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# Mill Court Care Home

## Mock Inspection Report and Improvement Plan

Date: 1<sup>st</sup> and 2<sup>nd</sup> of September, 2026

## Scope

Delphi Care Solutions was commissioned to complete an independent, evidence-based mock inspection of Mill Court Care Home.

Delphi completed the mock inspection on 2<sup>nd</sup> and 3<sup>rd</sup> of September, with all work carried out on a face-to-face/on-site basis over two days.

During the mock inspection, we identified areas of very good practice and potential areas for improvement. Throughout the day, we shared high-level feedback relating to these findings with the home and local managers.

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

| CQC KEY LINES OF ENQUIRY |                          |                       |                           |                         |                |
|--------------------------|--------------------------|-----------------------|---------------------------|-------------------------|----------------|
| Safe<br>24/32 = 75%      | Effective<br>18/24 = 75% | Caring<br>15/20 = 75% | Responsive<br>21/28 = 75% | Well-Led<br>22/28 = 79% | Overall Rating |
| Good<br>●                | Good<br>●                | Good<br>●             | Good<br>●                 | Good<br>●               | Good<br>●      |

## Rating

CQC Quality Statements scoring system:

**4** = Evidence shows an exceptional standard.

**3** = Evidence shows a good standard.

**2** = Evidence shows some shortfalls.

**1** = Evidence shows significant shortfalls.

We use these thresholds to convert percentages to scores:

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

## R/A/G Rating

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

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

| SAFE: Score Range 1 – 4 per area (maximum Score 32)       |                                              |                                            |                                            |                                          |                                   |                                     |                                                       | Total score  |
|-----------------------------------------------------------|----------------------------------------------|--------------------------------------------|--------------------------------------------|------------------------------------------|-----------------------------------|-------------------------------------|-------------------------------------------------------|--------------|
| Learning Culture                                          | Safe Systems, Pathways and Transitions       | Safeguarding                               | Involving People to Manage Risks           | Safe Environments                        | Safe and Effective Staffing       | Infection Prevention and Control    | Medicines Optimisation                                | 24/32<br>75% |
| SCORE: 3                                                  | SCORE: 3                                     | SCORE: 3                                   | SCORE: 3                                   | SCORE: 3                                 | SCORE: 3                          | SCORE: 3                            | SCORE: 3                                              |              |
| EFFECTIVE: Score Range 1 – 4 per area (maximum Score 24)  |                                              |                                            |                                            |                                          |                                   |                                     |                                                       |              |
| Assessing Need                                            | Delivering Evidence-Based Care and Treatment | How Staff Teams and Services Work Together | Supporting People to Live Healthier Lives  | Monitoring and Improving Outcomes        | Consent to Care and Treatment     |                                     |                                                       | 18/24<br>75% |
| SCORE: 3                                                  | SCORE: 3                                     | SCORE: 3                                   | SCORE: 3                                   | SCORE: 3                                 | SCORE: 3                          |                                     |                                                       |              |
| CARING: Score Range 1 – 4 per area (maximum Score 20)     |                                              |                                            |                                            |                                          |                                   |                                     |                                                       |              |
| Kindness, Compassion, and Dignity                         | Treating People as Individuals               | Independence Choice and Control            | Responding to People's Immediate Needs     | Workforce Wellbeing and Enablement       |                                   |                                     |                                                       | 15/20<br>75% |
| SCORE: 3                                                  | SCORE: 3                                     | SCORE: 3                                   | SCORE: 3                                   | SCORE: 3                                 |                                   |                                     |                                                       |              |
| RESPONSIVE: Score Range 1 – 4 per area (maximum Score 28) |                                              |                                            |                                            |                                          |                                   |                                     |                                                       |              |
| Person Centred Care                                       | Care Provision Integration and Continuity    | Providing Information                      | Listening to and Involving People          | Equity in Access                         | Equity in Experience and Outcomes | Planning for the future             |                                                       | 21/28<br>75% |
| SCORE: 3                                                  | SCORE: 3                                     | SCORE: 3                                   | SCORE: 3                                   | SCORE: 3                                 | SCORE: 3                          | SCORE: 3                            |                                                       |              |
| WELL-LED: Score Range 1 – 4 per area (maximum Score 28)   |                                              |                                            |                                            |                                          |                                   |                                     |                                                       |              |
| Shared Direction and Culture                              | Capable Compassionate and Inclusive Leaders  | Freedom to Speak Up                        | Workforce Equality Diversity and Inclusion | Governance Management and Sustainability | Partnership and Communities       | Learning Improvement and Innovation | Environmental Sustainability/ Sustainable Development | 22/28<br>79% |
| SCORE: 3                                                  | SCORE: 4                                     | SCORE: 3                                   | SCORE: 3                                   | SCORE: 3                                 | SCORE: 3                          | SCORE: 3                            | N/A                                                   |              |

## **Overview**

We carried out an unannounced on-site mock inspection at Mill Court Care Home.

Mill Court Care Home is registered with the Care Quality Commission (CQC) to provide regulated activities under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service is registered to provide:

- Accommodation for persons who require nursing or personal care.

The service is registered as a residential care home and provides care and support to people within the following service user groups and specialisms:

- Adults over 65 years.
- Adults under 65 years.
- People living with dementia.

Mill Court Care Home is located at Christmas Hill, Shalford, Guildford, Surrey, GU4 8HN, within the Surrey local authority area. The CQC location ID is 1-20396033727.

The registered provider is permitted to accommodate a maximum of 60 people at Mill Court Care Home. The conditions of registration state that the provider must not provide nursing care at this location. Mrs Nicola Louise Woods is the registered manager, and Mr Dominic Jude Kay is the nominated individual responsible for the regulated service.

