Elmcroft Care Home

Mock Inspection

23rd and 25th July 2025

Overall rating: Good

Individual key question ratings:
Safe: Good (63%)
Effective: Good (67%)
Caring: Good (65%)
Responsive: Good (67%)
Well-led: Good (75%)

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Introduction

Inspection Update Elmcroft Care Home – Mid-Point Mock

The mid-point mock inspection at Elmcroft Care Home took place over two days, the 23rd and 25th July 2025. The objective was to review whether the service had sustained progress since the last inspection, where the home was rated Good. Both the Registered Manager and the Operations Manager were present throughout the inspection period.

During the visit, I spoke with the Deputy Manager, nurses, chef, maintenance officer, head of housekeeping, care staff, administrator, residents, and relatives. I would like to extend my thanks to all who gave their time and shared their views so openly.

Service Overview

Elmcroft Care Home is a residential care service within the Abbey Healthcare Group, providing both personal and nursing care to adults under and over 65. The home is registered to support up to 54 residents. At the time of inspection, 18 residents were living at the service. The home is structured to meet a range of needs, including residential care, nursing needs, and varying stages of dementia, with designated units in place to support these requirements.

Elmcroft is supported by Abbey Healthcare's quality, compliance, and operations teams. At the time of the visit, the Operations Manager had been in the home to provide ongoing support to the service and Registered Manager. The Registered Manager, who has been in post since August 2024, has now successfully completed registration with the Care Quality Commission (CQC) since our last inspection in February 2025

Inspection Framework

This mock inspection was carried out in line with the CQC's key questions and Quality Statements assessment framework.

The purpose of this mock inspection was to provide an independent review of the service and evaluate the progress and developments made since the last CQC inspection.

Key Question: Safe

Quality statements assessed against:

Safety is a priority for everyone, and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.

Where people raise concerns about safety and ideas to improve, the primary response is to learn and improve continuously. There is strong awareness of the areas with the greatest safety risks. Solutions to risks are developed collaboratively. Services are planned and organised with people and communities in a way that improves their safety across their care journeys. People are supported to make choices that balance risks of harm with positive choices about their lives. Leaders ensure there are enough skilled people to deliver safe care that promotes choice, control and individual wellbeing.

Learning Culture – Score: 3

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Residents and their relatives consistently shared positive feedback about their experience of care within the service. They reported feeling safe, well supported, and confident that staff were knowledgeable about their individual needs. Families told us they were kept fully informed of any changes and found staff to be proactive in addressing concerns and anticipating needs. One relative told us "*staff are informative , they call us if they notice any changes , even skin changes*", they went on to say that "*no changes of medication is made without the team informing us".*

The service has demonstrated sustained progress in maintaining open and transparent communication. Residents and relatives are regularly given opportunities to influence the delivery of care through structured meetings, with minutes showing that feedback, comments, and suggestions are actively sought, recorded, and acted upon. This reflects a culture of inclusion and continuous improvement. One relative told us that *"this new manager is not one who sits in the office, we attend monthly family meetings".*

The management ethos strongly emphasises empowering staff to take ownership of the care they deliver. By encouraging professional development, supporting initiative, and valuing staff contributions, the management have created a positive environment where staff feel motivated and confident to provide person-centred, responsive care. This sustained approach underpins the consistent high-quality outcomes observed for people using the service.

Staff told us they felt supported and valued under the new management. One member of staff said, "*we feel valued. The manager takes our input into consideration, shares learning with us, and this is also with the nurses — they share learning with us too.*"

This showed that learning was being cascaded across all levels of the team and that staff felt their contributions were respected and acted upon. It reflected a culture of openness and shared learning, where staff were empowered to contribute to ongoing improvements in the service.

The Registered Manager has implemented a Health Improvement Strategy for Elmcroft, designed to strengthen quality monitoring and governance through focused learning for staff. As part of this, the Registered Manager shared case-based evidence of improved outcomes. These included the proactive management of recurring urinary tract infections (UTIs), reviews of long-term conditions, and enhanced approaches to supporting people living with dementia through the effective use of ABC (Antecedent, Behaviour, Consequence) charts.

There was evidence that the Registered Manager has continued to drive internal monitoring of care, which had directly contributed to improved experiences for residents. Systems and processes were in place to measure the quality and safety of the service, with learning from these leading to measurable improvements. Residents benefited from staff responding effectively to incidents, supported by risk analysis and resulting actions that promoted health and wellbeing across the service.

The Registered Manager demonstrated a robust system for clinical risk management, which led to changes in practice. For example, when reviewing the call bell audit, the manager identified increased calls from a resident experiencing emotional distress. This was shared as learning with the team, and as a result, the frequency of calls decreased, showing a positive impact on the resident's wellbeing.

This meant risks were monitored effectively, and shared learning directly improved people's experiences and outcomes.

A Community Mental Health Nurse we spoke with confirmed that the Registered Manager had strong oversight of residents receiving 1:1 support, regularly checked the ABC charts, and was proactive in her approach to ensuring residents' needs were met.

The resident's care plan also evidenced learning from this approach, with clear identification of behavioural triggers, communication methods, however interventions to support the resident effectively are not clearly demonstrated

There is evidence that the service learns from incidents. For example, where a medication error had occurred, the reporting process was robust, and a thorough investigation took place. However, it was noted and discussed during the inspection that lessons learned are not always explicitly translated into clear, definitive actions to minimise the risk of recurrence. Strengthening this aspect will ensure that learning is consistently embedded into practice and supports ongoing improvement in safety

During the visit, skin integrity analysis confirmed that there were no current pressure injuries. Where bruising had been reported, there was clear evidence that this had been appropriately documented, reported, and monitored. Staff routinely reviewed skin integrity during daily handovers and meetings, ensuring early identification of any changes or deterioration. Where concerns were identified, these were escalated appropriately, including timely referrals to the Tissue Viability Nurse (TVN). This demonstrated that effective monitoring systems were in place to promote safety and prevent harm.

The home holds daily meetings with all heads of department, enabling any actions to be identified and addressed promptly. This is further supported by structured monthly governance meetings, where action plans are developed, progress is monitored, and lessons learned are shared with the wider staff team. This consistent cycle of reflection and follow-through demonstrates a strong culture of learning and accountability across the service.

The Registered Manager also shared the Health Improvement Analysis Report, which evidenced the developments made through service redesign to strengthen governance. Key areas of improvement include enhanced skin integrity monitoring, more robust post-falls reviews, and proactive management plans for residents with recurrent urinary tract infections. These initiatives highlight the service's commitment to learning from experience, embedding improvements into practice, and ensuring that people consistently receive safe, effective, and responsive care.

There was clear evidence of a strong learning culture within the service. The Registered Manager demonstrated how they identify gaps in knowledge and practice and take proactive steps to address these. Staff confirmed that learning and development are strongly encouraged, with one staff member commenting that "*the manager encourages us to attend courses and is receptive to new ideas of working."*

The service has access to a range of training portals, ensuring that staff can continually update and expand their knowledge. During the visit, the Registered Manager shared the training matrix, which demonstrated a wide breadth of completed training across the team. This highlighted the commitment to equipping staff with the skills necessary to deliver safe, effective, and person-centred care.

A recent example of this learning culture in action was the implementation of a dementia strategy. Dementia Champions were identified and supported to complete specialist training, enabling them to cascade knowledge and promote best practice throughout the service. This approach reflects a strong ethos of continuous learning, professional development, and shared responsibility, ensuring that improvements in care are sustained and embedded into everyday practice.

Where people had a concern or complaint, records showed these were fully investigated, with clear evidence of communication throughout the process. The outcomes of investigations were shared with the person who raised the concern, demonstrating a commitment to openness and transparency.

People we spoke with told us that the Registered Manager was highly visible, approachable, and proactive in responding to any issues. They confirmed that they felt listened to and reassured when concerns were raised. Several people also reported that they had observed marked improvements in the service since the new manager took over, which they attributed to the open and transparent way the service was being led.

This approach reflects a positive culture where openness and accountability are prioritised, and where people feel confident that their views are taken seriously and acted upon.

Safe systems, pathways and transitions – Score: 3
We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored, and assured. We ensure continuity of care, including when people move between different services.

There was clear evidence that the service worked effectively with people and its healthcare partners to establish and maintain safe systems of care, where safety was actively managed, monitored, and assured. The service has built strong and collaborative relationships with external healthcare professionals, ensuring that both proactive and reactive care needs are consistently met.

For example, the Registered Manager meets with the GP on a weekly basis to undertake structured reviews of residents within the service. This provides regular oversight of people's health needs and ensures timely interventions are made. During the visit, we spoke with a visiting dentist, who confirmed that they conduct routine oral health checks for people living in the home. We also spoke with a Community Mental Health Nurse, who highlighted that they visit regularly to support residents, including those subject to Section 117 aftercare under the Mental Health Act, and to oversee medication reviews for individuals prescribed antipsychotics.

The continuation of weekly GP rounds, alongside input from specialist healthcare professionals, demonstrates the service's commitment to partnership working. This approach ensures residents benefit from a holistic model of care where health needs are proactively monitored, risks are reduced, and people receive coordinated, person-centred support.

People receiving 1:1 support were regularly reviewed, with the Registered Manager maintaining oversight by examining each incident, identifying potential triggers, and analysing patterns. One of the service's Health Improvement initiatives focused on mental and behavioural support. Staff told us they felt more confident in supporting residents experiencing emotional distress, which was supported through the use of ABC charts and targeted teaching sessions. We reviewed the newly developed behavioural tracker, which further enhanced the ability to monitor, analyse, and respond effectively to behaviours.

Although progress has been noted, it was also identified that meaningful activities were not always consistently documented within care notes. Care plans did, however, evidence the involvement of relevant professionals in residents' care and reviews, and this approach should be applied more widely to ensure consistency.

