



MDM care & quality CQC Mock inspection

Sep 30, 2026 / Edward Mussett

Complete

Name of Home	Temple Ewell
Conducted on	Sep 30, 2026 9:00 AM BST
Prepared by	Edward Mussett
Name of Provider	Crownwood Healthcare
Current CQC rating	Inadequate
Previous MDM indicative rating	Requires improvement
Overall indicative assessment rating	Good
69%	
Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-Led	Good
Total combined percentage score	69%

Summary

Summary

The home was inspected by the Care Quality Commission (CQC) in May 2026, where inspectors identified seven regulatory breaches across multiple domains. The service was rated Inadequate overall, with significant concerns relating to safety, governance, staffing oversight and the consistency of care delivery. In response, the provider commissioned a full mock inspection in early August 2026 to assess progress and determine whether improvements were beginning to embed. During that review, we identified two to three potential breaches, and the home was assessed as Requires Improvement in all domains and overall. Improvements were visible, but systems were not yet consistently applied, and further work was required to ensure regulatory compliance and sustained quality.

This most recent review was undertaken as part of a follow-up quality assurance process, drawing on a wide range of evidence. We spoke with four residents, nine colleagues (including nurses, care staff and sponsored staff), one visiting pharmacy professional and one relative, all of whom provided consistent feedback about the home's progress. We reviewed eight care plans, including those relating to catheter care, end-of-life needs, mobility risks, nutrition and skin integrity. We examined risk assessments, MUST and Waterlow scores, Rockwood frailty assessments, MAR charts, patch rotation records, insulin site documentation, daily handover notes, RCA documentation, clinical meeting records, diet logs, training files, governance audits, and environmental safety checks. This provided a comprehensive and triangulated view of practice. Based on this evidence, no breaches of regulation were identified. The home has demonstrated substantial and sustained improvement across all areas of practice within a short period. Leadership is now visible, supportive and effective; staff morale has significantly improved; clinical oversight is stronger and more consistent; care plans are more robust and reflective of people's needs; and residents are experiencing safer, more person-centred care. The culture within the home is notably more open, reflective and responsive, with staff demonstrating confidence in raising concerns and contributing to ongoing improvement.

The home is now indicatively rated as 'Good' overall. This represents a significant and commendable improvement from both the May 2026 CQC inspection and the August mock review. The home has moved from Inadequate to Good within five months, demonstrating strong leadership focus, effective action planning, investment in training and external consultancy, and a clear commitment to delivering safe, high-quality care.

Continued attention to embedding learning, strengthening documentation and maintaining governance oversight will support the home in sustaining this level of performance.

Quality statements

Safe

Total score and indicative rating

64.3

Good

Learning culture

2

The home has started to build a learning culture around safety, with clear evidence that incidents such as wounds, bruising and medication issues are being reviewed rather than simply recorded. Root cause analysis (RCA) is now consistently completed for wounds and pressure related concerns, which is a positive step and shows that the service recognises the need to understand why things happen, not just what happened.

Staff told us they feel able to raise concerns and described the manager as approachable, visible and supportive. A sponsored colleague told us that, of the four care homes they have worked in since coming to the UK, this home is "the best by far", specifically because management "always check on our welfare" and they feel they can go to them with any problems. This kind of feedback suggests a culture where speaking up is encouraged rather than discouraged.

However, while RCA is being completed, the learning drawn from these investigations is often too generalised. Actions such as "staff to be more vigilant" or "continue monitoring" do not clearly describe what will change, who is responsible, or how the home will know if practice has improved. We saw similar patterns in complaints learning, where responses were appropriate but the identified learning was not always specific or measurable, and there was limited evidence of how this learning was cascaded and followed up; for example, a resident missed four doses of promethazine at the start of a new cycle because the pharmacy had not dispensed the medication, despite the home ordering it correctly. Staff chased the pharmacy and the medication was later delivered. This shows the system can respond, but the incident was not discussed in a clinical meeting, which would have allowed the team to consider whether any additional safeguards or contingency arrangements were needed.

The manager's walk rounds, which are recorded and were observed during our visit, are a strength. They allow real time observation of practice and the opportunity to address issues immediately, for example, picking up that beds had not yet been made and speaking directly with staff about expectations. This supports a live learning culture, but it needs to be backed up with more structured, documented learning outcomes.

Safe systems, pathways & transitions

3

The home has a number of systems in place that support safe care. Daily handovers take place and are attended by a member of the management team during the week. Staff told us these handovers are used to discuss changes in residents' needs, risks and priorities for the day, and we saw that they help shape how the day is organised. This supports continuity and ensures staff are working from up to date information.

The home uses an EMAR system for medicines, which provides a structured, auditable record of administration. We saw that where medicines were not given, staff recorded reasons, which supports safe monitoring and review. Patch medicines and insulin injections were recorded clearly, showing when and where they were applied or administered.

We saw evidence of the home working with external partners, including GPs, hospice teams, SALT and pharmacy. For example, a resident who had become palliative and was struggling to swallow medication had been referred appropriately to SALT. The manager told us they had asked the GP to review non essential medications, but the GP deferred this to the hospice team. While this shows appropriate engagement with external professionals, it also highlights the need for continued advocacy to ensure timely decisions are made.

In another case, a resident missed four doses of promethazine at the start of a new cycle because the pharmacy had not dispensed the medication, despite the home ordering it correctly. Staff chased the pharmacy and the medication was later delivered. This shows the system can respond, to resolve issues in a timely manner.

Safe environments

3

The home provides a generally safe and well maintained environment. We saw multiple communal areas available for residents, including a lounge, dining space, bar room, courtyard garden, and an accessible outdoor area that had recently been improved with screening to make it more pleasant. Several bedrooms

had been nicely decorated, and residents were encouraged to spend time in communal spaces, which staff told us had increased significantly in recent months.

Environmental safety systems were in place and up to date. Fire safety documentation, including PEEPs, had been reviewed and with clear review dates recorded. Evacuation equipment was available and staff were able to describe what they would do in the event of a fire. Fire risk assessments had been commissioned and completed by external providers and action planning was completed following these. Health and safety compliance was up to date and the home had carried out appropriate checks to gas and electrical systems as well as lifts and lifting equipment and legionella.

Pressure relieving mattresses we reviewed had automated pressure settings, reducing the risk of user error and supporting safe pressure area care.

Residents and rooms we visited had wall mounted lock boxes in the rooms or wardrobes, allowing to secure personal items. Laundry systems were personalised, with each resident having their own small laundry bag, reducing the risk of items being misplaced.

The home has made improvements to outdoor access, and daily notes showed residents were supported to sit outside. The environment was clean, tidy, and conducive to social engagement.

Safeguarding

3

Staff we spoke with had a clear understanding of safeguarding and whistleblowing. They were able to explain what abuse might look like, how they would report concerns, and how they would escalate if they felt issues were not being addressed. Staff told us they felt confident that management would act on concerns and that they could raise issues without fear of repercussions.

We reviewed incidents involving bruising. In cases where bruises had no identifiable cause, the home had appropriately referred these to safeguarding, including a facial bruise for one resident. This shows that the home understands safeguarding thresholds and is willing to share concerns quickly with external agencies when needed.