At the time of the mock inspection, Mill Court Care Home was rated Requires Improvement overall by CQC. The latest assessment report was published on 12 February 2026, and the service was rated Requires Improvement across all five key questions

## **Safe**

### **Learning culture: Score 3**

The service demonstrated a positive approach to learning from incidents, audits and feedback. We reviewed Well Tower Quality reports and internal audits that had identified concerns with some PRN medicine prescriptions, including a lack of clear instructions about when medicines should be administered. In response, the service developed an action plan, reviewed the relevant PRN protocols and arranged a meeting with the local GP practice to agree how these issues would be addressed. We found that the actions and learning had also been discussed through daily flash meetings and with the internal clinical development nurse.

Following feedback about auditing arrangements and high call bell response times, the service added actions to its central improvement plan. This included considering the recruitment and deployment of staff during twilight hours to respond flexibly to periods of increased demand identified through call bell data. The matter was followed up through support and review meetings and reflective discussions with staff teams. However, this work had not yet been fully formalised through a monthly call bell analysis report setting out emerging themes, contributing factors, actions taken and lessons learned. Introducing this would provide clearer evidence of how the service uses call bell information to drive and sustain improvement.

Records showed that care plans and risk assessments were updated following changes in people's clinical presentation, revised professional guidance and readmission to the home after hospital treatment, including following falls. We also reviewed medication competency assessments completed after medication incidents or where concerns had been identified regarding staff confidence. This demonstrated that the provider responded to incidents by reviewing staff practice, reassessing competency and providing additional support where required.

### **Safe systems, pathways, and transitions: Score 3**

The service had systems to support safe admissions, transfers and continuity of care. We reviewed pre-admission assessments that described people's needs before they moved into the home. Staff demonstrated a clear understanding of the admission process and identified key priorities, including recording people's weight and height, assessing skin integrity, completing relevant risk assessments and developing care plans. Staff explained that information was obtained directly from people and, where appropriate, from their next of kin. They described how care plans and risk assessments were established promptly following admission.

Discharge notifications and information about changes following hospital admission had been incorporated into people's care records in the sample of records we looked at. Communication with local authorities, commissioners and healthcare organisations was recorded, and we saw evidence of referrals to local health services when people's needs changed. Records included contact with GPs, district nurses and tissue viability nurses. One manager described a "triangle of care" approach, which involved liaising with the person, their family and relevant professionals when there was a change in their clinical presentation.

Members of the local management team understood Barchester Healthcare policies and internal clinical governance procedures. They also demonstrated knowledge of events that required statutory notification. Communication and oversight were supported through management meetings, senior staff meetings and daily flash meetings attended by heads of department.

The service operated within Barchester Healthcare's care and life enrichment framework, which covered care, meaningful activity, nutrition, the environment and the involvement of people. The laundry room contained corporate housekeeping manuals and best-practice guidance covering monitoring arrangements, quality requirements, Control of Substances Hazardous to Health, cleaning methods, expected standards, and health and safety.

We reviewed the red emergency grab bag. It contained working torches, fire signage, high-visibility jackets, identification wristbands, foil blankets and a first aid kit containing items that were within their expiry dates. Current personal emergency evacuation plans were not held in the grab bag. The provider told us these were available electronically on a telephone for use in an emergency. The provider should ensure that current evacuation information is immediately accessible, reliable and available during an emergency, including if electronic systems or devices cannot be accessed.

### **Safeguarding: Score 3.**

People were protected from abuse and improper treatment. We reviewed relevant Deprivation of Liberty Safeguards authorisations, including the required signatories and associated Mental Capacity Act processes completed with the relevant funding and managing authorities. The service maintained a dedicated safeguarding folder containing current guidance from the local authority. There were no open Section 42 safeguarding enquiries at the time of our inspection.

Since July 2026, the service had submitted four adult safeguarding referrals. These included an unwitnessed fall that resulted in a fracture. The referral stated that the person's care and support documentation would be reviewed following their discharge from hospital. We cross-referenced this with the person's care records and found that the relevant documents had been updated.

The service had previously experienced a period of whistleblowing concerns. These had been investigated and closed. One concern had recently resurfaced but was reviewed and closed shortly afterwards. Staff told us they had not witnessed abuse at the service. They demonstrated an understanding of the signs of abuse, the action they should take and the internal and external whistleblowing routes available to them.

Staff described a recent concern involving a person entering other residents' rooms. The manager investigated the matter and used available photographs to establish who had entered the rooms and inform the action required. This demonstrated that staff recognised concerns and that management took action to understand and manage potential risks to people.

The CQC notification folder contained a substantial amount of historical safeguarding information. Records were categorised and indexed to support management oversight. This included clinical analyses, accident forms, medication error forms, CQC notification forms and records of lessons learned. We also reviewed duty of candour reports, CQC notifications and incident analyses, which provided assurance that incidents were being reviewed and associated learning recorded.

In one case, a person returned from hospital with two fractures that the hospital had not communicated to the service. This identified a weakness in the transfer of information when people returned to the home. Although the omission did not originate within the service, the provider should continue to strengthen its hospital discharge and readmission checks so that injuries, changes in need and required follow-up actions are identified promptly. Safeguarding training compliance was 92% at the time of our inspection.

### **Safe environments: Score 3**

The service had systems to assess and manage environmental risks, and the home was clean, organised and appropriately maintained. However, we identified several environmental safety issues that required action to reduce avoidable risks to people.

A helium cylinder was stored in the care office on the top floor without suitable warning signage identifying the presence of compressed gas due to a recent activity. However, the provider should ensure the cylinder is appropriately secured, labelled and included within relevant environmental and fire risk assessments.

The top floor kitchen contained an in date first aid kit supported by a completed monthly checklist. There was no sign on the kitchen door identifying the location of the kit, which could make it more difficult to locate during an emergency. The provider told us that first aid kits were stored in a consistent location across its homes and that staff were informed of this through training, which provides assurance of location.

Cleaning staff were observed working throughout the home using secure cleaning trolleys, with no chemicals left accessible to people. Evacuation mats and fire extinguishers were available in corridors, and window restrictors were fitted throughout the building.