At the time of the visit, an embargo placed on the service by commissioners remained in place, meaning no new residents had been admitted. As a result, we were unable to evaluate the admission process in practice. However, evidence reviewed demonstrated that the service was working safely in partnership with external professionals to meet the needs of people currently living in the home. This collaborative approach ensured that care was responsive, person-centred, and continuously improving

Residents' changing needs were discussed as part of the daily morning handover and within the senior team's daily flash meeting. During the inspection, we observed a flash meeting where staff spoke confidently about residents' changing needs, demonstrating awareness and accountability. This process was further supported by the Registered Manager's daily walkabout, which provided opportunities to engage directly with both staff and residents prior to the meeting, ensuring first-hand oversight of care delivery.

The flash meetings created an effective forum for timely escalation of any changes in health or care needs, enabling swift decision-making and prompt referral to external professionals when required. The deputy manager, who facilitated the flash meeting, also demonstrated how identified actions were triangulated across records, observations, and staff feedback to ensure follow-through and accountability.

Safeguarding – Score 3

We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

All staff spoken with were confident in their knowledge of what constitutes abuse and how to identify potential safeguarding concerns. Staff were able to clearly describe the procedures for reporting, including who they would escalate concerns to both within the service and to external agencies. They also demonstrated knowledge of how to directly contact outside organisations if needed. Written safeguarding information was displayed on noticeboards, providing staff with accessible guidance on reporting pathways.

Any safeguarding concerns or reports were discussed at the daily flash meeting, ensuring timely escalation, oversight, and a shared learning approach across the team. Staff confirmed that they had received training in Safeguarding of Vulnerable Adults (SOVA), and this was evident in their confident responses during discussion.

We observed staff gaining consent before providing any support, introducing themselves, and explaining what they were doing. Staff were seen involving people in decisions about their care and wellbeing as much as possible.

Staff were able to confidently describe the person-centred techniques they use to keep people safe, including examples of supporting residents who were upset or agitated. They gave accounts of using diversional therapy based on residents' care plans, alongside learning from behaviour monitoring records. Residents were observed to be supported with emotional reassurance, and for a person living with dementia, staff were able to demonstrate how they offered comfort and engagement during moments of sadness or agitation.

Care plans, particularly those relating to behaviours, mental health, and emotional wellbeing, contained person-centred strategies. While the care plans overall provided a clear framework for delivering person-centred care, the daily care notes did not always accurately evidence staff interventions or reflect the person-centred approaches staff described in practice. This creates a disconnect between what is planned, what staff say they deliver, and what is being recorded. Strengthening the consistency and accuracy of daily records will ensure that the evidence of person-centred care delivery is fully aligned with residents' individual care plans

We found that there was not a full understanding of the Deprivation of Liberty Safeguards (DoLS) process. While care plans recorded that a DoLS authorisation had been approved, there was a

disconnect between the documentation and the application. The application had not been submitted as an urgent DoLS, which would have provided immediate authorisation and ensured safeguards were in place without delay. This meant that, although staff were aware of DoLS and the need for authorisation, gaps in understanding and recording could place people at risk of not being fully protected in line with legal requirements.

Residents living with dementia or cognitive decline had been assessed for their mental capacity to make informed decisions about their care and choices, including accommodation. However, the Mental Capacity Act (MCA) had not been consistently referenced across all care plan domains. This meant that while assessments had taken place, there was a risk that staff may not always be guided by clear documentation of how the MCA should be applied in day-to-day decision-making

The safeguarding tracker was reviewed, and the Registered Manager demonstrated that safeguarding practices aligned with the service's safeguarding policy and reporting procedures. Where safeguarding concerns had been raised, there was clear evidence of immediate and follow-up actions being taken, as well as action plans being developed and monitored.

At the previous inspection, we found that the home held weekly MDT Hub meetings to review the safety of residents, including accidents and incidents, safeguarding concerns, staffing updates, and feedback from professionals. We noted that this process has since been relaxed, as the provider and commissioners had received reassurance that safeguarding and safety processes were being consistently followed.

There was evidence of learning from safeguarding concerns, including in relation to bruises and skin tears, with clear actions taken to minimise risks and prevent recurrence.

Involving people to manage risk – Score 2
We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

There was evidence that learning had been applied to the identification and management of risks, ensuring care was delivered in a safe and supportive way. Staff worked proactively with healthcare professionals, including dentists and the GP, to promote people's health and safety. The Registered Manager reported having a strong and collaborative working relationship with the GP, which supported focused care planning and timely reviews.

A relative told us: "*every time the GP wants to review my mother's medication, I am involved. I am kept up to date and my input is taken into consideration. I feel that staff always act in my mum's best interests and are proactive."*

This meant people benefited from safe, well-coordinated care where risks were identified early, managed effectively, and supported by strong partnership working with healthcare professionals and families.

Staff were able to describe and demonstrate an understanding of the risks relating to the residents they supported. They confirmed that they read care plans regularly and that the nurse in charge was proactive in discussing any new or emerging risks. Care plans showed that risks were reviewed in a timely manner, demonstrating oversight and monitoring.

However, during observation, we noted that one resident's care plan recorded that they were able to eat independently, yet staff were seen assisting them at mealtimes. This indicated that staff may not always be fully informed of residents' current needs, or that care plans were not consistently updated to reflect changing abilities.

In addition, although risks were being reviewed within care plans, there was limited evidence that these reviews were carried out collaboratively with residents or their representatives. This reduced opportunities for people and their families to be fully involved in decisions about how risks were identified and managed.

This meant that, while risks were monitored and staff were aware of their responsibilities, there was a disconnect between documented care, observed practice, and resident involvement. Strengthening the consistency of care plan updates and embedding collaborative reviews would ensure risks are managed in a fully person-centred and transparent way.

As previously discussed, there was a disconnect between the care plans and the care delivered, as reflected in the daily care notes. Care plan domains often contained generalised statements which were not consistently evidenced in the care notes. This created a gap between the planned approach to care and the documented record of what was actually delivered.

We also found inconsistency in the quality and level of detail within the care plans reviewed. Some plans were comprehensive and person-centred, while others lacked sufficient detail to guide staff practice. For example, one care plan identified that a resident required pain management; however, it did not specify what recognised pain assessment tool should be used when the resident was unable to verbalise their pain. This lack of detail meant staff did not always have clear guidance on how to assess and respond to the resident's needs.

This meant that while care plans were in place and risks were considered, improvements were needed to ensure they consistently reflected people's current needs and provided clear, specific instructions to guide staff practice. Aligning care plans with daily records and ensuring the inclusion of appropriate assessment tools would provide a more accurate and consistent reflection of people's care.

Falls care domains were person-centred and identified individual behaviours that increased risk, for example residents not using their prescribed mobility aids. This is a sustained area of improvement Where residents at high risk of falls wished to maintain independence, suitable equipment was provided, and staff were diligent in observing their use. For example, staff were alert to the risks of a resident forgetting to apply the brakes to their wheelchair and were seen monitoring this appropriately.

Good practice was also evidenced in relation to residents on anticoagulation therapy. For example, where a resident required a tooth extraction, staff implemented a short-term care plan to monitor for any excess bleeding, demonstrating a proactive and safe approach to risk management.

We also reviewed post-falls monitoring records, which showed that staff carried out thorough checks, escalation where required, and learning was incorporated into care plans to reduce future risks.
This demonstrated that risks were well understood, managed proactively, and that there was evidence of learning and improvement embedded into care planning and delivery.

Risks relating to residents' continence needs had been identified and managed through detailed care planning. For example, constipation resulting from medical conditions or side effects of pain medication had been recognised, with care plans outlining how this should be managed and monitored. Residents' ability to report symptoms of a urinary tract infection (UTI) was also considered, alongside guidance for staff on the signs to observe and the actions required if concerns arose.The link between independence with continence needs and associated risks, such as falls in bathrooms, had been identified, with care plans highlighting strategies to support residents safely while promoting independence.

Where residents required catheter care, support plans were in place which detailed the rationale for catheter use, the type of catheter, and significant events for staff to observe, such as during catheter changes. Plans included the date of the next scheduled catheter change, the frequency of bag changes, and clear instructions for staff to ensure these were undertaken consistently. Review dates for care plans were also recorded, supporting timely updates and ongoing relevance

Risks to residents' skin integrity were assessed using the Purpose T risk assessment tool, and staff demonstrated competence in applying this tool. The outcomes of these assessments were recorded within the relevant care plan domains.

However, we found that the results of risk assessments were not always consistently reflected within the skin integrity care plan reviews. This limited the opportunity for an objective review of whether care plans accurately reflected residents' current care needs. As a result, there was a risk that care planning did not always fully align with assessed levels of risk.

This meant that while robust assessment processes were in place and staff demonstrated competence in their use, improvements were needed to ensure that the findings from risk assessments were consistently embedded into care plan reviews to provide a clear and up-to-date picture of residents' skin care needs

Safe environments – Score: 2

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Relatives spoke positively about the home's environment. One relative told us, "*They are really trying, the place is always clean*." Another said, "*The minute I walked into the home I knew this was the place – it is so calm and welcoming."*

Cleaning records were checked and found to be well maintained. During the visit, housekeeping staff were observed to be proactive in carrying out their duties and diligent in maintaining cleanliness across the home. The environment was also a standing item in the daily flash meeting, ensuring any concerns could be raised promptly and addressed without delay. Daily managerial oversight further strengthened this process, allowing swift responses to any environmental issues.

The home was presented in a clean and well-maintained way. In addition, there was evidence of ongoing improvements to the environment, including initiatives to promote a dementia-friendly setting that supports orientation, independence, and wellbeing for residents living with cognitive decline.