For one resident with recurrent bruising linked to their mobility, the home had taken steps to reduce risk, including environmental adjustments and increased monitoring. However, these measures were not fully captured in the care plan, which means the preventative work being done is not clearly visible to all staff and could be missed by new or agency colleagues. After we highlight this to the manager they made the correct amendments to the residents care plan.

Visitors and professionals told us they had no concerns about safety. A visiting pharmacy professional described the home as "nice", and visitors told us they would feel comfortable making a complaint or raising concerns if needed.

Medicines optimisation

2

Medication management in the home was generally safe, well organised, and supported by clear systems that enabled staff to administer medicines safely. The home uses an electronic medicines administration record (EMAR), and we saw that staff were confident in using this system. Records were clear, legible, and demonstrated good compliance with prescribed regimens. Where medicines had not been administered, staff consistently recorded a reason for the omission, which supports transparency and safe clinical oversight.

We reviewed the management of transdermal patch medicines, including analgesic patches. Records showed clear documentation of when patches were applied, where they were placed, and when they were removed. This level of detail is important to ensure patches are rotated appropriately and to prevent skin breakdown or accidental overdose. Staff demonstrated good understanding of patch rotation and were able to explain how they ensured patches were applied correctly and monitored throughout their use.

Injection sites for insulin were also recorded, demonstrating safe practice and appropriate monitoring. Staff were able to describe how they supported people with diabetes and how they monitored for signs of hypo or hyperglycaemia. Dietary supplements were used appropriately, and the home took a food first approach to weight loss, ensuring supplements were only used when clinically indicated.

We identified one resident who had missed four doses of promethazine at the start of a new medication cycle. The home had ordered the medication correctly, but the pharmacy had not dispensed it. Staff acted appropriately by chasing the pharmacy, and the medication was later delivered and administered. While the immediate response was appropriate, this incident had not been discussed in a clinical meeting, which would have allowed the team to reflect on whether any additional actions could have been taken. For example, the team could have considered whether earlier escalation to the pharmacy or GP was possible, or whether contingency stock might have prevented missed doses. The absence of reflective discussion represents a missed opportunity for learning and improvement. We have commented on this under the quality statement of 'Learning culture'.

We reviewed the management of PRN (as required) medicines. Most residents had clear PRN protocols in place that described when the medication should be given, what symptoms staff should look for, and when to escalate concerns. However, one resident had a PRN GTN spray prescribed but no protocol in place. The

manager told us that this medication had been discontinued, but this could not be confirmed during the visit. This requires follow up to ensure the medication is either removed from the EMAR system or supported by a clear PRN protocol if still active. PRN medicines without protocols increase the risk of inconsistent or unsafe administration.

We also reviewed the medication management for a resident who had recently become palliative and was experiencing difficulty swallowing their medication. Staff had appropriately referred the resident to the SALT team for assessment. The manager told us they had asked the GP to review the resident's non essential medications to reduce choking risk, but the GP had deferred this to the hospice team. While awaiting hospice input, it would be appropriate to re approach the GP to consider stopping or switching medications to liquid form. Staff told us they had already made a request, which may mean the delay is outside the home's control. However, continued advocacy is important to ensure the resident's comfort and safety. Controlled drugs (CDs) were managed correctly. We saw appropriate storage, accurate record keeping, and clear evidence of double signing. Staff were able to describe how CDs were administered and how discrepancies would be escalated. This reflects safe practice and compliance with legal requirements. Overall, medicines were managed safely, and staff demonstrated good knowledge and confidence.

Infection prevention & control

3

The home demonstrated safe and consistent infection prevention and control practices throughout the visit. The environment was clean, tidy, and well maintained, with no malodours or clutter observed in communal or private areas. Staff were seen to follow safe working practices, including appropriate handling of equipment, safe storage of clinical items, and maintaining clean surfaces.

Automated mattresses were in place for residents requiring pressure care. These mattresses were set to auto mode, which reduces the risk of user error and ensures pressure settings remain appropriate for each individual. This is an important IPC control measure, as poorly managed pressure areas can increase infection risk.

Communal areas were used frequently by residents, and staff encouraged people to spend time outside their rooms. This increases the importance of maintaining clean shared spaces. We saw that dining areas, lounges, and the bar room were clean and well presented. The courtyard garden and accessible outdoor space were tidy and safe, with screening added to improve comfort and reduce environmental contamination risks.

Staff were able to describe what they would do in the event of an outbreak and IPC audits were carried out regularly, the overall standard of cleanliness and organisation suggests that planned routine checks are taking place and were effective.

There was an IPC policy, colleagues undertook IPC training and were observed that colleagues wore correct uniforms and when needed PPE. Colleagues used hand sanitisers effectively when appropriate and those observed used correct handwashing techniques.

Residents who acquired an infection were supported to access medical review and treatments, such as blood tests and antibiotics where needed. Where antibiotics were prescribed or infections diagnosed we observed that short term care plans were in place.

Infection rates were monitored and discussed at weekly clinical meetings and handovers.

Involving people to manage risks

2

The home has established systems for identifying, assessing, and managing risks, and staff demonstrated a clear understanding of how to keep people safe. Risk management was evident through care planning, RCA processes, daily handovers, and the manager's regular walk rounds. These systems work together to ensure risks are identified early and addressed promptly.

Root cause analysis was consistently completed for wounds, bruising, and pressure related concerns. This demonstrates a commitment to understanding why incidents occur and how to prevent recurrence. However, while RCA was completed, the learning outcomes generated were often too broad, lacking specificity and measurable actions. This limits the home's ability to demonstrate that learning has been embedded and that risks have been fully mitigated.

Care plans were generally comprehensive and reflected people's needs well. Catheter care plans were in place, and care plans included prognosis related information. However, one resident with recurrent bruising did not have clear documentation of all measures taken to reduce risk- this was later corrected. Staff had implemented several interventions, including environmental adjustments and increased monitoring, but these were not fully captured in the care plan. This creates a gap between practice and documentation, which can affect continuity of care.

Daily handovers were attended by a member of the management team, allowing real time discussion of

risks and informing the running of the day. Staff told us these handovers were useful and helped ensure everyone was aware of changes in people's needs. This supports safe risk management and ensures information is shared effectively.

The manager's walk rounds were recorded and used to identify issues such as unmade beds, environmental concerns, and resident wellbeing. We observed the manager conducting a walk round during the visit, speaking with residents and staff, and addressing issues immediately. This visible leadership supports safe risk management and ensures risks are identified early.

Medication related risks were generally well managed, with clear documentation of patch applications, injection sites, and reasons for missed doses. However, the lack of clinical discussion around the missed promethazine doses represents a missed opportunity for reflective risk management.

To strengthen risk management further, the home should ensure that care plans fully reflect all risk reduction measures, that RCA learning outcomes are specific and measurable, and that clinical meetings consistently review incidents to identify whether additional actions could have been taken.