We inspected the sluice rooms and chemical storage areas. Cleaning checklists for each floor were complete, and the service maintained wider housekeeping records, external contractor customer care audits, signed Control of Substances Hazardous to Health risk assessments and relevant safety data sheets. The cleaning files were well organised, and weekly stock-level checks had been completed from the beginning of the year.

Laundry cleaning schedules had generally been signed daily. We identified one period containing three incomplete days. Earlier in 2026, when the housekeeping team was not fully staffed, some cleaning rotas contained gaps of more than one week. More recent cleaning schedules were complete, indicating that oversight had improved as staffing stabilised.

Spill kits were not stored within the COSHH cupboards. The provider clarified that spill kits were available on housekeeping trolleys, within clinical rooms and in the general manager's office. The provider should ensure that staff know where suitable spill-response equipment is located and that it is readily accessible at the point of need.

Records also showed that emergency lighting, gas and electrical systems, and lifting equipment were serviced and within their required inspection dates. These checks were managed through the provider's Data Station software. We also saw current servicing records for slings and other environmental equipment.

The laundry was clean and well organised, with systems for separating cleaning, drying and the redistribution of clothing to people's rooms. The kitchen was also clean and orderly, and relevant food safety guidance was displayed. Food within the cold store was generally labelled with appropriate use-by information. However, bananas stored in a clear container and some vegetables did not have date labels. The provider should ensure that all decanted or prepared food is labelled in accordance with its food safety procedures.

**Safe and effective staffing: Score 3.**

The service had effective systems for recruiting, supporting and developing staff. The service used Barchester Healthcare's Talent Acquisition Portal to manage recruitment and onboarding. We reviewed multiple staff files and found a consistent format across each record. The electronic dashboards included job and location details, contact information, HR compliance approval, completed application forms, offer and pay details, and appropriate right-to-work documentation.

Disclosure and Barring Service checks had been completed and were scheduled for renewal every three years. Management told us that the central HR team issued reminders when renewals were due. References and employment histories had been checked. Files also included proof of identity, contracts and addendums, job descriptions, CVs, interview notes, uniform records, clocking-in consent, DBS guidance and signed confirmation of the provider's values. The portal included a document tracker and an application pipeline, enabling managers to monitor applicants through each stage of recruitment and onboarding.

New staff completed induction reviews at 1, 6 and 12 weeks, supported by an individual personal development plan. Staff received supervision every three months, an annual appraisal and an additional mid-year appraisal. Supervision records contained relevant discussion about staff members' roles, responsibilities, performance and development. The service also used group supervision to address specific practice issues, including nail care and supporting people safely during periods of extreme heat.

The staff training matrix showed an overall completion rate of 97%, with the lowest individual subject compliance at 92%. The home manager demonstrated good oversight of training and explained that staff who were not up to date with mandatory courses could be removed from shifts until the required training had been completed. We saw evidence that this process was used in practice.

We reviewed staffing rotas and found that staff absences were minimal. Where absences occurred, the home manager demonstrated how staff were redeployed to maintain safe care and ensure that therapeutic and meaningful activities continued. This included selecting available staff whose experience and skills were suited to supporting the activity programme. The service reported that staffing numbers reflected its current occupancy and that recruitment planning was taking account of the proposed increase from 42 to 60 people. Bank staff were being considered for permanent roles as occupancy increased.

**Infection prevention and control: Score 3**

The service had effective arrangements to prevent and control infection. The home was clean and tidy, and hand hygiene dispensers were available throughout the building. Cleaning schedules were maintained to demonstrate that required tasks had been completed. During both days of the

inspection, we observed housekeeping staff cleaning and maintaining the environment. Cleanliness was also a standing agenda item at daily flash meetings, supporting ongoing oversight by managers and heads of department.

Infection registers were maintained within the medication files on each floor. We observed closed-lidded waste bins were in use. Appropriate infection prevention and control guidance was followed in toilets and areas used for personal care.

Staff wore appropriate personal protective equipment when providing personal care, administering medicines and handling food. The kitchen and laundry operated separate entry and exit routes to reduce the risk of cross-contamination from food and soiled laundry. The laundry was clean and organised, with suitable arrangements for separating, processing and returning clothing to people's rooms.

### **Medicines optimisation: Score 3**

We reviewed medicine administration records and identified two missing signatures, one from the previous night and another from the early morning. Stock checks confirmed that both medicines had been administered. We also found one instance where the numbering of medicines and the daily stock count had not been recorded. The manager acted promptly and completed a supervision with the staff member responsible for the missing signatures during the inspection process. We saw the matter was followed up through the appropriate staff wellbeing and human resources processes.

The service had three medication rooms, each located next to a care office. Medicines storage units were secured to the wall, and the rooms were temperature controlled. Medication room temperatures and cleaning checks had been completed consistently during the preceding months, with no gaps identified. Clinical guidance, medicines information, speak-up forms and relevant policies were available to staff in each room.

Medicines were stored at the required temperatures and were within their expiry dates, including items with limited shelf lives. The service maintained an up-to-date controlled drugs register and a medication returns book. Sharps bins were signed and dated. During the inspection, the provider addressed the need to secure sharps bins appropriately to the wall following advice.

PRN protocols had been reviewed and signed monthly. The information within the protocols was current and corresponded with the hospital discharge documentation we reviewed. Medication folders contained the provider's medicines policy, staff signature lists and transdermal patch records. An up-to-date British National Formulary was available in each medication room. The provider could further improve the accessibility of paper medication records by using clear visual identifiers to distinguish PRN medicines from regularly administered medicines.

## **Effective**

### **Assessing need: Score 3.**

The service assessed people's needs before admission and continued to review their needs as their circumstances changed. Each person had a pre-admission assessment recorded on Nourish, which included information about their needs, preferences and wishes. Admission records covered property, physical and personal care needs, cultural and religious requirements, social needs and relationships.