This meant people lived in a clean, safe, and supportive environment where staff were proactive, and managers ensured high standards of hygiene and design were maintained through consistent oversight and improvement

Processes were in place to monitor the safety and upkeep of the premises. The maintenance officer maintained records evidencing that environmental checks were carried out in line with current legislation and best practice. Equipment used to support residents was not always routinely checked by nursing staff to ensure it remained safe and fully functional. This meant that, while systems for environmental checks were in place, improvements were needed to strengthen oversight of equipment and ensure all safety devices were routinely tested and evidenced as part of the service's monitoring processes. The provider should ensure all clinical equipment and safety devices are subject to regular checks, with results documented to provide assurance that equipment is safe and fit for purpose

The service utilised electronic process to support the delivery of care such as safety sensor monitoring and call assistance, electronic care planning and medication administration. Checks on the working of call assistance devises were in place and staff confirmed that they were provided with adequate equipment that was reliable to monitor and record care delivery.

Safe and effective staffing – Score: 3

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.

At the time of the visit, 18 residents were being supported within one unit. Staffing was organised through a rota that aimed to provide five care staff, a registered nurse, the deputy manager, and additional staff where 1:1 support was required. This meant people could be confident that staffing was planned effectively, with management oversight ensuring safe and responsive care.

The Registered Manager told us she reviewed the rota to ensure there were always competent and confident staff on duty to meet residents' needs. Where referrals were required, these were discussed during the daily meetings, ensuring timely oversight and follow-up actions.

Due to the low occupancy resulting from the embargo, management had taken steps to support staff by redeploying care staff into other roles within the service and offering voluntary redundancy where appropriate. This meant that staffing levels were managed in a fair and transparent way, ensuring the service remained safe while supporting staff through a period of change.

Throughout the visit, staff were observed responding promptly to people's calls for assistance, and residents at higher risk of falls were seen receiving timely support. However, staff were not always observed engaging residents in meaningful ways, and the layout of the lounge did not consistently promote interaction or stimulation.

We reviewed the call bell audit for May, June, and July, which formed part of the service's governance process. Call bell analysis was available, and action plans had been developed in response to findings, supporting oversight and timely responses to people's needs.

This meant that while staffing levels and response times supported people's safety, improvements were needed to ensure the environment and staff practice also promoted meaningful engagement and social interaction.

People spoke positively about the staff and the support they received. One resident told us, "*staff are always happy to help me, they know my needs and always ask me if I am ok."*

Relatives also shared positive feedback about the home and its leadership. One relative said, "*from the day we came for a show round, we knew it was the right place. The new manager is visible, approachable, happy to listen, and always keeps us updated. We have been having monthly meetings with her."*

This demonstrated that people and their families felt supported, listened to, and reassured by staff and the management team, and that regular communication helped build trust and confidence in the care provided.

Residents were cared for by staff who had, in the main, been recruited safely. All recruitment files observed met the requirements of Regulation 19 of the Health and Social Care Act 2014. Checks had been carried out in line with Schedule 3, including Disclosure and Barring Service (DBS) checks, police checks for staff recruited from overseas, references, and interview records. Evidence of right-to-work documentation and sponsorship records for overseas staff was also in place.

Recruitment files demonstrated that full employment histories had been obtained, with explanations for any gaps provided. For staff in registered roles, evidence of recognised qualifications and professional registration was in place, including checks of Nursing and Midwifery Council (NMC) PIN numbers and their current status.

All staff had completed an induction programme, which was recorded and evidenced in the files observed. This provided assurance that staff were recruited in line with regulations, appropriately qualified, and supported to understand their roles from the outset

Staff spoken to said they felt supported in their role from the outset, one staff said "*I received all the training, and this new management supports learning at all levels*" , they continued to say of the latest training that "*I truly benefited from is the ABC behavioural charts*".

Nurses were supported with continuous professional development, and the home had an extensive training programme in place for all staff. The mandatory training matrix showed a compliance rate of 97%, providing assurance that staff had the required knowledge and skills to deliver safe and effective care.

Staff received supervision support through a hierarchy of supervisors, all of whom had completed 'effective supervision' training. There was evidence of a proactive approach to supervision, with the Registered Manager maintaining oversight to ensure sessions were completed and follow-up actions achieved.

The supervision matrix was in place; however, this could be strengthened by distinguishing between group and individual supervisions to provide clearer monitoring. Records showed staff were receiving supervision on a bi-monthly basis, and staff told us that "*we receive supervisions from the nurses and they tell me in advance".*

This meant there was a proactive approach to supervision and appraisal, supporting staff to feel heard, supported, and guided in their roles, with scope for further strengthening of oversight through the supervision matrix

Infection prevention and control – Score: 2
We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

While some areas of the home were identified as requiring refurbishment, the overall environment was clean and well maintained, with no unpleasant odours. Cleaning schedules and records were up to date, and both routine daily cleaning and deep cleans were observed to be taking place. Oversight was provided by the housekeeping lead and reviewed at the daily senior team meeting, ensuring standards were consistently maintained.

Relatives felt that the service was clean with comments including, *" it is clean, and welcoming".*

As previously noted, the identification of infection risks was included within residents' plans of care. For example, where there was a risk of urinary tract infections (UTIs), care plans clearly set out the signs and symptoms to observe and the actions required by staff.

Since the last review, there had been marked improvements in how short-term infection care plans were managed. These were now being reviewed more consistently and discussed daily during the flash meetings, ensuring timely oversight and prompt updates. Residents with active infections were also identified at the daily senior team meeting, which formed part of the service's wider auditing process.

Medicines optimisation – Score: 2
We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen.

Residents' abilities and the support they required with medication management were included within their medication care domains. However, where care plans identified that cognitive decline impacted a resident's memory and ability to manage their medicines, the guidance provided was not always specific. For example, in relation to pain management for a resident with cognitive impairment, the care plan did not set out how staff should assess the resident's pain when they were unable to verbalise it. This approach was not consistent across all care plans reviewed, creating a risk that staff may not apply a uniform or person-centred method of assessing and managing pain.

Medication support plans recorded residents' individual preferences around how they wished to take their medicines, as well as any known allergies. They also identified where medicines related to long-term health conditions, such as Parkinson's disease, where time-specific administration was important. Despite this, many of the plans continued to contain standardised information that described the service's general medication processes, such as how medicines should be returned, rather than focusing on the resident's specific needs. This issue had been highlighted at the previous inspection and had not yet been fully resolved.

In cases where residents were known to decline their medicines, the care plans advised staff to inform the GP if refusals became frequent. However, there was no clear explanation of what constituted "frequent," which meant staff did not always have the precise guidance needed to act consistently.

Overall, medication support plans remained too generic and lacked person-centred detail, creating a risk that staff may not always have the tailored information required to provide safe and consistent support. The outcomes of medication reviews carried out by GPs and specialist teams, such as the DISS team, were evidenced. During the inspection, we spoke with a community mental health nurse who was attending to review antipsychotic medication. While records showed that reviews had taken place, there was no clear indication of how frequently antipsychotic medicines should be formally reviewed. This suggested that reviews were often reactive rather than part of a structured, planned approach, which had also been identified at the previous inspection.

Where residents were at risk of experiencing pain, this was identified within their medication support plans, which included strategies for managing pain. However, there were shortfalls in the level of detail provided. The requirement to observe for non-verbal signs of pain was noted, but care plans did not consistently identify which recognised non-verbal pain assessment tool staff should use. Additionally, there was no evidence that non-pharmaceutical pain management approaches had been considered within care planning.This meant that while systems for medication review and pain management were in place, they lacked consistency and person-centred detail, creating a risk that residents' pain and medication needs may not always be managed in a planned, proactive, and holistic way

During the administration of medicines, staff demonstrated knowledge of residents' person-centred needs and were observed providing support respectfully. For example, one nurse was seen approaching a resident with patience and gentle persuasion to encourage them to take their prescribed medication. For those prescribed covert medication, the correct processes were in place and followed. We also observed that the opened dates of liquid and bottled medicines were clearly recorded, supporting safe practice.

However, some areas for improvement were identified. Devices to aid inhaler use, such as spacer devices, were not consistently available, limiting the effectiveness of administration. While the administration of eye drops was carried out in line with infection prevention and control (IPC) practice,

including the use of gloves, staff were observed dispensing medicines in a separate room away from the resident before administering them. This practice increased the risk of errors if staff were interrupted or distracted while carrying the medicines to the resident.

This meant that, although medicine administration was carried out respectfully and largely in line with best practice, some unsafe practices remained that increased the potential for error and required prompt action to address.

The safe administration practice of routinely performing stock checks against the electronic medicines administration record (eMAR) at the point of administration was not consistently evidenced during the inspection. A discrepancy in stock balance confirmed that daily stock checks were not being carried out reliably.

Once this was identified, the senior management team responded promptly by alerting all staff responsible for medicines management and assigning a nurse to complete a full audit of all medications. This immediate action provided assurance that discrepancies would be identified and addressed, while reinforcing expectations with staff.

This meant that although there were shortfalls in the consistency of daily stock checks, management oversight was effective in identifying the issue and taking swift corrective action.

The service cares for residents who required to receive controlled medications, which were observed to evidence good stock management and recording.

With the nursing unit closed, there was one functional treatment room in use. This room provided secure storage for medicines, and both room and medication fridge temperatures were correctly recorded. The service also held medical equipment for emergencies, including suction machines and nebulisers.

However, we found there was no evidence of routine checks on the working parts of nebulisers. This issue had been identified at the previous inspection and remained outstanding, creating a potential risk that equipment may not be fully functional when required.

Staff responsible for the administration of medicines had undertaken annual competency assessments, which were in date and evidenced at the time of the visit. This provided assurance that medication management was safe and carried out by competent staff.

