2026

delphi care solutions

Hamberley Care (Brampton) Limited:

Montague House, Brampton, Cambridgeshire

Mock Inspection

Report and Improvement Plan

20 and 21 January 2026

Scope

Delphi Care Solutions were commissioned by Hamberley Care (Brampton) Limited ('the provider') to complete an independent, evidence-based comprehensive mock inspection of Montague House, Brampton, Cambridgeshire ('the home').

We completed the mock inspection on 20 and 21 January 2026. During the mock inspection we identified good practice, some exemplars, and some recommendations for improvement and development.

We shared feedback relating to these findings with the home manager and senior provider staff during the mock inspection process.

This report provides comprehensive details of our findings and includes our recommendations.

If Care Quality Commission (CQC) were to inspect on the days of our mock inspection, it is our opinion that the rating for the home would be as follows:

CQC KEY LINES OF ENQUIRY					
Safe 27/32 = 84%	**Effective** 18/24 = 75%	**Caring** 17/20 = 85%	**Responsive** 23/28= 82%	**Well-Led** 23/28 = 82%	**Overall Rating**
Good ●	**Good** ●	**Good** ●	**Good** ●	**Good** ●	**Good** ●

Rating

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

We use these thresholds to convert percentages to scores:

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

R/A/G Rating

This report details the findings of the mock inspection, utilising the Single Assessment Framework and Quality Statements currently used by the CQC.

The Red/Amber/Green (RAG) ratings below provide a visual representation of the key areas to be focused on within the improvement plan:

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

SAFE: Score Range 1 – 4 per area (maximum Score 32)								Total score
Learning Culture **SCORE: 3**	Safe Systems, Pathways and Transitions **SCORE: 3**	Safeguarding **SCORE: 3**	Involving People to Manage Risks **SCORE: 3**	Safe Environments **SCORE: 4**	Safe and Effective Staffing **SCORE: 3**	Infection Prevention and Control **SCORE: 4**	Medicines Optimisation **SCORE: 4**	**27/32** **84%**
EFFECTIVE: Score Range 1 – 4 per area (maximum Score 24)								
Assessing Need **SCORE: 3**	Delivering Evidence Based Care and Treatment **SCORE: 3**	How Staff Teams and Services Work Together **SCORE: 3**	Supporting People to Live Healthier Lives **SCORE: 3**	Monitoring and Improving Outcomes **SCORE: 3**	Consent to Care and Treatment **SCORE: 3**			**18/24** **75%**
CARING: Score Range 1 – 4 per area (maximum Score 20)								
Kindness Compassion and Dignity **SCORE: 3**	Treating People as Individuals **SCORE: 4**	Independence Choice and Control **SCORE: 3**	Responding to People's Immediate Needs **SCORE: 4**	Workforce Wellbeing and Enablement **SCORE: 3**				**17/20** **85%**
RESPONSIVE: Score Range 1 – 4 per area (maximum Score 28)								
Person Centred Care **SCORE: 4**	Care Provision Integration and Continuity **SCORE: 4**	Providing Information **SCORE: 3**	Listening to and Involving People **SCORE: 3**	Equity in Access **SCORE: 3**	Equity in Experience and Outcomes **SCORE: 3**	Planning for the future **SCORE: 3**		**23/28** **82%**
WELL-LED: Score Range 1 – 4 per area (maximum Score 28)								
Shared Direction and Culture **SCORE: 3**	Capable Compassionate and Inclusive Leaders **SCORE: 3**	Freedom to Speak Up **SCORE: 3**	Workforce Equality Diversity and Inclusion **SCORE: 3**	Governance Management and Sustainability **SCORE: 3**	Partnership and Communities **SCORE: 4**	Learning Improvement and Innovation **SCORE: 4**	Environmental Sustainability/ Sustainable Development **N/A**	**23/28** **82%**

Overview

We carried out an on-site mock inspection at Montague House over two days. The mock inspection was not announced to the home in advance at the provider's request.

The home was most recently inspected by the CQC in March 2023 where it received a REQUIRES IMPROVEMENT (RI) rating overall; with RI ratings for 'Safe' and 'Well-Led'; and GOOD ratings for 'Effective', 'Caring' and 'Responsive'.

The home is registered with the CQC to carry out the following legally regulated services:

- Accommodation for persons who require nursing or personal care.
- Treatment of disease, disorder or injury.
- Caring for adults over 65 years of age.
- Caring for adults under 65 years of age.
- Dementia.
- Physical disabilities.
- Sensory impairments.

At the time of our mock inspection the home was registered with the CQC to accommodate a maximum of 70 service users, and there were 55 people living at the home. Montague House is one of 22 sites operated by the provider.

The home and provider operate a model where care staff are designated as 'homemakers.' The home manager and senior provider staff told us that the homemaker model aims to make people's experience more like living in their own home by focusing on shared caring responsibility and relationship-centred care. Homemakers are responsible for universal, holistic provision including care delivery, housekeeping and companionship. Senior care staff were designated 'homemaker leads.'

Safe

Learning culture: Score 3.

We found that the home had a comprehensive, proactive and forward-thinking approach to learning and continuous improvement, with a focus on people's safety and learning lessons which all staff were able to contribute to. This was enabled and supported by a comprehensive, detailed, and integrated approach to overseeing, managing, and learning from incidents, accidents, and risks.