Safe staffing, skills, training & supervision

3

The home has a stable and committed workforce, and staff morale has improved significantly in recent months. Colleagues consistently described the management team as supportive, visible, and approachable. Several staff told us that the manager operates an open door culture, and that they feel comfortable raising concerns or seeking guidance at any time. This was echoed by a colleague on sponsorship who told us that, since arriving in the UK, they had worked in four care homes and that this home was "the best by far." They attributed this to the supportive management team, who "always check on our welfare" and ensure staff feel valued. This feedback reflects a positive workplace culture and suggests that staff feel psychologically safe, respected, and listened to.

Staff demonstrated strong knowledge of safeguarding, whistleblowing, and their responsibilities in keeping people safe. Every colleague we spoke to was able to clearly explain how they would identify and report concerns, and how they would escalate issues if needed. This indicates that training has been effective and that staff understand their roles in protecting people from harm. Staff also described good teamwork, and we observed nurses and care colleagues working collaboratively throughout the visit. Nurses were visible around the home, engaging with residents and supporting care staff, which contributes to safe and consistent care delivery.

Staff files had been improved and now contained full employment histories for those we checked. This is important for safe recruitment and ensures the home has a clear record of each colleague's background. Regular auditing of staff files was in place, demonstrating ongoing oversight of recruitment and compliance. Colleagues received regular supervision and there was a tracker in place for this showing a good level of compliance, staff training had been completed via mix methods, such as e-learning and face to face and this included their 1 & 2 Oliver McGowan training, F2F fire training and moving and handling, in addition to bespoke commission face to face training for sepsis, MCA & distressed behaviours.

Agency use was minimal, and although some agency profiles had outdated training dates, the manager confirmed that updated profiles are requested whenever agency staff are used. This reduces risk and ensures temporary staff have the necessary skills and training to work safely in the home.

Daily handovers were attended by a member of the management team, allowing real time oversight of staffing, resident needs, and any emerging risks. Staff told us these handovers were helpful and ensured everyone was aware of changes in people's needs. This supports safe workforce coordination and helps ensure staff are deployed effectively throughout the day.

The home has invested in improving staff support and wellbeing, which is reflected in the positive feedback from colleagues. Staff told us they feel valued, supported, and part of a cohesive team. This is particularly important given the complexity of residents' needs and the emotional demands of care work. The supportive culture described by staff contributes to safer care, as colleagues are more likely to raise concerns, seek help, and work collaboratively when they feel respected and supported.

Effective

Total score and indicative rating

70.8

Good

Assessing needs

2

Assessments in the home were thorough, structured and clinically meaningful, providing a clear picture of each person's needs. Care plans we reviewed contained detailed information about people's clinical conditions, including catheter care requirements, prognosis, dietary needs, communication preferences and mobility-related risks. Staff demonstrated strong knowledge of these assessments and were able to explain

how they informed day-to-day care delivery, showing that assessments were not only completed but actively used in practice.

The home made effective use of recognised clinical tools. MUST assessments were completed correctly, with scores accurately calculated and used to inform nutritional monitoring and interventions. Where people were identified as at risk of malnutrition, staff could describe how they increased monitoring, adapted diets and used food-first strategies before considering supplements. Waterlow scores were also completed appropriately, and we saw that pressure-relieving equipment, including automated mattresses, had been implemented in line with assessed risk. Staff understood how Waterlow outcomes informed repositioning, skin checks and mattress settings, demonstrating safe and evidence-based practice.

For residents with catheter needs, care plans clearly described how the catheter should be cared for, monitored and maintained. Staff were able to explain how they supported people to maintain comfort, reduce infection risk and recognise early signs of complications. This reflects assessments that are clinically accurate and understood by the workforce.

We saw evidence that assessments were reviewed and updated when needs changed. For example, wound care documentation had been strengthened after the manager identified that one wound had not been measured. Measurements were then added, demonstrating responsive assessment practice and a willingness to correct gaps promptly.

However, one resident who required an end-of-life care plan did not have one in place. Although other care plans referenced prognosis, there was no specific plan outlining the person's wishes, comfort priorities, symptom-management needs or preferred place of care. This is a significant gap in assessment for someone with palliative needs and means staff do not have clear guidance on how to support the person in line with their preferences.

For a resident experiencing recurrent bruising linked to mobility, staff had taken several steps to reduce risk, including environmental adjustments and increased monitoring. However, these actions were not fully documented in the care plan. This means the assessment of risk and the preventative measures in place were not clearly visible to all staff, particularly new or agency colleagues, and could lead to inconsistent care. Overall, assessments were robust and clinically informed, with correct use of MUST and Waterlow tools. To strengthen practice further, the home should ensure that all risk-reduction measures and end-of-life preferences are fully documented so assessments consistently reflect the care being delivered.

Evidence-based care

3

Care and treatment in the home were consistently aligned with current evidence-based practice, recognised clinical tools, and relevant legislation. Staff demonstrated a clear understanding of how assessments, clinical guidance and best-practice frameworks informed the care they delivered, and we saw multiple examples where evidence-based approaches were applied correctly and consistently.

The home made effective use of nationally recognised clinical tools. MUST assessments were completed accurately, with scores calculated correctly and used to inform nutritional monitoring and interventions. Where people were identified as at risk of malnutrition, staff could describe how they increased monitoring, adapted diets and used food-first strategies before considering supplements. The home also used Waterlow pressure-area risk assessments appropriately, and we saw that pressure-relieving equipment, including automated mattresses, had been implemented in line with assessed risk. Staff understood how Waterlow outcomes informed repositioning, skin checks and mattress settings, demonstrating safe and evidence-based practice.

We also saw evidence of Rockwood Frailty scoring being used to support clinical decision-making.

Care plans were detailed and reflected people's clinical conditions, including catheter care, prognosis, dietary requirements, communication needs and mobility-related risks. Staff demonstrated strong knowledge of these assessments and were able to explain how they informed day-to-day care delivery, showing that assessments were not only completed but actively used in practice.

Pressure-area care was delivered in line with best practice. Automated pressure-relieving mattresses were used for residents at risk of pressure damage, and these were set to auto mode to reduce user error. Staff were able to explain how these mattresses supported safe pressure care and how they monitored them.

This reflects safe, evidence-based practice and reduces the risk of pressure-related harm.

Wound care was supported by root cause analysis (RCA), which is an evidence-based approach to understanding why wounds occur and how to prevent recurrence. Although learning outcomes need to be more specific, the use of RCA itself is a positive indicator of reflective clinical governance and a commitment to continuous improvement.

Nutrition and hydration were delivered in line with best practice. The home had revisited menus, ensured diabetic-friendly snacks were available, and maintained a specialist diet log that tracked weight loss, texture-modified diets and other dietary needs. Staff followed SALT guidance for thickened fluids and texture-modified diets, and we saw that people were served the correct diet. Staff were able to explain how they monitored people's food and fluid intake and how they responded to changes.

Medication management was generally safe and aligned with good practice. Patch rotation was documented clearly, insulin injection sites were recorded, and reasons for missed doses were captured. Staff were able to explain how they monitored people's clinical conditions and responded to changes. For a

resident who had become palliative and was struggling to swallow medication, staff had referred appropriately to SALT and requested a medication review. This reflects evidence-based practice around choking risk and medication burden at end of life. Although the GP deferred to the hospice team, the home recognised the need for timely review and had already made a request.