Summary score

Learning Culture	3
Safe systems and pathways	3
Safeguarding	3
Involving people to manage risk	2
Safe environments	2
Safe and effective staffing	3
Infection prevention and control	2
Medicines optimisation	2
Total score	20
Possible score	32

Rating for key question - Safe: Good

With a percentage score for the key question of 63 (19 divided by 32)

Action Plan:

Learning Culture –

- The sharing of learning should be explicit, clearly setting out what has been learnt and the recommended changes in practice. This approach will ensure that lessons are not only identified but also embedded across the service, supporting a culture where continuous learning and improvement are prioritised, and good practice is sustained**.**

Safe systems and processes –

- To ensure plans of care evidence who has been involved in the reviewing and planning of care.

Safeguarding –

- To ensure daily care notes consistently evidence staff interventions and reflect the person-centred approaches identified in care plans.
- To ensure care notes are audited against care plans monthly to monitor alignment and accuracy.
- To ensure staff are supported to Improve DoLS Understanding and Application
- To deliver refresher training on the Deprivation of Liberty Safeguards (DoLS), with a focus on urgent applications and documentation requirements.
- To ensure you Strengthen MCA Integration Across Care Planning
- To ensure that care plan domains are reviewed so that the Mental Capacity Act (MCA) is explicitly referenced where relevant.
- To provide staff with practical examples of how MCA principles apply to day-to-day decision-making.

Involving people to manage risk –

- To ensure daily care notes consistently reflect staff interventions and align with the person-centred approaches set out in residents' care plans.
- To ensure care plans are updated promptly to reflect changes in residents' abilities and needs, reducing disconnects between documentation and actual care delivery.
- To ensure care plan reviews are carried out collaboratively with residents and/or their representatives to embed person-centred and transparent risk management.
- To ensure care plans provide specific guidance on the use of recognised pain assessment tools, particularly for residents unable to verbalise pain, and include alternative strategies for times when verbal communication is not possible.
- To ensure care plan domains contain detailed, person-centred information rather than generic statements, supporting staff to deliver consistent and safe care.
- To ensure falls care plans remain person-centred and continue to identify risks and strategies, while monitoring is sustained through post-fall reviews and learning shared with staff..
- To ensure continence care plans remain detailed, covering constipation, catheter care, UTI risks, and clear staff guidance on signs, actions, and review dates.
- To ensure risks to skin integrity identified via the Purpose T risk assessment are consistently reflected in care plan reviews, providing an accurate and up-to-date picture of residents' needs.
- To ensure evidence of learning from incidents, post-falls monitoring, and risk assessments is explicitly embedded into care plans and shared across the staff team to drive continuous improvement.

Safe environments –

- To ensure the environment remains clean, safe, and welcoming through proactive housekeeping, with cleaning schedules and deep cleans consistently maintained and evidenced.
- To ensure environmental concerns are identified and addressed promptly by continuing to include environment checks as a standing agenda item in daily flash meetings, with oversight by the management team.
- To ensure the home continues to develop dementia-friendly design initiatives that promote orientation, independence, and wellbeing for residents living with cognitive decline.
- To ensure environmental safety processes remain robust by maintaining up-to-date maintenance records and checks in line with current legislation and best practice.
- To ensure all clinical equipment and safety devices (e.g., nebulisers, suction machines,) are subject to regular functional checks by nursing staff, with results documented for assurance of safety and fitness for purpose.
- To ensure a schedule of calibration and safety checks is implemented and monitored for all essential equipment, with evidence available for audit and governance review.

Safe and effective staffing –

- To ensure daily meetings remain a forum for discussing referrals and resident needs, enabling timely oversight and follow-up actions.
- To ensure fair and transparent staffing arrangements during low occupancy, with redeployment or voluntary redundancy managed in a supportive way.
- To ensure staff not only respond promptly to residents' needs but also engage in meaningful interactions, supported by improvements to the lounge layout to promote social engagement and stimulation.
- To ensure supervision is delivered regularly, with clear distinction in the matrix between individual and group sessions, and that staff continue to feel supported, listened to, and able to express concerns**.**

Infection prevention and control –

- To ensure ongoing refurbishment and environmental improvements also prioritise infection control by supporting safe, hygienic, and dementia-friendly design**.**

Medicines optimisation –

- To ensure medication care plans are person-centred, with specific guidance for residents with cognitive impairment, including how to assess and manage pain when residents are unable to verbalise it.
- To ensure non-verbal pain assessment tools are consistently identified and used in care planning and practice, with staff trained in their application.
- To ensure non-pharmaceutical pain management strategies are considered and included in care planning where appropriate.
- To ensure medication support plans avoid generic information and consistently focus on residents' individual needs, preferences, and conditions.
- To ensure clear guidance is given in care plans about medication refusal, including a definition of what constitutes "frequent" refusals and the actions staff should take.
- To ensure medication reviews, particularly for antipsychotic medicines, are clearly scheduled and documented as part of a proactive, structured approach, in line with NICE guidance and not only in response to issues.
- To ensure spacer devices and other required administration aids are consistently available to support the safe and effective delivery of medicines such as inhalers.
- To ensure medicines are dispensed and administered directly at the point of care, in line with NMC Standards for Medicines Administration, reducing the risk of errors from interruptions or distractions.
- To ensure daily stock checks against the eMAR are consistently carried out and documented, with regular audits confirming compliance.
- To ensure all emergency medical equipment, including nebulisers, is subject to routine checks of working parts, with results recorded and monitored through governance processes.

Key Question: Effective

Quality statement assessed against:

People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.

Everyone is supported to see what works well and not so well based on indicators of quality. Continuous improvement is always guided by this insight.

Assessing needs – Score: 3

We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

As identified under involving people to manage risk, residents told us they felt involved in discussions about the planning and assessment of their care needs, which were regularly reviewed. People said staff discussed their support needs, preferences, likes, and dislikes with them, and they felt listened to.

People spoken with were keen to provide feedback on how their needs had been met from the time they decided to live at Elmcroft. They told us they felt staff understood their needs and respected their individual preferences.

There was evidence that care plan reviews were being completed; however, the involvement of appropriate family members or residents was not consistently recorded across all documentation

Residents' needs were assessed using recognised clinical tools such as Purpose-T (skin integrity), MUST (nutrition), falls risk assessments, and the Abbey Pain Scale. These assessments informed the initial planning of care and staff were seen to carry out ongoing assessments to monitor changes in residents' needs. For example, following an incident such as a fall, staff ensured a post-falls assessment was completed, and such incidents were reviewed at the daily morning meeting.

People told us they felt involved in discussions about their care needs, with staff taking time to discuss support, preferences, likes, and dislikes. However, when reviewing care plans, the results of clinical tools were not always clearly reflected within the documentation to validate assessed needs or guide care delivery. This created a risk that assessments carried out in practice were not consistently embedded into the written care plan.

Lessons learned from incidents, such as falls, were discussed with staff and shared at meetings. However, as previously identified, the process for recording and evidencing what changes had been made as a result of these lessons was not always clear.

Professional involvement in care reviews was evident, for example GP and specialist input, but the outcomes of these visits were not always consistently documented within the care plans.

This meant that while residents' needs were assessed using clinical tools and people felt involved in care planning, improvements were needed to ensure assessment results and professional input were consistently reflected within care plans, and that lessons learnt were clearly evidenced through changes in practice.

Care plans were written in the correct narrative style, addressing residents by their first names. A strengths-based approach was evident; for example, communication care plans highlighted residents' communication abilities, and where sensory impairment was present, the care plans described how the resident would be supported. Care plans also identified residents' preferred modes of communication and recognised the impact that sensory loss could have on individuals, with support strategies outlined accordingly. However, care plans did not consistently evidence that residents with sensory loss had undergone a screening process, nor did they set out how frequently health checks (such as audiology or ophthalmology reviews) should take place. This meant that although care plans reflected strengths and support needs, they did not always demonstrate a fully person-centred approach, particularly in evidencing screening processes and planning regular health checks for residents with sensory loss.

Staff demonstrated they knew the person well and understood their individual communication needs. The person's first language was not English, and due to cognitive decline they sometimes switched between English and their language of origin. Staff worked closely with the family to gain insight into the person's background and preferences, and used observation of non-verbal cues to ensure their needs were understood. This showed staff treated the person with dignity and respect, and supported them in a way that was person-centred and compassionate.

We saw evidence that the service responded promptly to changes in the person's health. Staff had identified the day before our visit that the person appeared to be in discomfort. They escalated this appropriately and arranged for a dentist to review the person. The dentist attended the home during our inspection. This demonstrated that staff recognised and acted on concerns in a timely manner to support the person's health, comfort, and wellbeing.

Delivering evidence-based care and treatment – Score 2

We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

The service had implemented the use of the National Early Warning Score (NEWS) tool. This supported staff to recognise and escalate early signs of deteriorating health. We saw that staff understood how to use this system and were confident in reporting changes promptly.

The Registered Manager shared a case study demonstrating the impact of this approach. The Registered Manager, who is clinically trained, was able to carry out an assessment, diagnose the condition and arrange the right treatment. As a result, the person's health needs were met in the home without requiring an avoidable hospital admission. This proactive approach had contributed to a significant reduction in hospital admissions across the service. Residents were able to receive timely and appropriate care in their own home environment, reducing disruption and distress.

The service ensured that residents' nutrition, hydration and weight management were assessed and monitored using nationally recognised clinical assessment tools. The results of these assessments were incorporated into people's support plans. Where residents required food modification, appropriate referrals were made to speech and language therapists (SALT) and dieticians. Their professional recommendations were then included in nutritional care plans.

We observed that nutrition and hydration support plans contained information about the International Dysphagia Diet Standardisation Initiative (IDDSI).

During the inspection we noted a disconnect between one resident's care plan and the support provided in practice. The care plan recorded that the resident was independent with eating and drinking, however we observed staff providing assistance. While staff were knowledgeable about IDDSI levels and demonstrated safe practice, care records did not accurately reflect the resident's current level of need. This inconsistency increases the risk that staff unfamiliar with the person may not provide the correct support.