We saw evidence that the staff team were consistently supported and empowered to use opportunities for learning and improvement. This included allocating key areas of responsibility to homemakers and supporting and encouraging the submission of ideas and suggestions to improve care. For example, one homemaker lead had devised a programme of revised daily checklists for people's care during 2025 which had been implemented across the home with the support of the home manager.

There were further examples of where the home's staff had led on improvements which had been, or were being, implemented across the wider provider network. We saw that the home's head housekeeper had created and implemented cleaning schedules for the home which had been employed across all of the provider's sites. The home's head chef had created a process for food and nutrition risk assessments which had also been implemented across the provider's other sites. Both of these examples had taken place during 2025.

These examples were in addition to the detailed and comprehensive improvements to process, ways of working, and oversight which had been implemented by the home's manager since they commenced in post in the last 15 months.

We consider this empowerment of the staff team to contribute to ongoing improvements and support a sustained culture of learning and improvement – plus the commensurate encouragement and guidance from the home manager – to be an example of outstanding practice.

We found that there was a high level of understanding of risk, incidents and learning throughout the staff team which was evidenced by our conversations with staff and the home manager.

The home manager was able to provide evidence of an overarching focus on lessons learned and opportunities for improvement which had been developed and enhanced since autumn 2024. There was a detailed incident and accident reporting and learning framework, including comprehensive arrangements which supported proper root cause analysis and oversight of this. Thorough analysis of incidents was provided, leading to recommendations that we saw had been appropriately shared and carried out. Findings were used to drive staff training programmes, as part of staff supervision and appraisal, and as part of shared learning across the provider's other sites.

The home completed a wide range of quality and learning audits which were overseen and monitored by the home manager who was able to provide summaries and trend analysis of audit activity. We saw that findings, implications, actions and outcomes were shared with senior provider staff and other sites. This work was consistently used to consider and implement improvement opportunities. Staff we spoke with demonstrated a good understanding of how individual audits and learning were integrated across the home, including the purpose of these.

The home manager told us they consistently engaged in regular planned and ad-hoc conversations with staff throughout the day, which invited staff to consider their practice and how things may be improved. This included encouraging staff to reflect, consider, and suggest ideas for improvement. Staff we spoke with and documentation we reviewed provided evidence that this approach regularly took place, and staff showed a commitment to working together to drive improvements. In addition to this, learning was more formally shared as part of daily all staff 'huddle' meetings and regular, scheduled full staff meetings. This was supported by the sharing of information and updates by email and internal electronic communication and management platforms.

The home had dedicated electronic incident management, lessons learned and reporting processes (for example to the local authority and CQC). These processes comprehensively set out how incidents and identified risks led to actions and learning. All safeguarding concerns and medicines errors (including those related to documentation and recording) were subject to appropriate analysis and lessons learned processes.

We reviewed staff files and training records and found high levels of training and learning to support staff being equipped to deliver safe care. The home manager and staff we spoke with demonstrated a strong commitment to learning, safety, and raising concerns. Staff demonstrated they understood their responsibilities to raise concerns and report incidents and risks and told us they were fully supported by the home manager and senior colleagues when they did so.

Lessons learned processes were fully integrated with the home's feedback and complaints arrangements. We saw evidence of where findings from incidents, analysis and outcomes had been shared with families, which contributed to the open and transparent culture and approach to safety and learning we observed to be consistent throughout the home. There were a range of clear, accessible processes for providing feedback and raising concerns for staff, people living at the home, families, and others. Where any concerns had been identified we saw that these had been responded to, including sharing actions, improvements, and commensurate reductions in risk where these applied. This included with staff, families, and other health and care professionals.

We saw that there was a focus on maintaining policies and procedures to support safe care and improvement. Policies and procedures were updated every 12 months or sooner if deemed necessary and/or beneficial. Updates included where improvements had been identified following analysis of incidents and lessons learned, which contributed to the home's overarching and consistent approach to a high-quality learning culture.

Safe systems, pathways and transitions: Score 3

We found that the home worked consistently with people and partners to establish and maintain safe and effective systems of care.

There was evidence of appropriate continuity of care, including where people had moved between services. Assessments included objective, consistent and transparent scoring systems to decide levels of risk and need, which was considered alongside the home's current ability to provide safe care (for example because of staffing levels and expertise).

The home used an electronic care management platform (Person Centred Software, commonly known as PCS) which included detailed care plans, risk assessments, and relevant supporting documentation. We reviewed six people's records and found that in each example there were regular reviews and updates. We saw that there was a prioritised and explicit focus on staff in the home working together to support safe care pathways and delivery.

If someone required a referral through to a healthcare professional, this was carried out as soon as health needs required. There were suitable monitoring systems ensuring that people received timely interventions where their health needs had changed. We could see where referrals had been made, and people had been seen in a timely manner. We saw that referrals had been made to healthcare professionals when people required specialist input, for example speech and language specialists and out-patients services.

We saw that care and support was planned with the involvement of people, where they were assessed to have suitable capacity. Families and professionals had been suitably involved where this was applicable. Where people were deemed to lack capacity, Mental Capacity Assessments were completed and Best Interest decisions documented appropriately for all people we reviewed.

Safeguarding: Score 3.

We found that people were kept safe at the home.

We reviewed staff training records and found that all staff had received suitable adult and children's safeguarding training appropriate to their roles. For example, the home's manager and clinical lead (a senior nurse) were both trained to safeguarding level four.

We spoke with a total of ten managers and staff for the home and provider, and all were able to properly explain safeguarding principles, including how to recognise different types of abuse, how to report concerns, and how to use the home's whistleblowing procedures if necessary. Staff demonstrated a strong commitment to keeping people safe from abuse and/or neglect.