Staff demonstrated understanding of their responsibilities under the Mental Capacity Act (MCA) and were able to explain how they gained consent before providing care. They described how they supported people to make their own decisions wherever possible, and how best-interest decisions were made when people were unable to consent. Staff understood that consent must be revisited when needs change, and that decisions made at one point may not remain appropriate later. This reflects lawful, evidence-based practice and respect for people's rights.

How staff, teams and services work together

3

Staff worked well together and demonstrated good communication. Nurses were visible around the home and worked closely with care colleagues, supporting them with clinical tasks and responding to changes in residents' needs. Staff told us teamwork had improved significantly and that morale was high.

Daily handovers were attended by management and used to discuss residents' needs, risks and priorities. Staff told us these handovers helped ensure everyone was working from the same information and that they supported safe coordination of care. We saw that handovers informed how the day was organised and ensured staff were aware of any changes in people's needs.

The home worked with external professionals, including GPs, hospice teams, SALT and pharmacy. For example, the home referred a resident to SALT when they experienced difficulty swallowing medication, and they requested a medication review from the GP. Although the GP deferred to the hospice team, the home had taken appropriate steps to involve external partners.

Pharmacy engagement was evident when the home chased missing promethazine doses. Although the incident was not discussed in a clinical meeting, the immediate response showed effective communication with external partners.

Visitors and professionals told us they had no concerns about communication or teamwork. A visiting pharmacy professional described the home as "nice" and did not raise any issues.

The home was currently in the process of sending out some surveys to gain vital feedback on the services quality and performance.

Supporting people to live healthier lives

3

Residents were encouraged to spend time in communal areas, socialise and use outdoor spaces. Staff told us socialisation had increased significantly, and we saw residents using the bar room, lounge, dining space and courtyard garden. Daily notes showed residents were supported to sit outside, which promotes wellbeing and reduces isolation.

Nutrition and hydration were managed well. The home took a food first approach to weight loss, using dietary supplements only when necessary. Menus had been improved, diabetic friendly snacks were available, and specialist diets were tracked through a dedicated log. Staff were able to explain how they monitored people's food and fluid intake and how they responded to changes.

For residents with clinical needs, staff supported healthier living through appropriate monitoring and care. Catheter care plans were in place, wound care was monitored, and automated mattresses supported pressure care.

As part of the activities provision in the home, the team actively encouraged movement and exercise and we observed that things such as arm chair yoga were regularly scheduled. We further observed from records that some residents were supported by MDT services such as physiotherapy and dieticians to support with movement and weight management.

Monitoring and improving outcomes

3

The home had a range of systems in place to monitor people's outcomes, and these were increasingly used in a structured and clinically meaningful way. Staff demonstrated a clear understanding of how recognised clinical tools, daily monitoring processes and management oversight contributed to improving outcomes and identifying emerging risks.

Outcome monitoring was supported by the correct use of evidence-based assessment tools.

MUST scores were completed accurately and used to identify nutritional risk, with staff able to describe how they increased monitoring, adapted diets and used food-first strategies when scores indicated concern.

Waterlow assessments were completed correctly and informed pressure-area care, including the use of automated mattresses, repositioning schedules and skin integrity checks. Rockwood Frailty scoring was used to support clinical decision-making, particularly for residents with complex needs or those approaching end of life.

These tools provided a structured foundation for monitoring outcomes and ensured that changes in

people's needs were identified early.

Clinical outcomes were monitored through daily handovers, manager walk-rounds and ongoing documentation. Daily handovers were used to discuss changes in residents' needs, risks and priorities, and staff told us these discussions informed how the day was organised. Manager walk-rounds provided real-time oversight, allowing issues to be identified and addressed promptly. For example, wound measurements were added after the manager identified they were missing, demonstrating responsive monitoring and a willingness to correct gaps quickly.

Medication outcomes were monitored through the EMAR system, which provided clear, auditable records of administration. Reasons for missed doses were consistently recorded, supporting transparency and review. Patch rotation and insulin injection sites were documented clearly, demonstrating safe practice and appropriate monitoring. Staff were able to explain how they monitored people's clinical conditions and responded to changes, reflecting a good understanding of how medication outcomes influence wider health outcomes.

Nutritional outcomes were monitored through a specialist diet log, which tracked weight loss, texture-modified diets and other dietary needs. Staff were able to describe how they monitored people's food and fluid intake and how they responded to changes, including adapting diets, increasing monitoring and involving external professionals when needed. This reflects a structured approach to nutritional monitoring and supports positive outcomes.

However, while systems were in place, learning from incidents was not always specific or measurable, which limits the home's ability to demonstrate improvement over time. For example, missed medication doses were not consistently discussed in clinical meetings. This represents a missed opportunity to review outcomes, identify learning and agree actions to prevent recurrence. Similarly, learning from RCA was sometimes too generalised, lacking clear accountability, measurable actions and follow-up. Without specific learning outcomes, it is difficult for the home to evidence that improvements have been embedded and sustained.

Overall, the home had strong foundations for monitoring and improving outcomes, supported by correct use of evidence-based tools and responsive oversight.

Consent to care and treatment

3

Staff demonstrated a clear understanding of their responsibilities under the Mental Capacity Act (MCA) and were able to explain how they gain consent before providing care. Colleagues told us they always explain what they are doing, seek permission before interventions, and respect when people decline support. This was consistent with what we observed during the visit, where staff were seen offering choices, waiting for people to respond, and adapting their approach based on the person's wishes.

Staff described how they support people to make their own decisions wherever possible, and how they recognise when someone may need additional support to understand information. They were able to explain the principles of the MCA, including assuming capacity unless proven otherwise, providing information in ways people can understand, and making decisions in a person's best interests when they are unable to consent. Staff did not use inappropriate terminology and demonstrated understanding of lawful MCA practice.

Where people lacked capacity to consent to certain aspects of their care, staff were able to describe how best interest decisions were made. They explained that these decisions involved the person, their family where appropriate, and relevant professionals. Staff understood that best interest decisions must consider the person's wishes, feelings, values and past preferences, and must be the least restrictive option.

We saw evidence that DoLS authorisations were in place for people who required them. Staff were able to explain why certain residents were subject to DoLS, what restrictions were authorised, and how they ensured these restrictions were applied lawfully and only when necessary. Staff understood that DoLS protects people's rights and ensures that any deprivation of liberty is lawful, proportionate and regularly reviewed.

Choice was consistently offered throughout the home. Residents were encouraged to choose where they spent their time, including communal areas, their rooms, or outdoor spaces. Staff told us that residents were now coming out of their rooms more often, and this was supported by improved social opportunities and environmental changes. We saw residents choosing where to sit, what activities to engage in, and how they wished to spend their day.

Visitors told us they felt listened to and involved in discussions about care. Staff described the manager as approachable and supportive, which contributes to a culture where consent, choice and rights are respected. Staff were confident that they could raise concerns if they felt a person's rights were not being upheld.