People's nutritional needs were recorded within care and support plans. Where weight loss or the risk of weight loss was identified, fortified foods and supplements were included as part of their nutritional support. However, outcomes from weight monitoring were not routinely incorporated into care plans, which limited the ability to demonstrate oversight of progress and the effectiveness of interventions.

Daily meetings included a focus on nutrition and fluid intake, and daily records described residents' food and fluid consumption. A recently appointed chef demonstrated knowledge of residents who had experienced weight loss and received a weekly weight loss report. Fortified foods and drinks were available, and a kitchen whiteboard was maintained to highlight residents' individual needs, such as

gluten-free diets or IDDSI levels. Menus were aligned with allergen guidance, and the chef described appropriate dietary adjustments, including gluten-free and diabetic diets, sourcing specialist ingredients when required.

Despite these positive practices, residents were not always supported appropriately at mealtimes. We observed mealtime experiences to be task-orientated and uncoordinated, with residents not consistently supported to eat in their preferred location, including in their own rooms. On one occasion, a resident had food placed in front of them but was left unsupervised. In another instance, a resident refused food when offered, and staff did not attempt to encourage or support them before moving on to the next resident. People living with dementia or cognitive decline were not consistently supported, encouraged, or supervised during mealtimes.

This demonstrated that while some aspects of evidence-based nutritional care were in place, they were not consistently embedded across the service. The lack of coordinated mealtime support and inconsistent use of weight monitoring reduced the effectiveness of care delivery and meant that people were not always fully involved in planning and receiving care in line with legislation, good practice, and national standards.

Oral health was discussed at flash meetings, and the service had links with a dentist who carried out health checks. At the morning meeting, there was discussion on how to manage the care of a resident who had recently undergone a tooth extraction. Oral care support plans were in place and described the level of support people required to maintain their oral hygiene. However, these were not consistently in line with CQC's Smiling matters: oral health care in care homes or NICE guidelines, and did not include sufficient detail on important aspects such as the frequency of toothbrush replacement or the type of toothpaste to be used in accordance with people's needs or preferences

Residents and relatives gave us feedback about the food and mealtime experience. Overall, people acknowledged that standards had improved since the new chef started. Comments included:

- "*Since the new chef started, the food has really improved – it feels fresher and better thought out."*
- *"The meals are the same each week, but we always have options and that's important to me."*
- *"If we ask for something different, nothing is too much trouble – the chef always tries to make it happen."*
- *"I like that they give us choices; it makes me feel listened to."*
- *"My mum says the food is much nicer now, and she's happier because they cater for what she likes."*

This feedback reflected positively on the catering service and showed that residents and families felt their dietary needs and preferences were being taken into account.

How staff, teams and services work together – Score 3

There was clear evidence that the service works in close partnership with health and social care professionals to ensure people receive joined-up and consistent support. Information about people's needs is shared appropriately so that individuals do not need to repeat their story when moving between services.

Although a GP visit did not take place during the inspection, records, feedback and communication logs demonstrated strong collaborative working. Documentation showed regular liaison with the GP practice regarding people's care, and relatives confirmed they were kept informed about any changes. One family member told us, *"I cannot fault the care my mom is receiving. We are kept updated about any changes."* Another relative said, *"If there are any changes with medication, we are informed straight away. The manager and her team have a very collaborative relationship with the GP, which gives us confidence our loved one is being well looked after".*

The service makes timely referrals to other healthcare professionals when needed. This includes district nursing, mental health services, and the Dementia Intensive Support Service (DISS). Records showed the service worked closely with the DISS team to share best practice, and the DISS team had thanked the service for its "continued communication and support during reviews."

People also had access to visiting professionals such as dentists, chiropodists and opticians, who carried out preventative screening and treatment within the home.

Overall, there was consistent evidence of partnership working across all appropriate domains of care. These collaborative relationships helped people to remain well supported in the service, reduce the likelihood of unnecessary hospital admissions, and achieve positive health and wellbeing outcomes.

Supporting people to live healthier lives – Score: 3
We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.

The service continues to demonstrate sustained progress in supporting people to achieve positive outcomes. Staff work proactively with individuals and their families to ensure care is tailored to changing needs and that people are able to live as independently as possible.

Relatives told us they felt involved and informed about their loved one's care. One family member explained, "*Her care plan has recently been changed to accommodate her change in illness. We felt fully involved in this process, and staff made sure her needs were responded to quickly and appropriately*". Another shared, *"Even though my mother cannot take part in group activities, the*

home tailors' activities to her needs so she can still be included". There was clear evidence that people's health and wellbeing had improved because of the support they received.

Case Study: Supporting Connection and Engagement
One resident was initially very withdrawn, spending most of their time in bed and engaging only occasionally with staff. This raised concerns about their emotional wellbeing and risk of isolation. The activities co-ordinator took the lead in developing a personalised approach, reviewing the person's life history and identifying ways to build trust through gentle conversations and shared interests. By gradually introducing meaningful activities linked to the person's past experiences and preferences, the activities co-ordinator helped the individual gain confidence, reconnect with daily life, and develop a stronger sense of connection with others.

The service has also supported people who had previously struggled to engage with professionals or community activities. Feedback from healthcare professionals commended staff for improving people's quality of life, highlighting their ability to build rapport and trust.

Staff consistently demonstrate a positive culture of care by recognising when people's needs change, adapting care plans promptly, and focusing on outcomes that promote independence, dignity and wellbeing. This proactive approach has reduced unnecessary hospital admissions, improved people's quality of life, and ensured that individuals remain well supported in the home.

Monitoring and improving outcomes – Score: 3
We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

People receive support following assessments carried out by a range of healthcare professionals, including GPs, Speech and Language Therapists (SaLT), dieticians, and the Dementia Intensive Support Service (DISS). We saw evidence that the service responds proactively to these assessments and adapts care accordingly.

Relatives were positive about the support their family members received. One relative told us, "The care mum receives is great. She is well looked after, and staff are always there if any questions need to be asked." Another shared, "I spoke to my mother about the care she was receiving, and she told me she was very pleased with the care and attention. She feels the staff show excellent care and attention to the residents."

The Registered Manager has strengthened clinical oversight by ensuring focused reviews of care and medication are undertaken. Since being in post, the Registered Manager had initiated contact with a micro-suction practitioner to review ear health across the home. As a result, all residents received ear

health checks, and several benefited from microsuction to remove wax, which improved both comfort and hearing. In addition, the home has secured a dedicated dental service that now carries out three-monthly dental checks for all residents. This proactive approach demonstrates the service's commitment to anticipating needs, addressing potential issues early, and embedding continuous improvement into everyday care.

Consent to care and treatment – Score 2

We tell people about their rights around consent and respect these when delivering person-centred care and treatment.

People's consent was observed to be sought for their care and support, and staff delivered care respectfully. Residents' communication support plans described how they wished to be approached, including when staff entered their private rooms. During the inspection, staff were observed introducing themselves and explaining what they were going to do before providing any support. Residents were also offered choice about whether they wished to take part in activities, which demonstrated that consent was embedded into daily practice.

Where residents used tilt-space chairs that restricted their mobility, suitable assessments had been undertaken. These assessments ensured that equipment was used appropriately, promoted comfort and safety, and helped to maintain independence as much as possible while minimising risk. Care and support plans clearly described the strategies in place to support safe independence.

Staff we spoke to emphasised the importance of informed consent, and training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) had been completed. People's capacity to understand risk and be involved in decision-making was assessed. Staff adapted their communication where people had limited speech or cognitive decline, using clear language, reassurance, or visual prompts to support understanding and decision-making.

However, it was not always clear what the assessment of capacity related to, or what type of consent was being assessed. In some cases, assessments did not clearly inform the relevant areas of care. This was consistent with concerns previously identified about care planning not always aligning with MCA principles.

There was evidence that the service identified those with legal power of attorney to make decisions on people's behalf, and urgent authorisations and standard applications under DoLS were in place where required. The service understood its obligations under Regulation 18(2) of the Care Quality Commission (Registration) Regulations 2009, which requires services to notify CQC of the outcome of any DoLS application.

As previously identified, the narrative in care plans was not always consistent in recording where a DoLS had been granted, or where an urgent application had been submitted. This remains an area for improvement to ensure clear evidence of compliance with the MCA and DoLS framework

Summary score

Assessing needs	3
Delivering evidence-based care and treatment	2
How staff, teams and services work together	3
Supporting people to live healthier lives	3
Monitoring and improving outcomes	3
Consent to care and treatment	2
Total score	16
Possible score	24

Rating for key question – Effective: Good

With a percentage score for the key question of 67% (16 divided by 24)

Action Plan:

Assessing needs –

- To ensure care plan reviews will clearly record the involvement of appropriate family members and/or residents, including their views and contributions**.**
- To ensure outcomes of tools such as MUST, Purpose-T, Abbey Pain Scale, and falls risk assessments will be clearly documented within the relevant care plans.
- To ensure lessons learned from incidents are clearly evidenced
- To ensure professional input is consistently reflected in care documentation
- To ensure care plans are person-centred and communication-focused
- To ensure care plans will continue to be written in a strengths-based narrative style, highlighting abilities as well as support needs.

Delivering evidence-based care and treatment –

- To ensure people's nutritional needs are fully embedded in care planning
- To ensure outcomes from weight monitoring will be incorporated into care and support plans to evidence progress and the effectiveness of interventions.

- To ensure residents receive consistent and person-centred mealtime support
- To ensure nutrition and hydration are delivered in a coordinated way
- To ensure the chef will continue to maintain an updated kitchen whiteboard to highlight individual needs
- To ensure oral health care aligns with CQC's Smiling matters and NICE guidance, which includes oral health care plans will be updated to include detail on frequency of toothbrush replacement, type of toothpaste, and personalised support strategies.
- To ensure ongoing feedback on food quality and mealtime experience will be gathered through residents' meetings, surveys, and direct family contact.