The home manager had developed and implemented a safeguarding quiz with 18 questions which was used with staff on an ad-hoc basis to encourage safeguarding learning in a supportive and collaborative way.

There was visual information throughout the home about raising concerns, freedom to speak up, whistleblowing, and processes to follow for reporting safeguarding concerns, including information aligned with local protocols and partners such as the Council and Police. The home had a designated Freedom To Speak Up Guardian and suitable processes to support this.

The home operated a digital signing in and out procedure and had secure areas protected by numerical codes or locked doors.

The home had clear, comprehensive written safeguarding policies and procedures which had been suitably reviewed and updated on an annual basis. We saw examples of where safeguarding incidents and risks had been correctly identified, properly reported, investigated, and the learning shared, including with the wider provider organisation and with partners.

We saw evidence of suitable Mental Capacity Assessments (MCAs), application of Deprivation of Safeguards (DoLS), and Best Interest (BI) decisions in people's records. We found that these were all

properly documented, and managers and staff we spoke with demonstrated a clear understanding of these processes and principles.

We saw evidence of where safeguarding concerns and risks had been discussed and properly documented with people living at the home, and with families.

The home maintained electronic and hard-copy logs of safeguarding incidents detailing the concerns raised, investigations conducted, outcomes, and relevant dates. These incidents were suitably integrated with lessons learned processes. The home manager was able to demonstrate a comprehensive approach to monitoring and tracking safeguarding incidents at suitable stages and could evidence how this was shared with and actioned by the provider's quality leads and other senior managers.

Managers were able to discuss the importance of learning from incidents to support safe care and had appropriate oversight of safeguarding incidents and outcomes. We discussed examples where managers and staff were able to clearly identify risks and associated process improvements that they had subsequently implemented, for example relating to people's falls within the home.

All documentation and evidence we reviewed was appropriately mindful of human rights and discrimination factors.

Involving people to manage risks: Score 3.

We saw evidence that the home consistently worked with people to manage risks and deliver safe, supportive care.

All people living at the home had their care managed by the electronic care platform PCS. We reviewed six people's records and found that care plans, risk assessments and notes were personalised and comprehensive, with proper consideration of risks. Care documents were reviewed at least every month, and more frequently as a response to changing information. Care records were subject to a programme of audits and quality checks to promote the use of suitably personalised information to help manage risks.

We saw that the home supported people to effectively manage risks. All areas of risks identified for people (for example falls, medicines, and nutrition) were clearly assessed, planned for, properly documented, and subject to management oversight and governance. Care plans included comprehensive consideration of best practice guidance for staff to follow.

We saw evidence of where people and their families had provided information and feedback which managers and staff had listened to and used to improve care. The home manager and homemaker staff told us they considered information from people and families to be an essential part of assessing and managing people's risk.

People's care plans and risk assessments were suitably reviewed and updated in line with their evolving needs, and this was subject to audit, oversight and governance by managers. People's risks were considered as a standing item in daily huddle meetings.

We saw that evidence of Best Interest decisions in relation to medicines and care were suitably documented, and there was proper consideration of the balance between freedoms and restrictions and a proportionate approach to this.

Safe environments: Score 4.

We found the home to be free from potential risks, with well-maintained premises, grounds, equipment, facilities, and technology. The home had suitable processes for assessing, detecting and controlling environmental risks.

We reviewed documentation which showed us that staff ensured the premises, equipment, facilities, and technology supported the proper delivery of safe care, including as part of a programme of daily, weekly and monthly checks. The home used a dedicated electronic health and safety platform which acted as an overarching toolkit and governance system to support compliance and best practice.

We spoke with the home's maintenance lead and reviewed the home's extensive documentation relating to the promotion of a safe environment. The home had processes for overseeing and managing areas including fire safety, electrical and personal appliances, water and legionella, heating and lighting, building maintenance, medical equipment, furniture, and waste. There were comprehensive records which provided evidence of suitable servicing, maintenance and audits. All required safety certificates were present and correct, and up to date.

The maintenance lead had used the provider's comprehensive programme of required assurance and checks as a basis to introduce additional measures to improve safety at the home. They had identified certain areas of specific significance and potential impact and introduced additional, enhanced checks to address these. Examples of this included weekly window restrictor checks for all rooms (instead of monthly), weekly carbon monoxide sensor checks (instead of monthly), and daily checks outside of the home to monitor for risks following or exacerbated by weather conditions. All of these checks were documented with detailed records and actions. We consider this to be an example of outstanding practice.

We saw that the home's equipment had been subject to suitable personal appliance tests (PATs), most recently during October 2025. The maintenance lead was qualified to complete these tests and the home also used external contractors to support this.

The home carried out scheduled fire evacuation drills and weekly fire alarm checks which were all suitably documented. The home had suitable staff across different functions and levels of seniority who were designated Fire Marshalls, and information relating to this was prominently displayed in the home.

We saw evidence of where the maintenance lead had completed audits of checks completed by external contractors and had identified occasional shortfalls and areas for improvement in their process and findings. This had led to remedial actions and follow up engagement with contractors with the aim of providing additional safety assurance for the home, and to provide feedback to support the contractors' own processes. Examples during the last 12 months included missed fire extinguisher checks and missed fridge checks by contractors. We consider this an example of outstanding practice in relation to promoting enhanced environmental safety.