Caring

Total score and indicative rating

75

9/18

Good

Kindness, compassion & respect

3

Throughout the visit, we observed staff interacting with residents in a warm, respectful and compassionate manner. Staff approached people gently, spoke to them at eye level, and used calm, reassuring tones. We saw staff offering choices, waiting patiently for responses, and adapting their approach based on each person's communication style. This demonstrated genuine kindness and an understanding of how to support people respectfully.

Residents told us they felt well cared for and described staff as "kind" and "helpful." One visitor told us they were enjoying a beer with their friend in the dinning room and described the home as "excellent," with "wonderful staff" and a "friendly atmosphere." This feedback reflects a culture where kindness is embedded in everyday practice and where people feel comfortable and valued.

We saw staff supporting residents to sit outside, spend time in communal areas, and engage socially. Staff encouraged people to come out of their rooms more often, and colleagues told us socialisation in the home had increased significantly. This reflects compassion and an understanding of the importance of emotional wellbeing.

Privacy and dignity were respected. Residents had access to wall mounted lock boxes in their rooms or wardrobes, allowing them to secure personal items. Bedrooms were nicely decorated, and staff ensured doors were closed when providing personal care. We saw staff knocking before entering rooms and waiting for permission to enter, which supports dignity and respect.

Staff treated visiting professionals with kindness and respect. A visiting pharmacy professional told us they had "no concerns" and described the home as "nice," reflecting positive professional relationships and respectful interactions.

Treating people as individuals

3

Care in the home was delivered in a way that recognised people as individuals. Staff were able to describe residents' preferences, routines and personalities, and we saw these reflected in daily practice. Residents were encouraged to spend their time as they wished, whether in communal areas, their rooms, or outside. Staff told us that residents were now coming out of their rooms more often, and this was supported by improvements to communal spaces and increased social opportunities.

We saw multiple areas around the home that residents could choose to use, including a bar room, lounge, dining space, courtyard garden and an accessible outdoor area that had been screened to make it more pleasant. Staff encouraged residents to choose where they wanted to sit and how they wanted to spend their day, which supports individuality and autonomy.

Menus had been revisited and improved, and diabetic friendly snacks were available. Texture modified diets were provided correctly, and staff followed SALT guidance. The specialist diet log ensured that dietary needs were tracked and met. This reflects personalised care that takes account of people's health needs and preferences.

Daily notes showed residents were supported to sit and spend time in places of their choosing, such as outside, communal spaces or their own rooms. Staff were able to describe how they adapted care for people with specific needs, such as those with catheter care requirements or those who were palliative.

Visitors told us they felt involved and listened to, and staff described the manager as approachable and supportive. This supports a culture where individuality is respected and where people's unique needs and preferences are taken seriously.

Some residents living at the home had autism, during our visit we reviewed one of the residents care plans and visited them in their room. The care plan highlighted that the resident used to like going shopping but can no longer do this due to their health needs; the home ensured that this resident received one to one support and access to online shopping. When we visited the resident they told us that they missed going out to Tesco to the cafe there and having a nice coffee. They understood that this was no longer possible due to complications relating to their physical health. The home had access to a fresh bean coffee from a self service machine and we saw that residents were offered to purchase coffees and hot drinks from this.

Independence, choice and control

3

Residents were supported to maintain independence and control over their daily lives. Staff encouraged people to choose where they spent their time, and we saw residents using communal areas, outdoor spaces and their rooms freely. Staff told us socialisation had increased significantly, and this was supported by environmental improvements and increased opportunities for engagement.

Choice was consistently offered. Staff asked residents where they wanted to sit, whether they wanted to join communal meals, and how they wished to spend their day. We saw staff offering choices around drinks, snacks and activities, and waiting for residents to respond before proceeding.

Residents had access to wall mounted lock boxes in their rooms or wardrobes, allowing them to secure personal items. This supports independence and control over belongings and reduces the risk of items being misplaced.

For residents with clinical needs, staff supported independence by explaining care interventions and seeking consent. For example, staff recognised that a palliative resident struggling to swallow medication needed a review of non essential medications to reduce choking risk. This reflects respect for the person's comfort, preferences and right to refuse or adapt treatment.

Staff were able to describe how they supported people to make decisions and how they respected people's choices, even when those choices differed from staff recommendations. This reflects a culture where independence and autonomy are valued.

Responding to peoples immediate needs.

3

Staff demonstrated consistent, real-time responsiveness to people's immediate needs throughout the visit. We observed staff noticing when residents required assistance, offering support promptly, and responding to requests without delay. Staff presence in communal areas was purposeful rather than passive; colleagues were attentive, engaged and positioned in ways that allowed them to observe changes in residents' comfort, mobility and emotional presentation. This meant staff could intervene early, preventing distress and reducing risk.

Daily handovers played a central role in ensuring staff were aware of any changes in people's needs. These handovers were attended by a member of the management team, which strengthened oversight and ensured emerging risks were identified at the start of each shift. Staff told us these handovers helped them organise the day safely, prioritise residents with higher needs, and respond quickly when situations changed. This reflects a structured approach to responsiveness and supports continuity of care.

Call-bell responsiveness had improved significantly. During previous reviews, delays of over four minutes had been identified in specific rooms. During this visit, call-bell response times were consistently prompt, and staff were able to describe how they monitored call-bell activity throughout the day. This improvement reflects a more proactive and accountable approach to meeting immediate needs.

For residents with clinical needs, staff responded promptly and appropriately; such as referring residents to SALT and dietician services.

Environmental responsiveness was also evident. Staff had made specific adjustments to one resident's room, including padding certain pieces of furniture to reduce the risk of injury linked to mobility and behavioural presentation. This was a targeted, personalised intervention that demonstrated staff awareness of the resident's immediate risks and a willingness to adapt the environment quickly to keep them safe. The home had also made wider environmental improvements, such as screening in the outdoor area to increase privacy and comfort. Staff told us these changes had made the space more pleasant and increased its use, reflecting responsiveness to resident feedback and preferences.

Visitors told us they felt listened to and that staff responded to concerns quickly.

Pain scores were used to support decision making when residents were not able to tell colleagues that they were in pain.

Work force well-being

3

Staff wellbeing had improved significantly, and colleagues described morale as "so much better." Staff told us the manager was supportive, visible and approachable, and that they felt comfortable raising concerns. A sponsored colleague told us this was the best home they had worked in since arriving in the UK, specifically because management "always check on our welfare."

Staff described feeling valued and supported, and this was reflected in their interactions with residents. We saw staff working collaboratively, supporting each other, and maintaining a calm and positive atmosphere. Nurses were visible around the home and worked closely with care colleagues, which supports staff confidence and wellbeing.

The home utilised a colleague of the month program to celebrate colleagues efforts and promote team work.

Environmental improvements, increased social opportunities for residents, and strengthened clinical oversight all contributed to a calmer and more supportive working environment. Staff told us they felt proud of the improvements made in the home.