Consent to care and treatment –

- Refer to previous actions required relating to MCA and DoLs under Safe

Key Question: Caring

Quality statement assessed against:

People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.

Kindness, compassion and dignity – Score 3

We always treat people with kindness, empathy and compassion, and we respect their privacy and dignity. We also treat colleagues from other organisations with kindness and respect.

Residents and relatives spoke positively about the care provided by staff. Comments included:

- "*The staff performed an amazing job with a great level of patience and care on a daily basis looking after all of mum's needs. Everyone at Elmcroft performed to the highest standards, leaving us with the assurance that mum was very happy and comfortable"*
- *"Well looked after, always there for you if any questions need to be asked"*
- *"Always in contact with me, especially when I cannot visit. Staff are very informative about my mum's welfare and always ring me when she has not been well or had a fall"*

These examples demonstrated that families had confidence in the kindness and attentiveness of staff, and that communication was timely and respectful.

Staff were knowledgeable about person-centred strategies to support residents, including those living with dementia. They explained how they met residents' needs in ways that maintained dignity and promoted positive outcomes. For example, residents who preferred to remain in their rooms were observed receiving timely interventions, with staff knocking before entering and introducing themselves. Staff consistently spoke to residents with understanding and respect, ensuring they felt valued.

There is an example shared as a case study 'where a person living ar Elmscroft with cognitive decline , was reluctant to engage . Over time the activity coordinator, was able to establish trust through small, meaningful interactions. Staff encouraged the resident to join in activities at their own pace and provided opportunities that matched their preferences — such as one-to-one chats and quiet social engagement rather than larger group events. The resident began to participate more, gradually spending time outside their room, and reported feeling more comfortable and accepted within the home.

On the day of the inspection, the activities co-ordinator had been leading a community trip but returned early because one resident had become unwell. She immediately prioritised the resident's needs, providing reassurance and support, while still ensuring that the remaining group was able to enjoy their day by rearranging another place to visit. This demonstrated not only flexibility and professionalism but also a deep sense of kindness and responsibility towards every individual.

Overall, the culture at Elmcroft was one of kindness, compassion and dignity. Staff took time to understand people's individual needs, communicated with patience, and created an environment where residents felt cared for, respected, and supported to live with comfort and assurance.

Treating people as individuals – Score: 2
We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

The service ensures that residents' care, support and activities reflect their individual needs, preferences, strengths, aspirations and protected characteristics. Life histories are gathered which detail how people like to spend their time, significant relationships, and cultural backgrounds. This information is used to plan personalised wellbeing engagement.

The activity co-ordinator demonstrates good knowledge of residents' needs and has developed a meaningful programme of activities and wellbeing interventions. Residents are supported to engage in community activities, including shopping trips, the local Dementia Choir, and the Friends and Neighbours (FaNs) programme. Pet therapy is offered, and a weekly activity planner is always available.

Residents spoke positively about the activities:

- *"I enjoy the pet therapy sessions "*
- *"I like that I can choose whether to go out or stay in my room. The staff always bring me something to do"*
- *"I was nervous about joining group activities, but the staff encouraged me gently. Now I look forward"*

Records show that people who were previously reluctant to engage are gradually supported to participate, with staff building trust and rapport. This demonstrates the service's commitment to person-centred practice and respect for residents' choices.

Since our last visit, the service has strengthened its approach to meeting spiritual needs, the service has ensured church services are also accessible via television.

Residents living with dementia or cognitive decline are supported through structured group and one-to-one activities. Families also shared positive feedback on the impact of activities:
"We're pleased the home takes the time to ask about Dad's hobbies.

"We are really impressed that the staff respect our father's choice not to join group activities and instead provide one-to-one time. It makes him feel valued."

As part of its refurbishment programme, the service is creating "snug" spaces designed to provide residents with comfortable, relaxing areas for social and individual use. During the inspection, a mural was being painted on the wall, with a music-themed design to stimulate memory and conversation. A vinyl record player was also available, providing opportunities for reminiscence and sensory stimulation.

These developments form part of the service's wider dementia strategy, ensuring that the environment is enabling, familiar and supportive for people living with dementia. By incorporating music, art and homely features, the refurbishment aims to reduce anxiety, encourage engagement, and promote wellbeing.

The service recognises that while meaningful engagement is offered, staff are not always consistently interacting with residents in a purposeful or stimulating way outside of planned activity sessions. The service is working to improve this so that opportunities for everyday wellbeing are not missed, particularly for people living with dementia.

Independence, choice and control – Score: 2
We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.

The service has sustained progress since the last visit, with evidence of improvements in activity provision, dementia support, and community engagement. Residents were supported to be as independent as possible. Appropriate equipment was provided to assist people with daily living tasks, such as mobility aids and specialist chairs, and risks were assessed and mitigated to promote independence. For example, a resident who was identified as being at risk of falls was enabled to remain independent .Staff ensured risk management strategies were in place, including regular checks and oversight, so that the individual could maintain autonomy while remaining safe.

Staff were observed to be diligent in monitoring risks and provided frequent oversight to ensure safety. A range of assistive equipment was in place, including height-adjustable beds, crash mats, pressure-relieving equipment, and falls reduction sensory aids. Support plans identified residents' strengths alongside areas where support was required.

A structured programme of activities was available weekly, and residents received a copy of the planner to enable choice. Where residents chose not to take part, their decisions were respected. The activity co-ordinator provided one-to-one time in residents' rooms to reduce isolation and offered personalised activities such as drawing.

Relatives' meetings are held regularly, providing families with the opportunity to share feedback and suggestions. The service is committed to community integration, with plans in place to support residents to remain active outside the home. This includes outings such as trips to Care Home FaNs (Friends and Neighbours) support groups.

Staff expressed enthusiasm about supporting residents living with dementia, highlighting the impact of the training they had received. They described how the bite-size training sessions delivered directly by the Registered Manager had helped them feel more confident and knowledgeable in their roles.

Leadership within the service was described positively. The manager was seen to be highly visible, approachable, and informative, rather than remaining in the office. Residents and families valued this accessibility. The administrator was also described as helpful and supportive, contributing to smooth day-to-day operations.

Although moments of meaningful engagement and their benefits were observed and noted in some daily records, this was not consistently captured. Sustaining progress will require ensuring that these examples of personalised and impactful engagement are routinely recorded and embedded in practice.

Responding to people's immediate needs – Score 3
We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Residents living with long-term conditions and acute health needs are reviewed and assessed collaboratively with the GP service through a weekly clinic held within Elmcroft.

The service has established strong links with the local GP practice, with a dedicated care home direct line available for timely escalation of possible acute illness. This collaborative approach ensures that residents' health needs are responded to quickly and effectively.

The Registered Manager, having previously worked as an advanced practitioner, provides additional expertise in supporting staff to recognise and escalate deteriorating conditions. This has strengthened the quality of clinical oversight and improved confidence in staff decision-making.

Focused reviews with the GP have also enabled medications for people living with long-term conditions to be reviewed and optimised. This ensures that treatment plans remain appropriate and responsive to residents' changing needs. Care plans are regularly reviewed and updated to reflect any changes in illness, ensuring people receive safe and effective care.

One relative shared that their family member's care plan had recently been changed to accommodate a change in their illness, and they added that they "*would not hesitate to recommend Elmcroft to other families who need help caring for their family or friends".*

Workforce wellbeing and enablement – Score: 3
The service cares about and actively promotes the wellbeing of its staff, supporting and enabling them to deliver person-centred care.

Staff reported feeling supported and valued at Elmcroft, including those who had been sponsored from overseas. They told us that "*the management team show their support and that they are here to help"* and "*the manager has implemented things to really help us".* Staff described receiving supervision that met their needs, provided opportunities for feedback, and included regular "check-ins" to see how people were feeling. Records of supervision were checked. As identified previously, it is recommended to clearly explain the supervision structure used within the home.

Staff meetings were reviewed and demonstrated that staff were encouraged to talk and share their views. In addition, there is a staff suggestion box in reception, which staff can use to raise ideas or concerns anonymously. A whistleblowing poster was also visible on the notice board, ensuring staff know how to raise concerns externally if needed.

The Registered Manager demonstrated her commitment to knowing the staff team well, undertaking annual appraisals for every member of staff and overseeing supervisions to ensure any required actions were followed up. Staff said the Registered Manager takes time to talk to them individually, recognises talent, and empowers them to undertake further training. Staff also described with pride the company platform used to recognise and nominate staff achievements, and several highlighted occasions where they had received staff awards.

During times of low occupancy, the organisation has supported staff by moving them into other roles where possible, as well as offering voluntary redundancies where appropriate. This approach demonstrated openness, transparency, and a focus on staff wellbeing despite operational challenges.

Staff surveys are conducted, and feedback is taken on board to inform changes. Staff confirmed they felt listened to and involved in decisions that affect their work. They reported that they are free to approach the manager at any time, describing her as visible, approachable, and supportive was not always clear whether these sessions were one-to-one or group-based; however, staff were able

Summary score

Kindness, compassion, and dignity	3
Treating people as individuals	2
Independence, choice and control	2
Responding to peoples immediate needs	3
Workforce wellbeing and enablement	3
Total score	13
Possible score	20

Rating for key question – Caring: Good

With a percentage score for the key question of 65% (13 divided by 20)

Action Plan:

Treating people as individuals –

- To ensure staff consistently interact with residents in a purposeful and stimulating way outside of planned activity sessions, by embedding meaningful engagement into daily care routines.

Independence, choice and control

- As indicated under treating people as individuals

Key Question: Responsive

Quality statement assessed against:

People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics.