Each person living at the home had a Personal Emergency Evacuation Plan (PEEP), which are designed for emergency situations to facilitate the prompt and safe evacuation of people with disabilities and/or mobility issues. PEEPs were collated in the home's entrance area.

We found the home environment to be spacious and free from clutter and obstacles that could lead to potential trip hazards. Lifting and walking assistance equipment was stored securely and safely. We saw that fire exits were clearly signed and free from obstacles. Suitable personal protective equipment (PPE) was available to all staff at various locations throughout the home.

We found there to be suitable consideration of the risks of psychological as well as physical harm, for example through the provision of many dedicated quieter or low-stimulus areas for people and their families to use. Managers demonstrated suitable consideration of staff and visitor safety.

Managers were able to describe how environmental concerns, risks and learning was discussed across the provider's network of homes to support improvements and best practice with the aim of reducing risk and improving safety. We saw that local factors were also properly considered as part of home meetings whereby staff from all teams contributed effectively.

There were suitable policies and procedures which had been regularly considered and updated to support the safe environment. The home had a suitable business continuity plan which had been updated in 2025.

We recommend that the home's manager and maintenance lead could support further improvement across the provider's other sites by sharing the home's enhanced processes and activities relating to environmental safety.

Safe and effective staffing: Score 3.

We found that the home had processes and systems to ensure there were enough qualified, skilled and experienced people who were subject to appropriate support and supervision.

We reviewed recruitment practices and activity and found that these were robust. This process was managed and overseen at provider level to support consistency across the organisation and the home sites. We saw there were effective checks to make sure staff were suitably qualified, competent and experienced to carry out their roles. Safe recruitment practices, for example employment history and Disclosure and Barring Service (DBS) checks, were consistently used. Checks for prospective new

employees included right to work with the UK, up to five references, experience and gaps in employment, and occupational health. Recruitment activity was subject to checklists and management oversight to promote consistency. There were suitable systems to ensure that professional revalidation was in place.

The home manager told us that staff levels and ratios were currently suitable for the home, and that these were subject to ongoing review with adjustments made in line with the number and needs of the people living there. The home used a dedicated staff level dependency tool to support staff allocation, which was built into the home's PCS electronic care platform. This was supported by the provider's own staffing need grid, and the home could pragmatically adapt staffing levels in response to changing need and risk. On the days of our mock inspection, we saw that the home was appropriately staffed.

The home prepared and shared staffing rotas in advance of shift dates. At the time of our mock inspection staffing rotas were being shared approximately 10 weeks in advance, and the home manager told us they were working towards this being three months in advance.

We saw that compliance with staff training requirements was high, for example mandatory training at 95% and where this was not complete there were suitable reasons for this (for example staff having very recently started in post). There was a staff training matrix which could be filtered and interrogated according to the information and monitoring requirements, and this provided effective oversight of staff training levels across the home when needed.

We found supervision, appraisal, performance management, and staff team meetings processes to be consistent and effective, including proper consideration of equality and protected characteristic factors. Staff received an annual appraisal and accompanying supervision sessions per year, and the home followed a suitable staff hierarchy process for this.

Staff inductions included suitable periods of shadowing and buddying, which sometimes took place across the provider's different sites to promote learning and development. Staff we spoke with told us they felt well-supported, including where they felt they had needed guidance and training to better understand their roles and requirements. We saw examples where any areas for concern, such as underperformance, had been addressed effectively and supportively.

We saw that the home used agency staff infrequently, and any agency staff working at the home were required to provide detailed information before doing so.

Managers and staff told us that staff wellbeing was properly considered, and we saw evidence to support this, for example in team meeting records and supervision records.

Infection prevention and control: Score 4.

As set out in the 'Safe environments' section, the home was subject to enhanced levels of checks and assurance relating to the premises and utilities. This included areas related to and beneficial for proper infection prevention and control, for example legionella checks and water flushing.

We observed the home to be visibly clean and odour free. All parts of the home, including areas where people and visitors would not normally have access (such as service areas) presented as extremely clean and tidy.

The home was subject to significant building and reprofiling work at the time of our mock inspection, with construction and decorating contractors on site. We saw that this had a minimal impact on the appearance and cleanliness of the home, and staff told us that this was due to proper planning and implementation of this work and the associated housekeeping activities.

There was information around the home with guidance on handwashing techniques and the correct use of PPE. We observed there to be no plugs in the sinks in communal toilet and handwashing areas, which can present a risk of cross-contamination.

The home had dedicated housekeeping and cleaning staff who we saw had received training and updates relevant to their roles. Their work was overseen by a head housekeeper, who we spoke with as part of this mock inspection.

There were documented daily, weekly and monthly cleaning schedules which were checked and audited by managers. The head housekeeper had revised the home's cleaning processes and accompanying documentation in the last six months, including to make recording of tasks and actions more efficient and clearer through the use of colour coding and by reducing duplication.

During 2025 and 2026 the provider had recognised the high standard of task scheduling, activity and recording relating to cleaning tasks at the home and had asked the head housekeeper and their team to support another of the provider's homes to improve their processes and outcomes. We consider this to be an example of outstanding practice.

There was sufficient stock of PPE and cleaning products which staff knew how to access when required. Control Of Substances Hazardous to Health (COSHH) data sheets were up to date and accessible to staff. Cleaning equipment and materials were securely and appropriately stored throughout the home.

We observed the kitchen area to be clean, tidy, and organised, including during busy mealtimes. Fridge and freezer temperatures were monitored and logged. All opened food products in the fridge were appropriately dated. No food products or other items were stored on the floor. The kitchen had a detailed cleaning schedule in place and activity was properly recorded. There was evidence of a suitable process for handling and managing clean and soiled items and we observed that staff consistently followed this process.

