

The provider had clear arrangements in place to promote Freedom to Speak Up. Information was displayed throughout the home, contact details for the Freedom to Speak Up Guardian were readily available, and staff had access to additional reporting routes, including senior management, regional support, human resources and confidential reporting mechanisms. These arrangements promoted openness and transparency across the service.

Freedom to Speak Up formed part of the provider's wider governance framework. Concerns, incidents, complaints and lessons learnt were reviewed through clinical governance processes and communicated to staff through team meetings, stand-up meetings and shift handovers. This ensured learning was shared across the workforce and contributed to improvements in practice.

During the inspection, we observed staff openly discussing care, seeking advice from colleagues and escalating concerns appropriately. Leaders actively encouraged discussion and professional challenge, creating an environment where staff were comfortable raising questions and contributing to improvements in the quality and safety of care.

People and relatives also had access to clear complaint procedures and opportunities to provide feedback through resident meetings, surveys and discussions with the management team. These arrangements provided additional assurance that concerns could be raised openly and acted upon promptly.

Workforce equality, diversity, and inclusion: Score 3

Leaders promoted an inclusive working environment where staff were treated fairly, respected and supported to develop within their roles. Staff consistently described the service as welcoming and inclusive, and told us they felt valued regardless of their background or role within the home.

The provider demonstrated a commitment to equality, diversity and inclusion through staff development, internal promotion opportunities and access to leadership programmes. Functional lead and champion roles were available across different departments, providing staff with opportunities to develop specialist knowledge and progress their careers. Employee achievements were recognised through initiatives such as Employee of the Month awards and celebrations of professional achievements, thereby promoting a positive and inclusive workplace culture.

Equality, diversity and inclusion formed part of the provider's induction, mandatory training and supervision processes. Leaders also promoted cultural awareness through events held within the home, creating opportunities for staff and people living at the service to recognise and celebrate different cultures and backgrounds.

Overall, we found leaders had established an inclusive workplace where equality, diversity and inclusion were promoted, staff development was encouraged, and people benefited from a workforce that felt supported, respected and valued.

Governance, management, and sustainability: Score 3

Leaders had established effective governance arrangements to monitor the quality, safety and sustainability of the service. Since the previous CQC inspection, the provider had implemented a comprehensive programme of quality assurance and service improvement, strengthening oversight across all aspects of the home and providing greater assurance that improvements were being sustained over time.

We reviewed the provider's governance systems and found a structured approach to quality assurance, supported by an annual governance calendar, scheduled audit programme and regular clinical governance meetings. Governance arrangements monitored key areas of performance, including medicines management, infection prevention and control, care planning, safeguarding, accidents and incidents, falls, complaints, staffing, training compliance, supervision, health and safety and environmental safety. Leaders demonstrated how information from these systems was used to identify risks, monitor performance, and drive continuous improvement.

Clinical governance was supported through a digital governance system that enabled leaders to monitor actions, allocate responsibilities and evidence completion. We reviewed governance records

and found that actions arising from audits, incidents, complaints, and the previous CQC inspection were assigned to responsible individuals, monitored against agreed timescales, and reviewed until completed. This assured that governance processes were focused on achieving sustained improvement rather than simply identifying issues.

Performance was monitored using a range of quality indicators and key performance measures. Leaders reviewed themes and trends relating to falls, complaints, safeguarding concerns, medication incidents, pressure damage, infections, hospital admissions, staffing, mandatory training and other clinical outcomes. Findings were discussed within clinical governance meetings, enabling emerging risks to be identified promptly and learning to be shared across the service. We found evidence that governance information informed action planning and service development, demonstrating a proactive approach to quality improvement.

The provider maintained effective oversight through regular support and assurance from senior operational leaders. Provider audits, regional oversight visits, and internal governance reviews provided additional scrutiny of the service, with progress against improvement plans routinely monitored. This provided independent assurance that actions were being implemented and that standards were maintained.

Governance extended beyond formal audits. Functional lead and champion roles had been established across the home, enabling staff with additional knowledge and training to support quality improvement within their specialist areas. Electronic care planning systems, digital governance tools, Cloud Profiles, the Resident Ambassador role and structured communication processes further strengthened oversight and promoted consistent standards of care throughout the home.

We found evidence that learning from incidents, complaints, safeguarding concerns and audit findings was communicated effectively through daily stand-up meetings, shift handovers, staff meetings, newsletters and supervision sessions. The deputy manager also attended the home early each morning to ensure night staff received the same information and opportunities for discussion as day staff, supporting consistency across the workforce.

The governance arrangements observed during this inspection demonstrated a significant strengthening of management oversight compared with those observed during the previous CQC inspection. Improvements were supported by clear leadership, effective quality assurance systems and regular provider oversight. Importantly, governance processes had moved beyond identifying concerns and were focused on measuring outcomes, evidencing completed actions and embedding improvements into everyday practice.

Overall, we found governance systems were comprehensive, well organised and effectively implemented. Leaders demonstrated a clear understanding of the service's strengths, areas requiring further development and the actions needed to maintain and continuously improve the quality of care. The systems in place assured that improvements were sustainable and that the provider had the capacity to continue driving quality improvement across the service.

Partnership and communities: Score 3

The provider had developed strong partnerships with healthcare professionals, local organisations and the wider community to enhance people's wellbeing and improve outcomes. These relationships

supported people to remain connected to their community and ensured they had timely access to a wide range of services and opportunities.