The electronic care-planning system provided access to a range of recognised assessment tools that could be used to assess and review people's individual care needs. These included, as examples, the Ostomy Skin Tool and Cornell Scale for Depression in Dementia. Such tools were not necessarily applicable to every person but should be considered and completed where they are relevant to the person's assessed needs, presentation and circumstance.

Care plans contained detailed, person-centred information and were reviewed monthly. Following falls, incidents and hospital readmissions, we found that care plans and risk assessments had been updated to reflect changes in people's presentation and support needs. In two cases involving falls, relevant information from the person's return from hospital had been added to their care plan so that staff had current guidance about increased care and monitoring requirements.

Accident and incident records provided a clear account of changes in people's presentation, the actions taken and the required management sign-off. This supported communication between staff and helped ensure that changes in need were identified and acted upon.

However, we identified some areas where the provider could strengthen their assessment processes. Some assessments available within Nourish were not consistently used or updated following admission. Although care plans were reviewed regularly and generally contained good information, records did not always demonstrate how people's wishes and preferences had been reviewed and changed over time. The provider should ensure that ongoing assessments capture the person's current voice, choices and desired outcomes, rather than relying primarily on information gathered at admission.

### **Delivering evidence-based care and treatment: Score 3.**

The service used recognised clinical guidance to support evidence-based care, including the 2026 British National Formulary and Royal Marsden clinical nursing procedures. Staff also had access to Barchester Healthcare's development directory, which set out available learning and professional development pathways. Current Surrey local authority guidance relating to revised DoLS thresholds was available within the home.

The daily stand-up meeting observed during the inspection included discussion about specialist dementia champion training. Best-practice guidance was also provided when staff completed particular assessments, including mental capacity assessments. This supported staff to apply relevant legal and professional guidance when assessing people and planning their care.

We found good evidence that risk assessments were updated following MUST and IDDSI assessments. Multifactorial risk assessments were also reviewed following falls, helping staff respond to changes in people's health and level of risk. Clinical guidance was stored within the document section of people's

electronic profiles. Some information was not accessible through staff handsets and should be made readily available to staff delivering care, such as the best practice guidance.

The electronic care-planning system provided access to a range of recognised assessment tools which could be selected according to people's assessed needs. The provider clarified that no resident required staff-managed ostomy care and that Cornell assessments for people living with dementia were current. The service should continue to ensure that staff consider the full range of assessment tools available and select those appropriate to each person's needs.

Within the documents section of a sample of people's electronic care records, we found useful infographic and best-practice guidance. However, this information was not accessible through the staff handsets used at the point of care. The provider should ensure that relevant guidance can be accessed promptly by staff delivering care and support.

### **How staff teams and services work together: Score 3**

The service had established systems to support communication and coordination between departments. We observed the daily 11am stand-up meeting attended by the home manager, senior care staff, administration and the head of housekeeping. Staff discussed operational and care-related matters, including sticking locks identified during a walkaround, outstanding staff name badges, nail care, dust on picture frames, a malodour in one person's room and a leak in another. The meeting also reinforced people's choice and control within the dementia units, shared updates from Barchester Healthcare and promoted the provider's "Tell Barchester" initiative.

The service used a shift allocation tool to assign responsibilities and communicate priorities. This included the Resident of the Day, weight monitoring, appointments, fire marshal duties, senior care allocations, observations, refreshments, waste disposal, telephone calls, cleaning tasks and night duties. This provided staff with a structured overview of responsibilities and supported continuity throughout each shift.

Pulse meetings enabled staff teams to discuss tissue viability, skin integrity, nutrition, clinical concerns and required actions. Information from these meetings was shared with the home manager and general manager each week so that identified issues could be followed up. The level of detail recorded had improved over recent months, reflecting progress in communication and the culture of the service.

Staff told us the meetings helped them remain informed about developments in the home, particularly when returning after a period of leave. The systems in place supported departments to work together and respond to concerns.

### **Supporting people to live healthier lives: Score 3.**

The service provided facilities and activities that supported people's physical, emotional and social wellbeing. These included a sensory room, hairdressing salon, activity room, golf activities and sensory boxes. Activity spaces were accessible, with activities set out in communal areas so people could choose when to participate and leave when they wished.

The activity team provided a combination of group activities and individual support to meet people's different interests and psychosocial needs. Opportunities included visits to garden centres and car

shows, hand and foot massage, entertainment from singers and piano players, and activities designed to encourage movement and coordination.

Activities were adapted to support people with different levels of mobility and ability. Examples included KerPlunk-style activities involving picking up and placing balls, and noughts and crosses offered on the floor or table so that people using wheelchairs could participate. The activity lead demonstrated a good understanding of inclusion and involving people's relatives and friends where appropriate.

### **Consent to care and treatment: Score 3.**

The service had systems to obtain consent and assess people's capacity in accordance with the Mental Capacity Act 2005. Mental Capacity Act training compliance was 92%. Management explained that the outstanding training primarily related to bank staff who were overseas or had not worked at the service for some time. Staff with low training compliance were not rostered to work until the required training had been completed.

We reviewed mental capacity assessments relating to personal care and decisions about living at the service. The assessment forms were comprehensive and followed the statutory criteria for determining capacity. Assessments considered people's wishes, preferences and feelings and were supported by capacity and cognition care plans, which were reviewed monthly. Best-practice guidance was attached to completed assessments, and current local authority guidance concerning relevant case law and revised DoLS thresholds was available within the home.

The service maintained copies of registered lasting powers of attorney for health and welfare and property and financial affairs. These were obtained from the Office of the Public Guardian, stored securely in the manager's office and used to inform care planning and decision-making. Where people lacked capacity to decide where they should live, mental capacity assessments and best-interest decisions had been completed, with relevant representatives involved and agreements signed by attorneys.