Responsive

Total score and indicative rating

68

Good

Person-centred care

3

Care in the home was delivered in a way that placed people at the centre of decisions. Staff demonstrated detailed knowledge of residents' preferences, routines, personalities and histories, and we saw this reflected in daily practice. Residents were encouraged to spend their time as they wished, whether in communal areas, their rooms, or outside. Staff told us that residents were now coming out of their rooms more often, and this was supported by improvements to communal spaces and increased social opportunities. Daily handovers ensured staff were aware of any changes in people's needs, and management presence in handovers supported real time responsiveness. Staff told us these handovers helped them organise the day safely and respond to residents' needs effectively.

For residents with clinical needs, staff responded promptly. For example, when a palliative resident struggled to swallow medication, staff referred them to SALT and requested a medication review. This shows responsiveness to discomfort and risk.

Environmental improvements, such as screening in the outdoor area, were made to respond to residents' feedback and comfort. Staff told us these changes had made the space more pleasant and increased its use. Visitors told us they felt listened to and that staff responded to concerns quickly. A visiting pharmacy professional described the home as "nice" and raised no concerns about responsiveness.

Care provision, integration and continuity

3

The home demonstrated good continuity of care through daily handovers, management oversight and effective teamwork. Staff told us handovers were used to discuss changes in residents' needs, risks and priorities, and we saw that these discussions informed how the day was organised. This supports continuity and ensures staff are working from up to date information.

The home worked with external professionals, including GPs, hospice teams, SALT and pharmacy. For example, the home referred a resident to SALT when they experienced difficulty swallowing medication, and they requested a medication review from the GP. Although the GP deferred to the hospice team, the home had taken appropriate steps to involve external partners.

Pharmacy engagement was evident when the home chased missing promethazine doses. Although the incident was not discussed in a clinical meeting, the immediate response showed effective communication with external partners.

Visitors and professionals told us they had no concerns about communication or teamwork. A visiting pharmacy professional described the home as "nice" and did not raise any issues.

The home had also had a recent visit from the local authority quality assurance team who found the service to be providing a good level of quality and care provision. The home works well with the local authority and CHC commissioners and offers discharge to assess beds. However due to the current CQC rating the home is under embargo. Commissioners have expressed that an improvement in CQC rating, in addition to their own positive findings would mean that residents care would then be commissioned again.

Providing information

3

The home had clear information available for residents and visitors. The complaints process was displayed in an easy read format in the foyer, alongside the home's current CQC rating. This supports accessibility and transparency.

Staff were able to describe how they provided information to residents in ways they could understand, including explaining care interventions, offering choices and waiting for responses. We saw staff using calm, clear communication and adapting their approach based on each person's communication style.

Listening to and involving people

2

The home demonstrated openness to feedback. Visitors told us they felt comfortable raising concerns and that staff listened to them. One visitor described the home as "excellent," with "wonderful staff" and a "friendly atmosphere." Another visitor, whose partner was on an assessment bed, told us they had no concerns.

The complaints process was displayed clearly in the foyer in an easy read format. The complaint tracker showed that complaints had been responded to appropriately, with timely communication and clear outcomes.

However, learning from complaints was sometimes too generalised. Learning statements tended to reflect broad themes such as "staff reminded to follow procedure" or "communication to be improved," without specifying what exactly would change, who would be responsible, or how the home would check that improvements had been embedded. This limits the home's ability to demonstrate that learning has been

fully acted upon.

Staff described the manager as approachable and supportive, and colleagues told us they felt able to raise concerns. This supports a culture where feedback is welcomed and acted upon.

Equity in access

3

Residents were supported to access all areas of the home in ways that were safe, dignified and responsive to their individual needs. Although residents were not independently mobile, staff ensured that this did not limit their ability to choose where they wished to be. We observed staff responding promptly when residents asked to move to different areas, including communal lounges, dining spaces, their own rooms and outdoor areas. Staff presence in communal spaces meant they were available to assist without delay, ensuring equitable access regardless of mobility level.

Physical access had improved since earlier reviews. There was a courtyard garden and an additional, separate outdoor space had been enhanced with screening and environmental adjustments to make it more comfortable and inviting. Staff told us these improvements had increased residents' use of the area, demonstrating responsiveness to environmental barriers and a commitment to ensuring people could access pleasant, safe outdoor spaces. Residents were supported to sit outside when they expressed interest, and daily notes reflected this, showing that access was facilitated consistently. The home had added some furniture in selected locations at way points around the home to further create additional spaces for people to access.

Access to nutrition and hydration was equitable and supported by evidence-based tools. Menus had been revisited and improved, diabetic-friendly snacks were available, and texture-modified diets were provided correctly. Staff followed SALT guidance for thickened fluids and modified diets, ensuring people with swallowing difficulties could access safe and appropriate meals. The specialist diet log tracked weight loss, dietary needs and nutritional risks, ensuring that people with higher needs were identified and supported promptly. This reflects a structured approach to ensuring equitable access to food and hydration. Clinical access was also supported well.

Call-bell responsiveness had improved significantly, supporting equitable access to assistance. During previous reviews, delays of over four minutes had been identified in specific rooms. During this visit, call-bell response times were consistently prompt. This improvement ensures that residents, regardless of location, mobility or dependency, can access help when they need it, reducing risk and supporting dignity.

We also saw personalised environmental adjustments to support equitable access to safe care. For one resident experiencing recurrent bruising linked to mobility, staff had padded specific pieces of furniture in their room to reduce the risk of injury. This was a targeted, individualised intervention that demonstrated staff awareness of the resident's specific access needs and a willingness to adapt the environment quickly to keep them safe. Staff were able to explain why these adjustments were made and how they monitored their effectiveness.

Equity in outcomes and experiences

3

The home demonstrated a clear commitment to ensuring that people experience care and outcomes that are fair, consistent and responsive to their individual circumstances. Staff showed awareness of the factors that can lead to unequal experiences, such as frailty, communication needs, cultural background, mobility limitations, and complex clinical conditions—and took steps to reduce the impact of these on people's day-to-day lives.

Residents who required additional support to access communal areas, outdoor spaces or social opportunities were consistently assisted by staff. Although residents were not independently mobile, colleagues ensured this did not disadvantage anyone. Staff responded promptly when residents asked to move to different areas, enabling equal access to social interaction, fresh air, and meaningful occupation. This prevented isolation and ensured that people with higher physical dependency had the same opportunities as others.

Clinical outcomes were monitored in a way that supported equity. People with higher clinical risk, such as those with wounds, swallowing difficulties, frailty, or nutritional concerns, were identified early through structured tools including MUST, Waterlow and frailty scoring. Staff were able to describe how they adjusted monitoring, diet, equipment and clinical oversight for individuals with greater vulnerability. This ensured that people with more complex needs received proportionately more support, reducing the likelihood of poorer outcomes.

Where residents were at risk of injury due to mobility or behavioural presentation, staff made personalised environmental adjustments. For one resident, padding was added to specific furniture in their room to reduce the risk of bruising. This was a targeted intervention that demonstrated staff awareness of how environmental factors can disproportionately affect certain individuals. By adapting the environment, the home ensured that this resident's experience and safety were not compromised by their specific needs. Staff also demonstrated sensitivity to cultural and personal preferences. Visitors told us they felt listened to and involved, and staff described how they adapted communication styles to suit individual residents.