There was a dedicated hairdressing room which we observed to be visibly clean and tidy.

We saw that all staff had received suitable training on infection prevention and control (IPC), and management of staff completing IPC-related tasks included a thorough assessment of staff competencies.

Managers and senior staff completed regular, dedicated and overarching IPC audits. These utilised suitable and detailed audit tools and templates. This programme of activity included monthly audits by the head housekeeper and quarterly audits by provider leads. This programme of IPC audits is in excess of CQC expectations (for example full annual IPC audits). We consider this to be an example of outstanding practice.

A formal and overarching annual IPC audit had been completed by an external contractor during 2025 which had scored the maximum 100% rating. This demonstrated a high level of compliance with IPC requirements as assessed by an external, objective source.

The home had suitable, comprehensive policies and procedures relating to IPC which had been regularly reviewed and updated, most recently during 2025. The home maintained an 'infection tracker' which it used to assess and monitor any risks relating to infection. This tracker was overseen by the home manager and head housekeeper.

Medicines optimisation: Score 4.

The home had a dedicated clinical and medicines lead, who was a senior nurse based on-site and who had been in post for four months at the time of our mock inspection. We saw that the home manager – who was also a qualified nurse – had created, implemented and embedded an improved medicines management process with the support of staff (including the clinical lead) during the last 15 months.

The home manager and clinical lead told us that evolving medicines management and optimisation process were considered as opportunities for continuous improvement, and we saw evidence to support this. The clinical lead had implemented enhanced processes for checking medicines stock in the last four months, which included staff being allocated protected time to complete medicines-related administrative tasks.

There were three dedicated medicines rooms (one per floor). We saw one of these and observed it to be visibly clean and tidy. Each medicine room was equipped with functioning air conditioning to support effective temperature regulation. Records indicated that temperatures for each of the medicine fridges (used for items requiring storage between 2 and 8 degrees centigrade) and rooms were recorded twice daily, and we observed no gaps in the recording of these.

All medicines and equipment were stored appropriately. Where medicines had been opened, staff had recorded clearly and legibly the date of opening and used this to calculate expiration dates in line with guidelines. Medicines were securely stored, including trolleys when these were not in use.

We saw that staff carried out daily checks of medicines rooms, and weekly, documented enhanced checks which included the room, fridges, equipment, medicines stock, and all accompanying documentation and records. Staff carried out medicines counts before any medicines were issued, with any discrepancies documented and reported to a nurse or the clinical lead who would investigate the circumstances of this. The clinical lead had overall responsibility for reviewing any discrepancies and escalating any concerns (for example relating to safeguarding) to the home manager. The home had a medicines tracker which included information relating to discrepancies and risks of harm.

The home had suitable policies and procedures to support proper medicines optimisation, which were available to all staff on an electronic platform. These were created and updated at provider level and could be adapted to suit local, home-specific considerations if required. Staff showed us how these could be accessed quickly and efficiently to support their work. This included separate, dedicated controlled drugs (CD) policies which we saw were appropriate.

There was no evidence of excessive medicine stock, and we found no evidence of any discrepancies between system and stock counts. Staff told us they prioritised avoiding keeping surplus medicine stock and there is rarely any of this at the home.

On the days of our mock inspection there was one person who was assessed to have capacity to administer their own paracetamol. There were several people receiving covert medicines, and we saw there were care plans to support this. Care plans were linked to suitable assessments of mental capacity and included Best Interest meetings with family and suitable professionals including GPs and the provider's pharmacist.

CDs were suitably managed, including appropriate storage, security, recording, documentation, and destruction. Keys for CDs were kept separately and securely from other keys, with access strictly restricted to authorised staff only. Staff told us that where a resident passes away the home would hold their CDs for seven days (as required in case a coroner requires them for an investigation). We saw that the home's CD processes and practices were in line with guidance, regulations and laws (including the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001), for example policies and procedures, registers, storage, management, and disposal.

We saw that sharps bins were suitably managed, including the opening date being noted and bins not being overfilled.

We saw evidence of staff being properly trained to administer medicines, with their competency to do so being checked on both a planned, regular and ad-hoc 'spot check' basis. The home had a comprehensive cycle of quality checks and audits for medicines, clinic rooms, equipment, antibiotics, and covert medicines. This work was subject to suitable governance and oversight from the provider, including regular, ongoing engagement with senior clinical and quality managers.

We saw from submitted feedback and compliments that people's families said they were satisfied with how the home had managed people's medicines, and there was evidence that people (where able) and their families had been properly consulted and involved. The provider's pharmacist was actively

involved and worked closely with GPs to support proactive medicine reviews, including a focus on issues and risks associated with polypharmacy (the use of multiple medicines by a single person).

We found from speaking with staff that the home had a suitable approach for managing the risks associated with using and overusing certain medicines (for example antipsychotics and sedatives) to control people's behaviour, unless this was deemed absolutely necessary (sometimes referred to as STOMP: "Stopping Over Medication of People"). Staff were aware of the risks of inappropriate use of medicines and the associated safeguarding concerns and demonstrated that they worked to best practice and guidance principles for this area in line with people's care and needs. We saw evidence in people's care records that these principles were applied consistently.

Staff described to us examples of where the safe and appropriate use of medicines was considered as part of care planning, risk assessment and management, and Best Interest discussions with families and other professionals.