However, records did not always demonstrate how people's current wishes and preferences had been sought between formal reviews. As capacity can fluctuate, Resident of the Day records should provide a clearer ongoing account of people's involvement and any changes in capacity.

Where locked or coded doors were used on the dementia unit, there should be explicit reference to these restrictions as a standard part of the best-interest decision form. The record should describe the nature and purpose of the restriction, its impact on the person, less restrictive options considered, and how the decision will be reviewed.

## **Caring**

### **Kindness, compassion, and dignity: Score 3**

Throughout the inspection, we observed staff treating people with kindness, patience and respect. Interactions were warm and attentive, and staff appeared to know people well. Staff responded calmly when people living with dementia became unsettled or expressed a wish to leave the home. They used

sensitive distraction and redirection techniques to reduce distress while maintaining people's dignity. This approach was described by staff and observed in practice.

Staff respected people's choices in their day-to-day care. In one instance, a relative raised a concern that a person was not wearing their hearing aids. Records confirmed that the person had been offered their hearing aids earlier but had chosen not to wear them. Staff respected this decision while communicating openly with the person's family, demonstrating an appropriate balance between individual choice, family involvement and wellbeing.

People were supported to participate in activities in ways that reflected their abilities and preferences. Activities were adapted for people with reduced mobility, including table-based and floor-based options for people using wheelchairs. Individual activities, community visits, sensory support, massage and opportunities to spend time in the garden were also provided. Communal activity spaces remained open and accessible, allowing people to join and leave activities according to their wishes.

Staff told us they had sufficient time to provide care and did not feel rushed. This was reflected in the patient and person-centred interactions observed during the inspection. Staff demonstrated a strong commitment to maintaining people's comfort, autonomy and dignity, including when supporting people with complex dementia-related needs.

### **Treating people as individuals: Score 3**

The service sought to understand people's individual backgrounds, interests and preferences. Electronic care profiles included a biography section where information about people's lives and experiences could be recorded. One person showed us the biographical record they had been personally involved in maintaining, demonstrating direct participation in developing their care information.

Pre-admission and ongoing assessments considered people's cultural and religious needs, social relationships, personal care preferences and life histories. Care plans generally contained person-centred information and were reviewed monthly, providing staff with guidance about how each person wished to be supported.

Staff demonstrated knowledge of people's individual preferences and adapted support accordingly. Examples included arranging one-to-one time in the garden for a person who did not usually participate in group activities, supporting a person with an interest in cars to attend a car show, and adapting activities so people with different levels of mobility could participate.

### **Independence Choice and Control: Score 3**

People were supported to make choices about their daily lives and how they received care. Staff demonstrated an understanding of people's individual wishes and preferences and described how they involved people, or their next of kin where appropriate, in care planning and decisions about support.

Staff balanced people's independence with their safety. We saw examples of people being supported to access the community despite risks associated with mobility or road safety. In one case, staff worked with the person's family and used close support while building relational safety, enabling the person to continue going out while identified risks were managed.

People could choose how and when they participated in activities. Activity areas were open and accessible, allowing people to join and leave activities according to their preferences. The service offered group and individual opportunities, including garden visits, community outings and activities adapted for people using wheelchairs. When people living with dementia expressed a wish to leave the home, staff used calm distraction and redirection to support them safely. This approach was observed during the inspection.

Mental capacity assessments and risk assessments were used to support participation in decisions, including those relating to personal care.

### **Responding to people's immediate needs: Score 3.**

The service responded appropriately when people experienced changes in their health or wellbeing. Where people were at increased risk of falling or required enhanced monitoring, care records showed that planned observations had been completed. Daily notes were consistent with people's care plans and provided evidence that identified support measures were being followed.

In one case, staff identified that a person had a swollen hand. An incident form and body map were completed, and the person's skin integrity needs and associated risks were reviewed. Staff informed the family and contacted the GP and NHS 111 for clinical advice. Communication records and call logs provided evidence of the action taken.

We also reviewed the response to an incident where staff successfully administered CPR. Relevant incident records were completed, reviewed and signed off. Appropriate internal, statutory and external organisations were informed, and communication records demonstrated that staff acted in accordance with the absence of a DNACPR decision. A post-incident debrief was arranged to support the staff involved and identify any learning.

Call bell records included daily and weekly information about the number, type and location of calls and average response times. Recorded responses ranged from 7 seconds to 28 minutes. The manager explained that demand was higher during mornings, lunchtimes and evenings, and management staff provided support on the floor during these periods. This was observed during the inspection, and call bell performance was discussed at staff meetings. However, there was limited written analysis of longer response times, emerging themes, actions or lessons learned. The service had sought support from the regional director and another home to introduce a monthly analysis tool. This should be embedded to ensure delays are investigated and improvement actions are recorded, monitored and reviewed.

### **Workforce wellbeing and enablement: Score 3.**

The service supported staff wellbeing through supervision, development opportunities and practical support. Following a recent incident where staff had successfully administered CPR, a wellbeing huddle was held and counselling support was offered. Supervision records contained appropriate discussion about employment and wellbeing, and staff described feeling supported by managers.

Training and development opportunities were promoted throughout the home. Staff had access to externally delivered workshops, including tissue viability, distress reduction and GABLE training. One staff member undertaking a Level 4 NVQ received six hours of paid study time each week, attended

online coaching and was observed completing supervisions, risk assessments and appraisals. Care Certificate, Level 3 NVQ and annual refresher training were also available.

The service maintained a policy of the month folder, with policies divided across the year. The general manager explained that the deputy manager discussed the selected policy during team meetings before staff signed to confirm they had read and understood it. Records from previous months supported this, and the September policy had been circulated and staff signatures were being obtained.

Staff spoke positively about improvements within the home. One staff member with 11 years' service described the challenges previously experienced but felt the service was now progressing well. Senior staff held one-to-one discussions with care staff to consider how they were doing and what support they required.