Sponsored colleagues reported feeling valued and supported, which reflects an inclusive workforce culture that contributes positively to resident experience.

The home's approach to nutrition further supported equitable outcomes. Diabetic-friendly snacks were available, menus had been improved, and texture-modified diets were provided correctly. People with swallowing difficulties received SALT-recommended diets, ensuring that those with higher risk did not experience poorer nutritional outcomes. The specialist diet log ensured that weight loss and dietary needs were monitored consistently across all residents, preventing variation in nutritional oversight.

Call-bell responsiveness had improved significantly, ensuring that people with higher dependency or communication needs were not disadvantaged. Staff were able to describe how they monitored call-bell activity and how prompt responses supported dignity, comfort and safety for all residents, regardless of mobility or cognitive ability.

Accidents and incidents were reviewed through weekly meetings and monthly analysis and evidence supported that residents had positive outcomes, such as wound healing, and recovery from infection. We saw that there was a positive downward trend in clinical KPI's and incidents.

Planning for the future

2

The home supported residents to plan for future needs, although there were gaps in documentation. For example, one resident who required an end of life care plan did not have one in place. Although other care plans referenced prognosis, there was no specific plan outlining the person's wishes, comfort priorities, symptom management needs or preferred place of care. This is a significant gap in planning for someone with palliative needs.

For the palliative resident struggling to swallow medication, staff recognised the need to review non essential medications to reduce choking risk. This reflects respect for the person's comfort, preferences and right to refuse or adapt treatment.

Staff were able to describe how they supported people to make decisions and how they respected people's choices, even when those choices differed from staff recommendations. This reflects a culture where independence and autonomy are valued.

Resident were supported to have DNACPR's and respect forms in place where appropriate.

Well-led

Total score and indicative rating

67.9

Good

Shared direction and culture

3

Within just five months of the CQC's Inadequate inspection in May 2026, the new management team has created a clear, positive and increasingly embedded culture of openness, transparency and shared purpose. Staff across all roles consistently described a marked shift in the home's atmosphere, leadership approach and day-to-day working environment since the change in management.

Colleagues repeatedly told us that morale had "drastically improved", and this feedback was echoed by sponsored staff, nurses and care colleagues alike. Staff described the manager as visible, supportive and approachable, and explained that this leadership style had restored confidence and stability within the workforce. The manager's open-door approach meant concerns were addressed quickly and without judgement, which staff said made them feel listened to, valued and safe to speak up. This represents a significant cultural improvement from the position reported during the CQC's last inspection.

Sponsored colleagues described the home as the best they had worked in since arriving in the UK, specifically because management "always check on our welfare." This reflects a culture that actively values diversity, inclusion and equity, and demonstrates that improvements have reached all parts of the workforce, not just long-standing staff.

The new management team has also strengthened the environment and daily experience for residents.

Increased social opportunities, calmer communal spaces and improved oversight have contributed to a more settled and supportive working environment. Staff told us they felt proud of the improvements made in the home and confident that the service was now moving in the right direction.

Transparency with residents, families and professionals has also improved. Clear information was available in the foyer, including an easy-read complaints process and the home's current CQC rating. Staff told us they were encouraged to be open with families, and visitors confirmed they felt able to raise concerns and were kept informed. This reflects a leadership approach that prioritises honesty, accountability and engagement with the wider community.

Overall, the cultural shift achieved by the new management team in a short period has been significant and sustained. The home now demonstrates a shared vision, stronger values, and a workforce that feels

supported, respected and aligned with the provider's expectations. This cultural improvement has been a key driver in the home's progression from an Inadequate rating from the CQC to Indicative internal rating of Good within five months.

Capable, compassionate and inclusive Leadership

3

Leadership within the home was confident, visible and strategically focused, with the new management team demonstrating a clear commitment to raising standards and embedding a culture of continuous improvement. Staff consistently described the manager as supportive, approachable and present throughout the home. During the visit, we observed the manager conducting purposeful walk-rounds, engaging with residents, checking on colleagues and addressing issues directly. When unmade beds were identified, the manager intervened immediately, reinforcing expectations and modelling the standard of practice required.

Colleagues told us they felt able to raise concerns freely and that management responded promptly and constructively. This reflects leadership characterised by integrity, openness and psychological safety, where staff feel confident that their voice matters. Sponsored colleagues described the manager as someone who "always checks on our welfare," highlighting a leadership approach that prioritises wellbeing, inclusion and fairness across the whole workforce.

A notable feature of the new leadership approach has been the significant investment in staff development and external expertise. The management team commissioned external consultants to carry out independent quality reviews, strengthen governance systems and provide objective scrutiny of clinical and operational practice. These external reviews were used to identify gaps, validate progress and ensure improvements were aligned with regulatory expectations.

The home also invested in enhanced training programmes, ensuring staff had access to up-to-date learning in areas such as safeguarding, clinical risk management, MCA and consent, pressure-area care, nutrition, and person-centred practice. Staff told us they valued this investment and felt more confident in their roles as a result. This commitment to training reflects leadership that understands the importance of competence, capability and professional development in sustaining improvement.

To further strengthen oversight, the management team commissioned full mock inspections, carried out by external specialists. These mock inspections provided detailed feedback, highlighted areas requiring further work, and helped the home prepare for regulatory scrutiny. Staff told us these exercises were helpful and contributed to a clearer understanding of expectations and standards.

The manager demonstrated a strong grasp of the home's challenges and had taken targeted action to address them. Improvements to staff files, strengthened clinical oversight, revised menus, enhanced communal spaces and clearer governance processes all reflect proactive, capable leadership focused on both regulatory compliance and quality of life. These changes were purposeful and structured, showing that leaders were not only aware of previous shortcomings but were actively driving the service forward through consistent oversight, practical support and a clear strategic direction.

Overall, leadership at the home was inclusive, effective and forward-looking, with the new management team demonstrating the capability, credibility and commitment required to deliver sustained improvement. Their actions have directly contributed to the significant progress seen across the service within five months of the last CQC inspection.

Freedom to speak up

3

The home demonstrated a strong and increasingly embedded culture of openness, where staff, residents and relatives felt able to raise concerns, share ideas and speak up without fear. Multiple formal and informal routes were available for people to express concerns, and staff consistently told us they felt safe, supported and listened to.

There was clear Freedom to Speak Up signposting displayed in the home, providing staff with information on how to escalate concerns externally if they ever felt unable to raise issues internally. Staff were aware of this and told us they felt confident they could use it if needed, although they had not felt the need to do so since the new management team took over.

The home had a clear complaints policy, accessible to residents, relatives and visitors. An easy-read version was displayed in the foyer alongside the home's CQC rating, supporting transparency and ensuring people understood how to raise concerns. Staff were able to explain how they supported residents to make complaints and how they ensured people's voices were heard, even when communication needs were complex.

Leaders promoted an open-door culture, and staff repeatedly told us they could approach the manager at any time. They described the manager as visible, approachable and responsive, and said concerns were dealt with promptly and constructively. This leadership style created psychological safety and encouraged staff to speak up early, preventing issues from escalating.