The home worked collaboratively with a range of healthcare professionals, including GPs, community nursing teams, physiotherapists, speech and language therapists, tissue viability nurses, falls services, dentists, opticians and palliative care teams. We observed the weekly GP ward round during the inspection. We found professional recommendations were acted upon promptly and incorporated into people's care, demonstrating effective partnership working to support people's health and wellbeing.

The provider had established strong links with the local community. People regularly participated in events involving local schools, nurseries, churches, volunteers, musicians and therapy animal visits, creating meaningful opportunities for social engagement and reducing the risk of isolation. We found evidence that staff had completed safeguarding children training to support safe intergenerational activities and ensure children visiting the home were appropriately safeguarded.

Families and the wider community were actively encouraged to participate in life within the home. The provider organised regular events throughout the year, inviting relatives, local businesses and members of the community to attend. We also saw evidence of initiatives such as pop-up shops, enabling people to access shopping opportunities within the home and maintain links with local businesses and community organisations.

Advocacy services, faith leaders and community representatives were involved where appropriate to ensure people's individual needs, beliefs, and preferences continued to be respected. These arrangements helped people maintain important relationships and remain connected to their local community.

The registered manager demonstrated engagement with local authority provider forums and recognised the value of developing stronger relationships with other registered managers and partner organisations outside of the provider group. Increasing participation in local provider networks would provide further opportunities to share learning, develop collaborative approaches to common challenges and strengthen partnership working across the wider health and social care system.

Overall, we found that the provider had established effective partnerships that enhanced people's experiences, promoted community inclusion, and supported positive outcomes through collaborative working with healthcare professionals, families, and the wider community.

Learning, improvement, and innovation: Score 3

The provider had established a culture of continuous learning and improvement, using information from audits, incidents, feedback and quality assurance processes to improve the quality and safety of care. Leaders demonstrated a proactive approach to identifying opportunities for improvement and embedding learning into day-to-day practice.

We reviewed the provider's clinical governance systems. We found information from incidents, complaints, safeguarding concerns, falls, medicines, call bell response times and other quality indicators was analysed to identify themes and trends. Where concerns were identified, actions were allocated, monitored, and reviewed through the provider's governance systems, providing assurance that learning led to measurable improvements.

The provider had implemented a range of innovative approaches to support positive outcomes for people. Electronic call bell monitoring enabled leaders to review response times and identify trends, with exceptions investigated where response times exceeded expected standards. We saw evidence that these reviews were completed and that actions were implemented where required. Falls prevention measures included the use of sensor technology and falls mats to reduce the risk of avoidable harm whilst maintaining people's independence.

The home had embraced several dementia-friendly initiatives to enhance people's wellbeing and experience. We observed the use of sensory rooms, dementia-friendly dining equipment, including coloured plates, memory boxes and personalised Cloud Profiles to support meaningful engagement and person-centred care. Leaders also described ongoing work to explore the use of virtual reality technology to enhance further the experiences of people living with dementia.

Learning was embedded throughout the organisation. The provider maintained a lessons learned file, safety alerts, and learning bulletins, with outcomes discussed through governance meetings, daily huddles, team meetings, and newsletters. Staff we spoke with were able to describe recent lessons learnt and explain how changes had influenced their own practice, assuring that learning was effectively communicated across the workforce.

Leaders used a range of quality assurance activities to improve practice, including dignity observations and audits. Where improvements were identified, leaders provided immediate coaching and on-the-spot support to staff, with learning shared across the wider team to promote consistent standards of care. This demonstrated that quality assurance was not solely focused on identifying concerns but on supporting staff development and improving outcomes for people.

The home also benefited from collaborative learning across the wider provider group. Leaders participated in area meetings with neighbouring sister homes, sharing good practice, discussing lessons learnt and learning from the experiences of other services. This supported continuous improvement and helped ensure successful initiatives were shared more widely across the organisation.

Overall, we found learning, improvement and innovation were embedded within the service. Leaders demonstrated a commitment to continually reviewing practice, embracing new approaches and using information effectively to improve the quality of care and experiences of people living at the home.

Environmental sustainability / sustainable development: Score N/A

In line with current CQC methodology, we do not currently assess this area.

Although this quality statement is not currently scored under the CQC Single Assessment Framework, we reviewed the provider's approach to environmental sustainability. We identified several positive initiatives that demonstrate a commitment to reducing the service's environmental impact.

The provider had implemented a Green Plan outlining its approach to sustainable development and environmental responsibility. We found evidence that sustainability was considered in day-to-day operations, with electronic care planning, digital governance systems, and electronic communication reducing reliance on paper-based documentation.

The home supported recycling across a range of waste streams, including paper, cardboard, plastics, batteries and waste cooking oil. Leaders also described initiatives to reduce food waste and promote responsible procurement, including sourcing produce from local suppliers where possible, such as local farmers and butchers. These arrangements supported local businesses whilst reducing transport-related environmental impacts.

The provider also promoted sustainable travel through a Cycle to Work scheme, encouraging staff to consider more environmentally friendly methods of travelling to work where appropriate.

Overall, we found the provider had embedded several practical sustainability initiatives into the day-to-day operation of the service. Whilst CQC does not currently assess environmental sustainability, leaders demonstrated an awareness of their wider environmental responsibilities and had taken proportionate steps to support sustainable service delivery.