## **Responsive**

### **Person-centred care: Score 3.**

Staff demonstrated a good understanding of people's individual wishes and preferences. Care plans generally contained personalised information and were reviewed monthly. Staff involved people directly in decisions about their care and, where appropriate, consulted relatives or next of kin to develop and review support arrangements.

Staff described how they supported people living with dementia who expressed a wish to leave the home. They used calm distraction and redirection techniques to reduce distress and maintain safety. We observed this approach being used sensitively in practice, with staff responding patiently and adapting their communication to the person.

Care was adjusted when people's needs changed. Following falls, incidents and hospital readmissions, relevant care plans and risk assessments were updated to provide staff with current guidance. People were also supported to take part in activities based on their interests and abilities, including individual time in the garden, community visits and activities adapted for people with reduced mobility.

However, records did not always demonstrate how people's wishes and preferences had been reviewed over time. Some Resident of the Day records contained blank sections or limited evidence of direct involvement. The provider should ensure records consistently capture each person's voice, choices and desired outcomes.

### **Care provision, integration, and continuity: Score 3.**

The service had systems to promote coordinated care and continuity of support. Pre-admission assessments provided staff with information about people's needs before they moved into the home. Staff understood the admission process, including the need to complete skin checks, weight and height measurements, risk assessments and care plans. People and, where appropriate, their next of kin were involved in gathering this information.

Records showed that changes following hospital discharge were generally incorporated into care plans and risk assessments. Staff made referrals when people's needs changed and maintained communication with GPs, district nurses, tissue viability nurses, local authorities and commissioners.

One manager described a “triangle of care” approach involving the person, their family and relevant professionals.

Continuity within the home was supported by daily stand-up meetings, senior meetings, handovers and a structured shift allocation tool. This identified appointments, observations, weight monitoring, the Resident of the Day, staffing responsibilities and other priority tasks. Pulse meetings also enabled staff to share information about nutrition, skin integrity, tissue viability and wider clinical concerns.

The provider used a staffing dependency tool where people’s needs changed, including where there was disease progression or increased complexity. This helped the service review whether staffing levels, skills and deployment remained appropriate to meet people’s changing needs. This supported continuity of care and ensured people continued to receive safe and responsive support.

### **Providing information: Score 3.**

The service provided information in a range of formats to help people understand their care and the support available. We saw visual staff boards identifying who worked at the home, information posters, a large-print information booklet and written menus displayed for people.

The service also used dementia-specific cue cards to support people who may have difficulty understanding or communicating information. These visual prompts helped staff adapt communication to people’s individual needs and supported their involvement in daily decisions.

However, some information could be made more accessible. Written menus were displayed, including larger menus outside the dining room and smaller menus on dining tables. The provider also used show plates and had picture cards available to support understanding and choice. The service should continue to review these arrangements against people’s individual communication needs and introduce alternative formats where required.

Accessible information should also clearly explain safeguarding, how to raise a complaint and how people can be involved in understanding and managing risks associated with their care.

Nonetheless, the service made reasonable adjustments and provided some information in accessible formats. Further work was needed to ensure important information was consistently available in large print, pictorial and easy-read formats, based on each person’s recorded communication needs and preferences.

### **Listening to and involving people: Score 3.**

The service had systems to involve people and their representatives in decisions about care such as six monthly reviews of care. Staff described speaking directly with people and, where appropriate, involving their next of kin. Care records included contact with relatives and evidence that people’s choices were considered in day-to-day care.

The service maintained a monthly personal interaction folder. Records described the purpose of each interaction, the action taken, its impact and the subsequent evaluation. One record focused on getting to know a person better and provided a detailed account of the conversation, helping staff understand how the person was settling into and engaging with the home.

The service demonstrated that people and their relatives were listened to and involved. However, some Resident of the Day records contained blank sections or limited evidence of people's current wishes and preferences. The provider should ensure that feedback, decisions and resulting actions are consistently recorded, including how involvement has influenced people's care and experience.

**Equity in Access: Score 3.**

The service supported people to access activities and opportunities according to their individual needs and abilities. Staff considered mobility, personal interests and preferred levels of participation when planning activities, helping to reduce barriers that could prevent people from taking part.

At weekends, the service organised a walking club that enabled people with greater mobility to walk in the local area, enjoy nature and reminisce. People who could not walk as far were supported to participate within the garden, providing a more accessible alternative while promoting similar social and wellbeing outcomes.

Staff adapted support for people who were less likely to participate in group activities. One person received individual time in the garden, where staff supported them to reminisce about their life and memories. Another person who had a particular interest in cars was supported to attend a car show, demonstrating that activities were tailored to individual interests rather than limited to opportunities available within the home.

We saw that the staff made reasonable adjustments to help people access meaningful activities, regardless of their mobility or preferred way of engaging. The service should continue to record the adjustments offered, people's participation and the outcomes achieved to demonstrate that access is equitable and barriers are identified and addressed consistently.

**Equity in experience and outcomes: Score 3.**

The service sought to ensure people experienced positive outcomes regardless of their mobility, health needs or level of risk. Staff adapted their approach to reflect people's individual circumstances and worked with them and their families to reduce barriers to meaningful participation.

In one instance, a person was encouraged to maintain a diary documenting their memories, experiences and time spent at the service. They showed this to us during the inspection, demonstrating how the service supported them to record and share what was important to them.

People were offered activities that reflected their interests and abilities. This included individual garden sessions, accessible walking opportunities, adapted activities for people using wheelchairs and community visits based on personal interests. These arrangements helped people who may otherwise have experienced barriers to achieve comparable social and wellbeing outcomes.

Positive risk-taking was used to promote participation rather than unnecessarily restricting people because of mobility or safety concerns. The service should continue to record how it identifies differences in people's experiences, makes reasonable adjustments and evaluates whether these result in equitable outcome

**Planning for the future: Score 3.**

The service supported people to plan for their future care and ensured that relevant decisions were reflected in their care records. Staff understood the importance of advance care planning and involving

people, their relatives and authorised representatives in decisions about future treatment and support.