The home also provided compliments and suggestions boxes, giving residents, relatives and staff an additional route to share feedback anonymously. This ensured that people who preferred not to raise issues

verbally still had a safe and accessible way to express concerns or ideas. Leaders reviewed this feedback regularly and used it to inform improvements.

Following the publication of the CQC report in May 2026, the home held a resident and relative meeting to discuss the findings openly, explain the improvement plan and invite feedback. Relatives told us they appreciated the transparency and felt reassured by the new management team's willingness to address concerns directly. This meeting demonstrated accountability and a commitment to involving people in shaping the home's future direction.

Staff told us they felt comfortable raising clinical concerns, operational issues and suggestions for improvement. They described examples where they had spoken up and seen changes made as a result, including adjustments to menus, improvements to communal spaces and strengthened clinical oversight. This reflects a culture where speaking up leads to action, reinforcing trust and confidence.

Sponsored colleagues told us they felt particularly supported and valued, and that management "always check on our welfare." This demonstrates inclusive leadership and ensures that staff from diverse backgrounds experience the same level of psychological safety and support as their colleagues.

Overall, the home demonstrated a mature and well-embedded Freedom to Speak Up culture, supported by clear signposting, multiple feedback routes, transparent communication and responsive leadership. These improvements have contributed significantly to the home's progression from Inadequate to Good within five months.

Workforce equality, inclusion and diversity.

3

The home demonstrated a commitment to equality, diversity and inclusion. Sponsored colleagues told us they felt supported and valued, and one described the home as the best they had worked in since arriving in the UK. This reflects a culture where diversity is respected and where staff from different backgrounds feel included.

Staff told us morale had improved significantly and that the manager was supportive and approachable. This reflects a culture where staff wellbeing is prioritised and where equity is embedded in daily practice. Staff files had been improved and now contained full employment histories, and regular auditing was in place. This supports safe recruitment and ongoing compliance.

Agency use was minimal, and although some agency profiles had outdated training dates, the manager confirmed that updated profiles are requested whenever agency staff are used. This reduces risk associated with temporary staff and supports equity in training and development.

Governance & assurance

2

The home had much stronger governance and accountability systems in place than were seen at the time of the CQC inspection in May 2026. Daily handovers were now consistently attended by management and used as structured forums to review residents' needs, emerging risks and priorities for the day. Staff told us these handovers helped them organise workloads safely and ensured everyone began each shift with a shared understanding of expectations. This reflects a more coordinated and accountable approach to oversight. Clinical governance had improved, with root cause analysis (RCA) completed for wounds and pressure-related concerns. This supported reflective practice and helped staff understand why issues occurred and how to prevent recurrence. However, while RCA was consistently completed, the learning outcomes were often too broad or descriptive, lacking clear accountability, measurable actions or defined review points. This limits the home's ability to demonstrate that learning has been embedded and sustained over time.

Care plans were generally comprehensive and reflected people's needs well. Staff were able to explain how assessments informed care, and documentation had improved significantly since earlier reviews. However, for one resident experiencing recurrent bruising, not all risk-reduction measures were clearly documented. This created a gap between practice and written guidance, which could affect continuity of care, particularly for new or agency staff.

Medication management was safe and supported by clear EMAR records, with patch rotation and injection sites documented appropriately. Staff understood how to escalate concerns and monitor clinical changes. However, missed doses were not consistently reviewed in clinical meetings, representing a missed opportunity for reflective governance and trend analysis. Ensuring these discussions take place would strengthen oversight and support continuous improvement.

Environmental improvements, increased social opportunities for residents and strengthened clinical oversight had contributed to a calmer, more organised and supportive working environment. Staff told us they felt proud of the progress made and more confident in the home's governance arrangements. These improvements reflect the impact of the new management team's investment in training, external consultancy, and structured quality assurance processes.

Overall, governance systems were much stronger, more consistent and more transparent than at the time of the last CQC inspection.

Partnerships and communities

3

The home demonstrated effective partnership working with external professionals, including GPs, hospice teams, SALT and pharmacy. For example, the home referred a palliative resident to SALT when they struggled to swallow medication, and they requested a medication review from the GP. Although the GP deferred to the hospice team, the home had taken appropriate steps to involve external partners.

Pharmacy engagement was evident when the home chased missing promethazine doses. Although the incident was not discussed in a clinical meeting, the immediate response showed effective communication with external partners.

Visitors and professionals told us they had no concerns about communication or teamwork. A visiting pharmacy professional described the home as “nice” and did not raise any issues.

Environmental improvements, increased social opportunities for residents, and strengthened clinical oversight all contributed to a calmer and more supportive working environment. Staff told us they felt proud of the improvements made in the home.

The home was regularly visited by a local church, which held services at the home and in the past the home has hosted local schools, such as at Christmas time for carol concerts, which it hopes to do so again this year.

Learning, improvement & innovation

2

The home demonstrated a clear and growing commitment to continuous learning and improvement, supported by a leadership team that has prioritised reflection, professional development and strengthened clinical oversight since the CQC inspection in May 2026. Staff described a noticeable shift in how learning is approached, with greater openness, clearer expectations and more structured opportunities to discuss practice.

The home used root cause analysis (RCA) to review wounds and pressure-related concerns, supporting reflective practice and helping staff understand why issues occurred. This represented a significant improvement from earlier reviews. However, while RCA was consistently completed, the learning outcomes were sometimes too broad or lacked measurable actions, which limits the home’s ability to demonstrate that learning has been fully embedded or revisited over time. Strengthening the specificity of learning will help ensure improvements are sustained.

The management team had invested in external consultancy, enhanced training programmes and mock inspections, which provided objective scrutiny and helped identify areas requiring further development. Staff told us these initiatives had increased their confidence and improved their understanding of best practice. This reflects a service that is actively seeking external expertise to accelerate improvement and embed learning across the workforce.

Environmental improvements and increased social opportunities for residents demonstrated that learning was not limited to clinical practice. Leaders had acted on feedback from residents, relatives and staff to create calmer communal spaces and more meaningful daily experiences. These changes contributed to a more supportive and therapeutic environment, and staff told us they felt proud of the progress made. Staff described the manager as supportive, visible and approachable, and said they felt comfortable sharing ideas for improvement. This reflects a culture where learning is encouraged and where colleagues feel psychologically safe to contribute to change. Staff gave examples of suggestions that had been acted upon, reinforcing that learning leads to tangible improvements.

Visitors told us they felt listened to and involved in discussions about care. The home held a resident and relative meeting following the publication of the CQC report, demonstrating transparency and a willingness to learn from external feedback. This approach supports a culture where improvement is shared, collaborative and informed by the people who use the service.

Overall, the home demonstrated a positive trajectory of learning and innovation, supported by strengthened leadership, external input and a more reflective workforce. To continue progressing, the home should ensure that learning outcomes from incidents are specific, measurable and revisited, and that improvements identified through RCA and quality reviews are consistently incorporated into governance processes.

Indicative rating

Sign off

Completed by

Ed Mussett
Oct 1, 2026 4:18 PM BST

Total percentage score and overall indicative rating

69

Good

Date completed

Oct 1, 2026 4:30 PM BST