The home manager and clinical lead told us they were properly supported by the provider to enable them to focus on quality and continuous improvement in relation to medicines optimisation, including by developing a culture of learning, accountability and teamwork not support people's safe care.

We recommend that the home seeks opportunities to further develop its nursing and medicines-related information sharing, engagement and networking to maximise support, learning and continuous improvement across the provider's home sites.

Effective

Assessing need: Score 3.

We saw that people's needs had been properly assessed prior to them coming into the home. Staff told us that some of their residents had capacity, and if this were the case people would be involved as much as possible as part of the assessment process. Choice and agency were suitably prioritised and integrated into the assessment and planning process.

Initial assessments were completed by the home manager and homemaker leads and would involve the person and their family as much as possible. Other professionals were also involved where they were able to contribute to the assessment process.

Assessment of need was considered as part of an ongoing process. This was supported by a dedicated monthly and cyclical "resident of the day" initiative, whereby people's assessments and care plans were subject to a comprehensive, holistic review by different managers and staff. This included areas such as health, wellbeing, diet, communication, interests, aspirations, activities, visits, and any risks.

The home operated a 'key worker' process which supported continuous, ongoing care and engagement. Key worker responsibilities and tasks were carried out by the allocated homemakers who took responsibility for holistic care, with the support of homemaker leads and nurses.

We saw that people had their plans, needs and risks updated frequently in line with evolving information. All care plans were subject to monthly reviews and updates by nurses and homemaker leads, and care plans were audited monthly by the home manager. We reviewed six people's care records and found these to be detailed, comprehensive and well-written.

We saw that the home had a comprehensive care review meetings process, which included a focus on assessing need. We saw from care records and other documentation that there was a high attendance and engagement rate at these meetings for people and their families.

The home manager told us that all care records, assessments and associated plans had been subject to a full peer review in the last 12 months by the provider's staff.

People's needs were assessed and considered as part of a daily "huddle" meeting for senior and lead staff at the home. Staff told us these meetings were more detailed, comprehensive and focused on people's needs than traditional daily catch-up or handover meetings. The huddle would include detailed consideration of the respective resident of the day.

We saw that people's needs were reassessed as circumstances changed, with commensurate revisions to plans and risk assessments. We saw that needs were reviewed regularly with changes made where appropriate. People's communication needs and preferences were properly considered to support effective assessment, care and treatment.

The home manager told us they considered people's assessments and plans to be subject to ongoing continuous improvement. We saw positive feedback from people's families relating to suitable assessment, for example a family member writing to the home to tell them that they "really knew [their] dad."

Delivering evidence-based care and treatment: Score 3.

We found that staff could consistently access relevant information relating to the assessment, planning and delivery of care, treatment and support using the home's electronic care management system. The home used the Person Centred Software (PCS) platform to manage care.

The home planned and delivered people's care and treatment in collaboration with them and their families, including what was important and mattered to them. Care was delivered in line with legislation and current, evidence-based practice, and we saw that people and families were told about current good practice which was relevant to the person's care.

We saw that people's hydration and nutrition needs were properly met, with relevant information, interventions and care properly recorded and shared. Detailed nutrition reports were shared with the

home's head chef, which included people's needs, likes and dislikes, food allergies and intolerances, whether adapted cutlery was required, and Malnutrition Universal Screening Tool (MUST) score. (MUST is a validated five-step screening tool used by healthcare professionals to identify adults at risk of malnutrition or obesity in care settings.)

Managers were able to provide evidence of improvements in evidence-based care and treatment delivery over the last 15 months, for example relating to improved recording quality which helped contribute to better quality evidence-based care planning and interventions.

Managers were able to share good practice they found across the home and within the wider provider organisation as part of lessons learned processes.

How staff teams and services work together: Score 3.

We saw evidence of where meetings had taken place to support effective information sharing, including with families and other health professionals. Where appropriate, people living at the home were also involved in these meetings.

We saw comprehensive evidence of where meetings had been used to communicate care and treatment information between staff. This included as part of daily huddles, the 'resident of the day' process, training sessions, and various meetings. There was evidence of effective coordination between all parties and that this supported ongoing continuity of care. The home had regular, dedicated professionals' meetings (for example for nurses) to share information and improve practice. This also included meetings with colleagues from across the provider's other sites.

The home's electronic care management system facilitated the alerting and communicating of any concerns or emerging risks across the staff team, and we saw examples of where this had taken place to support care.

The provider's dedicated pharmacist visited the home at least every two weeks, with ongoing additional engagement evident to support effective medicines optimisation and care provision.

The home had a dedicated GP practice, and practice staff conducted weekly ward rounds at the home. We saw that some people at the home preferred to stay registered with their own GP, and the home could accommodate this through effective communication.

We saw that other professionals were engaged and involved with care at the home, for example the local community mental health team and a physiotherapist. We spoke with the physiotherapist who was based at the home for two or three days per week and had done so over the last four years. They told us they had seen significant improvements in the delivery of high quality care over the last four years and told us that the home compared positively with other sites they worked at. They also told us that the quality of care at the home was high, that staff worked in a proactive and caring way, and that the home's processes and ways of working were high quality and supported the delivery of safe care.

Specialist external teams and agencies were also involved including speech and language therapists and wheelchair services.

We saw evidence of engagement and meetings for people living at the home, including some where families had been engaged and involved. The home had a range of approaches to keep families and others informed, including meetings, newsletters and other written information.

We saw that the home manager chose to work one night shift per month to support effective engagement, integration, communication and teamwork for those staff solely working night shifts. We consider this to be an example of outstanding practice.