People's care records included relevant information about their future wishes and clinical decisions, including DNACPR arrangements where applicable. Staff demonstrated that they understood the importance of checking this information before responding to an emergency. During a recent incident, staff successfully provided CPR because there was no DNACPR decision in place. Records showed that the incident was appropriately documented, reviewed and communicated to relevant organisations.

Mental capacity assessments and best-interest decisions were completed where people could not make particular decisions independently. Lasting powers of attorney were verified through the Office of the Public Guardian and used to involve authorised representatives appropriately. Care plans and risk assessments were also reviewed following hospital admissions, falls and changes in people's health, helping the service anticipate and plan for changing needs.

## **Well-led**

### **Shared direction and culture: Score 3.**

The service promoted a shared direction through Barchester Healthcare's values, policies and quality expectations. The staff room contained up-to-date information covering the provider's values, clinical standards, infection prevention and control, health and safety, staff wellbeing, quality guidance and bite-sized learning. Information about the staff assistance programme was also available.

The provider's values were reinforced through daily stand-up meetings and wider team discussions. During the meeting we observed, managers shared organisational updates, promoted the "Tell Barchester" initiative and reminded staff about supporting people's choice and control. The service also used a policy of the month programme to discuss key policies with staff and obtain signatures confirming they had read and understood them.

Staff described a substantial improvement in the culture of the home. One staff member said the culture was "a million times better" than it had previously been, although they acknowledged there were still good and difficult days. Another long-serving staff member described the challenges the service had experienced but felt that it was now progressing well. Senior staff held one-to-one conversations with care staff to understand how they were getting on and identify any support they required.

### **Capable, compassionate, and inclusive leaders: Score 4.**

The service was led by a highly experienced management team. The registered manager had worked for Barchester Healthcare for 12 years, progressing through roles including care practitioner, unit manager and deputy manager before becoming a home manager, and had 25 years' experience in care. The deputy manager had worked for Barchester Healthcare for 11 years.

Leaders were consistently visible throughout the home and demonstrated detailed knowledge of people's needs. We observed managers providing clear guidance, making timely decisions and responding dynamically when concerns were identified. Their actions remained focused on people's safety, wellbeing and individual outcomes.

Staff spoke positively about the management team and the improvements made within the service. One senior staff member told us the home had changed positively since the current management arrangements were introduced. The registered manager had also received recognition through the Queen of Care in Surrey award and the provider's "I'm a Director, Get Me Out of Here" challenge.

The service had received several compliments about staff and management, including cards and feedback recorded in the provider's central electronic database. Leaders demonstrated sustained, visible and compassionate leadership, supported staff effectively and placed people at the centre of decision-making.

### **Freedom to Speak Up: Score 3.**

Staff described an open culture in which they felt able to raise concerns. All staff interviewed said they would speak up if they witnessed poor practice or had concerns about people's safety. They understood the internal and external routes available to them, and Freedom to Speak Up information was displayed in the staff room.

Staff provided an example of a recent concern involving a person entering other residents' rooms. The concern was reported to management and investigated promptly. The manager reviewed available photographs to establish who had entered the rooms and determine the action required, demonstrating that concerns raised by staff were taken seriously.

Staff told us they had sufficient time to complete their duties and provide care without feeling rushed. They also had opportunities to raise concerns and discuss support needs through regular one-to-one conversations with senior staff. Pulse meetings and the provider's "Tell Barchester" initiative offered further routes for staff to provide feedback and escalate issues.

The service had previously experienced a period of whistleblowing concerns, which had been investigated and closed. A recently resurfaced concern was reviewed and concluded promptly. Overall, staff understood how to speak up and were confident that management would respond. The service should continue to monitor staff confidence and document how concerns, including whistleblowing matters, result in actions, feedback and shared learning.

### **Governance, management, and sustainability: Score 3**

The service had established governance systems to monitor quality, safety and regulatory compliance. We reviewed the statement of purpose, including Parts 2 and 3, and found that the aims, objectives and regulated activity reflected the service provided. The CQC notification folder contained the certificate of registration and other relevant registration documents. Current CQC ratings and liability insurance certificates were displayed within the home.

The regional director visited at least monthly, and a clinical development nurse was present during the inspection. The provider's clinical governance system monitored areas including tissue viability, accidents and incidents, safeguarding referrals, hospital admissions, infections and fluid monitoring. Incidents were assigned severity ratings from 1 to 4, with more serious events escalated to regional staff. The system could also generate reports on specific areas, including falls.

The home followed a clinical audit schedule. Medication and documentation audits were completed monthly, nutrition and dining audits every three months, infection control annually, and mattress and

meeting audits twice monthly. An annual environmental audit was due to commence in November. Departmental audits were completed by heads of department and the home manager, with scores and action plans held centrally. We saw examples of actions being created following overdue wellbeing checks and gaps identified through clinical audits. These were followed up through daily flash meetings, and the deputy manager cross-checked the home manager's work to support shared learning and accountability.

Medication auditing had changed in April and May, with 10% of people's records now sampled each month by the deputy manager and selected senior staff. However, the audit form was lengthy and included sections that were not relevant to a residential service. Given the history of medication concerns, including missing signatures and an undocumented daily stock count, the service should consider a shorter residential medication audit and increase senior staff involvement in monthly checks.

### **Workforce equality, diversity, and inclusion: Score 3.**

The service had arrangements to promote equality, inclusion and fair access to workplace support. Staff were able to raise individual needs through supervision, appraisal and confidential discussions with managers. Leaders described an open-door approach and encouraged staff to seek support where personal circumstances or workplace barriers affected them.

Staff described a supportive culture where colleagues from different backgrounds worked well together. Managers allocated responsibilities according to staff members' skills, competence and experience, while ensuring everyone had the opportunity to contribute to the running of the home.