People, those who support them, and staff can easily access information, advice and advocacy. This supports them in managing and understanding their care and treatment. There is partnership working to make sure that care and treatment meets the diverse needs of communities. People are encouraged to give feedback, which is acted on and used to deliver improvements.

Person-centre care – Score: 2

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

There was evidence that residents received care and treatment which was person-centred, and people provided feedback that their relatives were well cared for by staff who knew them well. Staff were also able to describe the person-centred needs of the residents they supported and were observed delivering often insightful care.

However, there was a lack of direct correlation between residents' care plans and the care notes completed on a daily basis. Care notes were often generic, lacked depth, and did not consistently reflect the individual needs identified within the care plan. This meant that personalised care, while sometimes being delivered, was not consistently evidenced in the records.

Residents' care and support plans also demonstrated inconsistency in both quality and detail. While some plans showed evidence of a positive behaviour approach, particularly for residents living with cognitive decline, the positive outcomes achieved through this approach were not reflected in the care plan. Similarly, where risks had been identified and reviewed, this was not always translated into the care planning process. Care domains did not consistently provide a clear sense of the individual, or how a condition, health state, or wellbeing need specifically manifested or impacted on the resident. Instead, care domains often contained generic statements that could be applied broadly, rather than detailed, person-centred information. The service should remain mindful of the distinction between a person-centred care plan and documentation that is training or process-driven.

Staff utilise an electronic care planning system to enter care notes at the point of delivery, such as during personal care, or when recording nutrition and hydration offered and received. However, moments of meaningful engagement with residents, including participation in activities or individual preferences, were inconsistently captured. This limited the ability to demonstrate how care plans translated into daily lived experiences for residents and reduced opportunities for shared learning and improvement.

While residents and relatives reported that staff delivered kind and attentive care, sustaining progress will require the service to ensure that positive outcomes are consistently reflected in care plans, that daily care notes contain sufficient depth to evidence person-centred support, and that risk identification fully informs care planning.

Care provision, integration, and continuity – Score: 3
We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

There has been sustained progress in how the service works collaboratively with health and social care professionals to support residents' health and wellbeing. Visiting professionals alluded to the Registered Manager's active involvement in ensuring that residents received timely and appropriate healthcare. People told us that if they needed support from a healthcare professional this was provided for them, and there was evidence that staff worked effectively with external teams such as the GP, DISS team, dentist, and SALT to achieve positive outcomes for residents. The service had also received feedback from professionals confirming the quality of this joint working.

Staff reported that they felt they worked well with healthcare professionals and that their input was valued and listened to.

The Registered Manager and senior team are closely involved in regular reviews and the tracking of residents' care, support, and treatment through multi-disciplinary team (MDT) discussions and clinical governance meetings. They undertake audits in key areas such as residents sustaining a fall and weight loss. Analysis was observed to identify trends and consider underlying health conditions which may contribute to risks such as falls.

In addition, the senior management team hold monthly governance meetings where trend analysis is shared and used to inform changes in practice. For example, analysis of call bell usage identified a training need around how staff perceived and responded to the behaviour of a resident. This learning was cascaded to the staff team to improve awareness and practice.

The Registered Manager demonstrated a high level of knowledge and understanding about the needs of the people using the service, with a clear focus on continuous monitoring and the sharing of relevant information with staff to maintain safe, effective, and person-centred care.

Providing information – Score 3

We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.

Staff demonstrated knowledge of residents' communication needs, with care plans detailing support for those living with sensory loss and those with cognitive decline. Staff were observed communicating in a meaningful way, allowing people time to process information and respond at their own pace. Care plans also included details of significant people residents wished to communicate with, including those holding power of attorney.

Information on how to raise complaints was clearly displayed, and people had multiple avenues to share feedback – through meetings, directly with the senior team via an open-door policy, or through the formal complaints procedure. Complaints were acted on promptly and effectively, with resolutions put in place and outcomes fed back to those involved.

Resident and relative meetings provided opportunities for open discussion on a range of topics, including staffing, activities, food, and laundry provision. Relatives were also given information about recent CQC inspection outcomes and the associated action plans. Notices throughout the home displayed useful contact details, ensuring accessibility.

People confirmed they had opportunities to discuss their care plans, and copies were provided where required. This demonstrated that residents and relatives were kept informed and actively involved in decisions about care and service delivery

Listening and involving people – Score: 3

The service makes it easy for people to share feedback, raise concerns, and be involved in decisions about their care. Staff were observed listening to residents and recognising non-verbal communication, respecting people's choices and recording when care had been offered and declined.

Residents reported, "I am consulted and informed about my care," and relatives confirmed that, "they ring me about any changes". People said they knew how to raise a concern or provide feedback and were aware of when meetings were being held.

Complaints were noted to be dealt with promptly and in line with policy. Records showed that when concerns were raised, they were investigated, lessons were learnt, and outcomes were communicated clearly. Those raising issues were also given the opportunity to meet with the manager or escalate to a formal complaint if they wished.

Relatives expressed confidence in communication, describing timely phone calls, prompt responses to emails, and informative meetings. Feedback confirmed that people felt involved, well informed, and reassured that transparency and integrity were central to how the service communicated.

Equality in access – Score 3
We make sure that everyone can access the care, support and treatment they need when they need it.

The service ensures that residents can access the care, support, and treatment they need when required, with both proactive and reactive healthcare available. Since the last visit, additional services have been introduced, including a visiting dental practice and ear health checks, further enhancing residents' access to on-site healthcare.

Where possible, external appointments are reduced by arranging regular GP clinics, optician visits, dental checks, and chiropody within Elmcroft. People confirmed that they had benefited from these services. Referrals to specialist teams such as SALT, dieticians, and the DISS team are facilitated promptly, and staff follow the guidance provided.

Equality and diversity are actively promoted. Staff have undertaken relevant training, and all roles have equal access to development opportunities. Champion roles have been established across the service to strengthen practice in key areas. Workforce development has empowered staff, supported by an extensive training programme, which has enabled staff to build specialist knowledge and progress into lead roles

Equity in experiences and outcomes – Score: 3
We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Sustained progress continues to be made in ensuring people are treated as individuals by staff who apply their skills and knowledge to care. Residents were supported to make informed choices about how they wished to spend their day, and these choices were respected while ensuring that people were not at risk of social isolation through the provision of one-to-one engagement.
Relatives confirmed they are regularly communicated with by knowledgeable staff when they visit and felt that their views were listened to.

There was also evidence that those who may be at risk of not being heard, such as people with communication barriers or cognitive decline, received collaborative care that led to positive outcomes. This included joint working with the GP and DISS team. For residents living with dementia, care planning provided staff with clear guidance on recognising and responding to non-verbal communication, ensuring individual needs were understood and met.

Planning for the future – Score: 2

We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

The provision of weekly GP visits enables residents living with long-term conditions to have their health reviewed regularly, ensuring changes are identified promptly and appropriate care plans are put in place. Daily meetings within the service further support timely discussion of residents' health, wellbeing, and care priorities.

Residents, and where appropriate their relatives, are supported to make informed choices about important life changes, including at the end of life. End of life care plans were in place, recording people's resuscitation status, preferences for their care, and the involvement of families or best-interest decision-making where applicable. Plans also reflected personalised wishes, such as music choices and who residents wished to be with them, demonstrating a focus on dignity and respect.

It was noted that DNAR plans did not always include details on actions to take in the event of reversible conditions such as choking. This limited clarity for staff when responding to potentially treatable situations. Similarly, while reference was made to the existence of PEACE plans to support hospitalisation decisions, these were not consistently embedded within support plans or referenced clearly.

Staff had completed training in end of life care, with nurses receiving CPD on the use of syringe drivers to manage pain. Anticipatory medications were available where required to ensure residents remained comfortable.

Staff had undertaken end of life care training and nursing staff had been provided with CPD relating to the administration of end-of-life medications to control and manage pain via a syringe driver. Anticipatory medications were appropriately in place.

Summary score

Person-centred care	2
Care provision, integrations and continuity	3
Providing information	3
Listening to and involving people	3
Equity in access	3
Equity in experience and outcomes	3
Planning for the future	2
Total score	19
Possible score	29

Rating for key question – Responsive: Good

With a percentage score for the key question of 67% (19 divided by 28)

Action Plan:

Person centred care –

- To ensure there is clear evidence that residents consistently receive person-centred care and treatment, and that care notes and plans reflect individual needs, preferences, and outcomes.

Planning for the future –

- To ensure that where a DNACPR is recorded to be in place, support plans consistently consider reversable causes of cardiac arrest such as choking and the appropriate actions to take
- To ensure that where a PEACE plan is in place, support plans record the detailed information contained within the plan for guidance to staff on the appropriate escalation actions and care to take for hospitalisation and treatment

Key Question: Well-Led

Quality statement assessed against:

There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.
There are effective governance and management systems. Information about risks, performance and outcomes is used effectively to improve care.

Shared direction and culture – Score: 3
We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

The service demonstrates a shared vision, strategy and culture grounded in transparency, equity, equality, human rights, diversity, inclusion, and community engagement.

There is clear evidence that the Registered Manager has embedded a positive culture of openness, transparency, empathy and support. Staff consistently spoke about the improvements within the service and the positive culture shift.
Staff said:

- "*The manager listens to us and makes sure our ideas are taken seriously – we feel valued now."*
- "*Communication has improved a lot, we know what's expected of us and we feel supported to do it well."*
- "*Training and development have given us more confidence to care for residents in a person-centred way."*

Relatives were keen to highlight the positive cultural shift brought about by the manager's leadership, reporting that they could clearly see the difference in the care and environment their loved ones experienced:

- *"We feel fully informed now – communication is open and transparent, and we are part of the journey."*
- "*The home feels happier and calmer, and that's reflected in how our relative is cared for."*
- "*We have confidence that the staff are well supported, and that shows in the kindness and patience they show to residents*"

Relatives valued being included in meetings, where updates on progress were shared openly, and their feedback was invited and acted upon. Many expressed that they would now confidently recommend

the service to others, describing themselves as "grateful for the improvements" and recognising the manager's role in driving them.