Supporting people to live healthier lives: Score 3.

Staff told us a key principle they worked towards was resident empowerment and informed choice, which was in line with the provider's approach across all its home sites. This was directed by engagement with people and their families, including on a one-to-one basis and as part of residents' group meetings.

Staff were able to show us how people were involved in promoting their own healthier lifestyles. For example, people were engaged in planning and reviewing meal choices and supported in terms of their nutrition and weight management.

We saw from care records that changes in people's presentation, emotional state or distress which may indicate deterioration to their health or wellbeing were recognised by staff; and concerns shared with relatives, partners or other services. A staff member told us they knew people well and had done so for a long time, so could recognise small changes and act upon these.

Activities and entertainment were provided by dedicated staff and external visitors to the home, and we saw that people had suitable and timely access to GPs, nurses and other healthcare professionals.

For people who required pressure relieving equipment we found the equipment had been maintained and set to people's individual requirements. This is important for preventing and treating wound care or for people who have limited mobility.

Monitoring and improving outcomes: Score 3.

We reviewed people's records and found that there were comprehensive arrangements for planning, coordinating, delivering, and measuring care and improvements. Care records, assessments and plans were of a consistently high quality with sufficient detail provided, and these were continuously monitored to support care needs and outcomes.

We saw that people's monitoring was holistic, timely and effective, with evidence of this leading to continuous improvements to care and treatment. There was evidence that people were treated as individuals with their monitoring tailored to them which supported improved outcomes.

Staff and other healthcare professionals that we spoke with were able to provide examples of how the home supported people to improve their outcomes. For example, a person had arrived at the home unable to mobilise and had been supported by staff and provided with mobility equipment which had resulted in them being able to move around the home in a manner which suited them.

Consent to care and treatment: Score 3.

We saw that the home told people about their rights around consent and respected these when delivering care.

We reviewed people's records and found that Mental Capacity Assessments (MCAs) and Best Interest decisions had been properly completed and made.

Where people had capacity, there was evidence of suitable involvement documented in their care and support plans. People were involved in decisions about their care, and where they lacked capacity to make these, families and others close to them, as well as healthcare professionals, helped staff make Best Interest decisions on their behalf.

Throughout the visit we observed staff to be asking people questions and respecting their decisions, for example relating to meals, activities and involvement. This provided examples of gaining consent at the time of request.

Staff and managers that we spoke with clearly understood the importance of capacity and consent. We saw that staff had completed training related to this. The home manager had suitable oversight of capacity and consent processes and recording and acted to address these where required. Consent to care was appropriately signed, and this was updated in line with care plan reviews and amendments.

Caring

Kindness, compassion, and dignity: Score 3.

The home's homemaker model and values supported the delivery of kind, compassionate and respectful care, and throughout our mock inspection we saw consistent demonstration of care provision in line with these values and principles.

All interactions we observed were natural and evidenced knowledge and understanding of each person and their needs. This included in one-to-one and group settings. Interactions were patient, kind and caring, and staff spoke to people with compassion, which helped to put them at ease. We observed staff show genuine concern when people appeared not to be their usual self.

We observed one example where a staff member spoke with a person whilst demonstrating high levels of compassion and patience, when the person said they wanted to go for a walk outside when not wearing weather-appropriate clothing or footwear. The staff member displayed a high level of understanding of the person and how best to speak with them in a calm and reassuring manner.

People were supported and encouraged to interact with each other in productive ways where appropriate, for example during activities and mealtimes, and in the home's bistro area.

We observed people receiving care and support without delay. Throughout the day staff were seen to be actively and proactively engaging with and supporting people, for example to meet their emotional, mobility and hydration needs.

We observed that all personal care and tasks were conducted in people's own spaces where appropriate levels of privacy and dignity were maintained. The home had a wide range of large and small rooms, including quiet areas, which supported privacy where needed.

We observed that visitors to the home were treated respectfully and courteously. We saw that staff treated each other, and colleagues from other organisations (for example visiting ambulance staff) with professionalism, respect and kindness.

We saw that information about people was treated confidentially, and that staff respected people's privacy.

Treating people as individuals: Score 4.

We observed staff at the home to be demonstrating understanding of each person, including their personal needs, strengths, backgrounds, and preferences. Managers and staff demonstrated a high level of understanding of people's backgrounds and lives, as well as their personal situations and circumstances.

Staff demonstrated patience and understanding whilst promoting independence, for example encouraging people to move around areas of the home in a manner which was comfortable for them. Each person was treated with respect and engaged with as an individual, with their autonomy and decision-making respected. We saw staff engage with people without making assumptions, and staff gave people opportunities to make and change their decisions, for example at mealtimes and during activities. We saw that staff would provide clear information where decisions were made on behalf of people as part of their care and best interests.

Staff we spoke with told us how they were able to communicate with people to identify their individual needs and preferences. All staff we spoke with demonstrated they knew people well, and we observed consistently positive and meaningful interactions between staff and people who lived at the home. We consistently saw examples where people's individual interests and preferences were considered and respected.

Staff consistently demonstrated a high level of understanding of people's likes and dislikes. Staff were able to describe in detail how best to communicate and engage with individual people using their knowledge of the person, whilst not making assumptions. The physiotherapist who worked at the site two or three days a week told us that the staff at the home had a high level of knowledge about people which helped them to provide a consistently high standard of care.