Staff had equitable access to learning, career development and progression opportunities. Development routes were available across different roles and levels, and staff felt encouraged to build their confidence, develop new skills and progress within the organisation.

### **Partnership and communities: Score 3.**

The service had developed strong links with the local community, enabling people to maintain relationships and participate in activities outside the home. Community club buses were observed in operation, providing access to local events, groups and community facilities. The home also had its own vehicle, which staff used to arrange outings based on people's interests, mobility needs and preferences.

The service had established partnerships with community organisations, including the Royal British Legion Club and other local groups. The home had been formally opened by the Mayor in 2014, and a commemorative plaque was displayed. These established links helped people remain connected to the wider community and supported a sense of belonging.

Staff worked in partnership with GPs, district nurses, tissue viability nurses and other health services. Records showed appropriate communication, referrals and follow-up when people's health needs changed. Managers described a coordinated approach involving the person, their family and relevant professionals to support continuity of care and positive outcomes.

External singers and other entertainers regularly visited the home, bringing community-based activities into the service for people who could not easily go out. Partnerships with healthcare

professionals, community organisations and local services were embedded in the home's approach, providing people with varied opportunities to maintain meaningful relationships and remain connected to their community.

**Learning, improvement, and innovation: Score 3.**

The service demonstrated substantial improvement in the quality of care and governance. Internal quality reports showed that the home's score increased from 24 out of 100 in October 2025 to 81 out of 100 in February 2026. Internal health and safety audits and Well Tower UK Quality Reports provided further oversight. Improvements were evident in medicines management, care quality, governance and the culture of the home.

The service maintained a lessons learned folder and produced monthly bulletins highlighting areas requiring improvement. Copies were displayed in the staff room so that learning could be shared across the workforce. Care plans and risk assessments were updated following incidents, falls and hospital admissions, while additional competency assessments were completed following medicine incidents or concerns about staff confidence.

Records showed that a complaint made to CQC about a bank staff member was investigated by management. This included obtaining feedback from people living at the home and other staff. The provider responded to the concern, reassured the regulator and the matter was subsequently closed. Staff also described a significant improvement in the home's culture. Senior staff held one-to-one discussions with colleagues, and staff were supported to complete the Care Certificate and Level 3 and Level 4 NVQ qualifications. One staff member received six hours of paid study time each week and support from an external coach.

Record-keeping audits sampled 20% of people's records on each unit every month. However, the forms included numerous sections marked as not applicable, which reduced their effectiveness. Despite this, the service demonstrated that it acted on concerns, shared learning and invested in staff development.

**Environmental sustainability / sustainable development: Score N/A**

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

## Improvement Plan

The following actions highlight the areas for improvement from the mock inspection. This can be used alongside any existing action plans or service improvement plans.

### Table Key –

- **Improvement:** The task to be completed.
- **R1:** The staff member responsible for completing the task.
- **R2:** The staff member responsible for checking and ensuring the quality once the task is complete.
- **Target date:** The target date R1 is to follow to complete the task.
- **Date completed:** The actual date the task is completed.

## Safe

| Improvement                                                                                                                                | R1 | R2 | Target date | Date completed |
|--------------------------------------------------------------------------------------------------------------------------------------------|----|----|-------------|----------------|
| Increase safeguarding training compliance from 92%.                                                                                        |    |    |             |                |
| Complete all Resident of the Day records and consistently document people's involvement, wishes and preferences in risk-related decisions. |    |    |             |                |
| Appropriately label and store the helium cylinder, provide accessible spill kits and improve food date labelling.                          |    |    |             |                |
| Strengthen checks of MAR signatures through a daily signed process and ensure daily stock counts are legible                               |    |    |             |                |
| Introduce a formal monthly call bell audit showing themes, extended responses, contributing factors, actions taken and lessons learned.    |    |    |             |                |

## Effective

| Improvement                                                                           | R1 | R2 | Target date | Date completed |
|---------------------------------------------------------------------------------------|----|----|-------------|----------------|
| Strengthen resident of the day reviews so each care plan clearly records how the care |    |    |             |                |

|                                                                                                                                                                           |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|
| need is being met and whether support remains effective.                                                                                                                  |  |  |  |  |
| Ensure care plan reviews consistently reference capacity considerations where they relate to specific care needs.                                                         |  |  |  |  |
| Make relevant clinical guidance accessible on staff handsets and ensure recognised assessment tools are used consistently.                                                |  |  |  |  |
| Explicitly record locked and coded doors as a standard consideration within best-interest decision forms, including their impact and less restrictive options considered. |  |  |  |  |

## Caring

| Improvement | R1 | R2 | Target date | Date completed |
|-------------|----|----|-------------|----------------|
| None.       |    |    |             |                |

## Responsive

| Improvement                                                                                                  | R1 | R2 | Target date | Date completed |
|--------------------------------------------------------------------------------------------------------------|----|----|-------------|----------------|
| Display accessible information on how to raise a complaint in all relevant areas of the home.                |    |    |             |                |
| Consistently record people's feedback and demonstrate how their involvement has influenced care and support. |    |    |             |                |

## Well-led

| Improvement                                                                                                                                  | R1 | R2 | Target date | Date completed |
|----------------------------------------------------------------------------------------------------------------------------------------------|----|----|-------------|----------------|
| Tailor audit tools to the residential service and strengthen targeted auditing of known risks, including medicines documentation.            |    |    |             |                |
| Refine record-keeping audits by removing irrelevant sections and clearly monitoring whether improvement actions are effective and sustained. |    |    |             |                |

## Sign Off

The report and improvement plan has been written based on the research conducted prior to visiting the site and the findings during the mock inspection. Any failings, or improvements made at the service thereafter will not be included.

By signing off the report and improvement plan you are accepting the detail and content written within.

Manager's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Delphi Executives Client Lead: Chris Alexander

Date: 05.10.26