Capable, compassionate and inclusive leaders – Score: 3

We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

The Registered Manager, now fully registered with the CQC, has demonstrated strong capability in managing the service, embedding improvement, and sustaining high standards of care. She has developed health improvement analysis documents and summaries of discourse around significant events in the context of CQC concerns, which have supported strategic intervention design and the strengthening of clinical leadership within the service. Her contribution has been integral in shaping an evolving medical model, ensuring governance systems are evidence-based, transparent, and outcome-driven.

The Registered Manager has consistently identified innovative ways to improve the triangulation of systems and processes, aligning them to clinical governance frameworks in a format that is both accessible and demonstrative of positive outcomes. She maintains clear and timely communication with internal teams and external professionals, creating robust audit trails that evidence action and accountability. Observations confirmed she responds promptly to communications and ensures clarity in agreed actions.

Working alongside the Operations Manager, the Registered Manager has been visible within the service, maintaining an open-door policy that ensures accessibility to staff and residents. Both leaders supported the team during a period of change, contributing directly to daily care and incident analysis. The Registered Manager also engaged in weekly clinical reviews with the GP, who commended her knowledge and input, recognising the value she added to resident health planning and outcomes.

Staff were consistently positive about the Registered Manager, particularly noting the tools and structures she introduced to support safe practice, effective communication, and consistent care delivery. These included a new handover document and safeguarding-focused tools, which were observed being actively and effectively used by staff during the inspection. Staff feedback included:

- "*She has brought in systems that make our work clearer and easier to follow. Everything is structured now, and we feel more confident about what we're doing"*
- *"The Manager sets out clear goals for us and explains why changes are being made. That helps us understand the bigger picture and do our jobs better"*

- *"She supports us individually—if you're unsure about something, she will explain it, guide you, and check back to make sure you feel confident"*

The Registered Manager has also developed staff into lead and specialist roles, including CHAPs, thereby strengthening clinical oversight and leadership capacity within the home. This has contributed to a calm, structured, and collaborative atmosphere, where staff clearly understood their roles and carried them out confidently.

Relatives were also highly positive about the impact of leadership, noting significant improvement and transformation within the service. Feedback included:

- "*The home feels much more organised and well-led now. We can see that changes have been put in place and that staff are more confident and supported."*
- *"The Manager knows the residents so well and can tell you immediately what their needs are. That reassures us that people are safe and well looked after."*
- *"Since the new leadership team came in, we've noticed a huge improvement in communication and consistency. They listen, and they act on what you say."*

Overall, there is clear evidence that the Registered Manager has strengthened governance, enhanced clinical leadership, and embedded an evolving model of care that prioritises safety, accountability, and positive outcomes for residents

Freedom to speak up – Score 3

We foster a positive culture where people feel that they can speak up and that their voice will be heard.

Elmcroft Care Home demonstrated a positive and inclusive culture, strongly influenced by the leadership of the Registered Manager. Staff consistently described the environment as supportive and empowering, with a clear emphasis on teamwork, accountability, and open communication. Regular meetings were in place, which staff and relatives found effective in ensuring transparency and collaboration.

The Registered Manager was recognised for creating a culture where people felt able to raise ideas and concerns with confidence, knowing they would be listened to and that action would follow. Staff highlighted that they felt their input shaped daily practice, and that this had led to greater consistency in care delivery and clearer communication across the service. Observations supported this, showing that staff communicated effectively with one another and with senior leaders, which contributed to a calm and well-coordinated environment.

Systems for raising concerns were clear, accessible, and underpinned by robust policies on complaints and whistleblowing. Staff and relatives expressed confidence that concerns were handled swiftly, fairly,

and with a focus on finding solutions, and that leadership maintained openness in the way issues were addressed.

Surveys and feedback processes were actively used to gather views from residents and families, and work was underway to strengthen these systems further so that they also captured the voices of people living with cognitive decline.

Daily senior team meetings were well-structured and inclusive, ensuring that staff received the information required to carry out their roles effectively. Clinical handovers were consistently detailed, aligned to best practice, and provided assurance of strong oversight of care.

The Registered Manager's approach to leadership was consistently praised for fostering a transparent, solution-focused, and well-led culture, ensuring that staff, residents, and relatives felt supported, valued, and confident in the quality of care being provided

Workforce equality, diversity and inclusion – Score: 3
We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

Elmcroft Care Home continues to demonstrate a clear commitment to equality, diversity, and inclusion within its workforce. The service employs a diverse staff team, and staff consistently reported that they feel respected, valued, and supported in their roles. Recognition initiatives, including staff achievement awards, have reinforced this positive culture and motivated staff to take pride in their contributions.

There was evidence of sustained progress in how the service develops and supports its staff. Training and professional development opportunities were accessible, enabling staff to build the right skills to meet the needs of residents. Staff were also encouraged to take ownership of service development through lead and specialist roles, which fostered a sense of responsibility and empowerment across the team.

The Registered Manager worked closely with staff, remaining visible within the service and approachable to all team members. Staff consistently commended the Manager's leadership, noting that they felt able to raise ideas and concerns openly and that their contributions were valued. Examples included staff highlighting how the Registered Manager:

- "*created opportunities for them to take on lead responsibilities that matched their skills and interests"*
- *"supported individuals to complete training that gave them greater confidence in specialist areas of care, and ensured regular feedback and guidance, which staff described as encouraging and motivating"*

Staff reflected that the Registered Manager's open and inclusive approach has contributed to a supportive working environment, where people feel proud of their roles and part of a team that is committed to delivering safe, person-centred care'

Overall, the service has embedded inclusive practices into its culture, with evidence that these values are not only upheld but continue to progress over time, driven by the Manager's leadership and commitment to staff development.

Governance, management, and sustainability – Score 3

The service has clear responsibilities, roles, systems of accountability, and robust governance arrangements. These are used to manage and deliver high-quality, sustainable care, treatment, and support. The service acts on the best available information about risk, performance, and outcomes, and shares this securely with others when appropriate.

The Registered Manager has embedded effective systems of governance, supported by the management team, which promote a culture of openness, learning, and accountability. External partners and agencies noted the team's willingness to engage with feedback and adapt practice to strengthen service delivery.

Audits, trackers, and monitoring tools were in place to provide oversight of quality and safety. Monthly clinical governance meetings, aligned to the seven pillars of clinical governance, ensured that risks were reviewed, outcomes analysed, and action plans developed. While progress had been demonstrated against many of these plans, the service now needs to ensure that evidence of completed actions and sustained improvement is consistently documented following each governance cycle.

There was also a sustained focus on staff development. Training records showed that staff were supported to acquire and maintain the skills required to meet people's changing needs, with ongoing supervision and appraisal to support accountability at every level.

In summary, Elmcroft has embedded strong systems of governance, leadership, and accountability. To demonstrate best practice, the service should continue to evidence how identified lessons have been acted on, and how these changes are embedded and sustained over time.

Partnerships and communities – Score 3

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

The service recognises its duty to collaborate and work in partnership so that services work seamlessly for people. They also share information and learning with partners to support continuous improvement.

At Elmcroft, there was clear evidence that the Manager maintained active oversight of partnership working, ensuring that collaborative arrangements with external professionals were consistent, effective, and outcome-focused. Staff and the Registered Manager worked closely with the local GP practice, specialist health services such as dieticians, the DISS team, and commissioners. This partnership approach supported the evolution of the service, embedding improvements, and achieving positive outcomes for residents, as evidenced throughout this report.

The Registered Manager also encouraged and facilitated engagement with the wider community. Links were established with local community groups, and residents were supported to take part in external outings, which enhanced their social interaction and wellbeing. This was strengthened by the appointment of a dedicated activities coordinator, whose role was to expand opportunities for meaningful involvement beyond the home.

Through these approaches, the service demonstrated that collaboration, both with professionals and the wider community, was not only embedded but overseen effectively by the Manager to ensure consistency and ongoing benefit for residents.

Learning, improvement and innovation – Score 3

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

The service recognised its duty to collaborate with external professionals and community partners, ensuring joined-up care that delivered positive outcomes for residents. Under the oversight of the Manager, staff worked effectively with GPs, dieticians, specialist teams, and commissioners. These partnerships contributed to improvements in care planning, clinical oversight, and resident wellbeing.

Residents also benefited from opportunities to engage with the wider community. Links with local groups and participation in outings were promoted, supporting social inclusion and enhancing quality of life. The appointment of a dedicated activities coordinator further strengthened this focus, ensuring community involvement was meaningful and consistent.

Feedback highlighted the value of these collaborative approaches:

- *"The Manager makes sure that external professionals are listened to, and their advice is followed through in practice"*
- *"Partnership working is stronger now—we work together with health teams, and it's clear that residents benefit from that joined-up approach"*
- *"The service helps people stay connected to their community, which makes a real difference to their wellbeing"*

Overall, Elmcroft demonstrated strong and effective partnership working, with evidence of sustained improvement. To progress further, the service should continue to demonstrate how lessons from partnership work are consistently embedded and evidenced over time

Environmental sustainability – sustainable development – Score not included at this time.
We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same

Summary score

Shared direction and culture	3
Capable, compassionate, and inclusive leaders	3
Freedom to speak up	3
Workforce equality, diversity and inclusion	3
Governance and assurance	3
Partnership and communities	3
Learning, improvement and innovation	3
Total score	21
Possible score	28

Rating for key question – Well-led: Good

With a percentage score for the key question of 75% (21 divided by 28)