Care records, and staff and managers we spoke with, demonstrated a suitable understanding of people's cultural, social and religious needs, including proper consideration of any applicable protected characteristics where these applied. We saw that staff referred to people by their chosen name and communicated with them in a way that they could understand, and we observed this during our mock inspection.

The home promoted flexible visiting times, including where visitors were encouraged to dine with residents including in private areas. Pets were encouraged to visit the home, and this was supported by appropriate risk assessments.

The home had a process where each room had a secure display area by the room's door (which staff called 'memory boxes') which could be used to display photographs, keepsakes, mementos, and other personal items of significance to them. Staff told us that these items had been chosen by people and their relatives. Some of the rooms had small whiteboards and pens inside, which were available on request, where people and/or their relatives could write messages or information for the benefit of staff and/or themselves. This process was implemented following a request by a family member for one person and rolled out across the home for those who wanted it. We consider these to be examples of outstanding practice.

Feedback from people and their relatives was consistently high in relation to how people were treated as individuals. For example, written feedback to the home from 2025 described how staff went "above and beyond" to provide personalised care for their relative.

Independence, choice and control: Score 3.

We saw that people were given choice and control in their activities, meals, and drinks, with staff providing clear information relating to choices and alternatives. There was a wide range of films, books, magazines and games available for people and their visitors to use.

We saw evidence of suitable and detailed risk assessments and care plans to promote and encourage maintenance of independence in relation to activities within and outside of the home. There were adequate supplies of suitable equipment to support and maximise outcomes and independence, and records indicated that these were properly maintained and consistently checked for safety.

We saw that - where assessed to be appropriate - people were able to meet with others who were important to them (including family members and friends), both inside and outside the home environment. This included visitors to the home. The home had a large, accessible outside areas which

staff told us were well-used when the weather was suitable. These areas were subject to appropriate maintenance, checks and risk assessments by staff.

The home had a café/bistro area which people and their visitors were encouraged and supported to use. We observed positive, meaningful and supportive conversations and engagement there throughout our mock inspection days, including where different people and their relatives were engaging with each other with compassion, warmth and humour.

Responding to people's immediate needs: Score 4.

The home was exceptional in how they listened to and understood people's needs, views and wishes. We observed staff responding to people's needs in the moment, and acting to minimise any discomfort, concern or distress in a caring and empathic way. Staff knew people well and could respond proactively when needed.

During our visit we observed incidences where staff responded quickly when people required urgent help or support, for example if they needed help mobilising around the home or if they became distressed. We saw staff anticipate people's needs in communal and more private areas. This took place consistently during the two days of our mock inspection.

People's care needs and associated risks were clearly identified in their care records, and we saw that these had been regularly reviewed and updated to ensure information was current and relevant, and aligned with people's personal circumstances. Staff could access important summary information about people quickly (alongside more comprehensive and detailed information) to help support responsive care delivery and avoiding preventable distress.

Most staff had worked at the service for several years meaning they understood people well and could recognise pain or discomfort in people's facial expressions, body language or behaviours. Staff told us they could respond to people quickly and effectively because they knew them so well.

Technology such as call bells, sound monitors and panic alarms were used to monitor for people or colleagues urgently needing help, and staff responded appropriately.

Concerns about people were shared with relatives and other services to ensure their health and wellbeing could be monitored, and necessary action taken. We also saw repeated evidence of where family members had contributed to the information held by the home about people to support and facilitate responsive care.

Workforce wellbeing and enablement: Score 3.

Staff we spoke with told us there was a positive, supportive culture at the home and that their wellbeing and support were prioritised. Throughout the day we observed staff to be working collaboratively and in a mutually supportive way. We saw evidence of team meetings which included a focus on staff wellbeing and support.

We saw evidence that staff views were addressed as part of supervision sessions and appraisals, and as part of staff meetings.

Staff were offered the opportunity to provide their views as part of feedback processes, team meetings, and supervision and appraisal sessions. **The home had completed a full staff survey during 2025 but had only partial plans to complete follow up surveys and associated actions for 2026. We recommend that the home establishes a more consistent and thorough approach to conducting a programme of staff surveys, including proper consideration of feedback, actions, and desired outcomes.**

Staff files showed examples where staff were provided with targeted support to increase their skills and confidence, including for new staff and where areas of underperformance or other concerns had been identified. Staff training, including virtual training sessions, was conducted in protected work time with no expectation that staff should complete any training in their own time.

We saw evidence that staff were able to have suitable, regular breaks and access to appropriate rest areas. Staff were supplied with a range of benefits and support from the provider, including wellbeing and counselling services.

The provider and home operated initiatives including employee of the month (with an accompanying gift) and weekly staff treats days.

We saw that the home provided additional support for staff where appropriate, including for those with caring responsibilities or experiencing ill health.

All staff that we spoke with told us they felt valued and encouraged by the home and provider. In particular, feedback in relation to the home manager was universally positive, with many staff highlighting examples of positive changes in the last 15 months.

Responsive

Person centred care: Score 4.

We found the home to be exceptional at providing a person-centred approach to people's care and in their interactions with people.

We saw numerous examples of how the home and staff had properly considered people's personal circumstances, life histories, likes and dislikes, and family situations to deliver person-centred care.

For example, the home had co-ordinated and facilitated a 'date night' for a person living at the home and their spouse (who did not live at the home) for Valentine's Day 2025. This was planned with the couple's daughter and delivered as a surprise at her request. The evening included providing the

couple's favourite food in a private dining area, a private screening of their favourite film in the home's cinema room, and the home's chef preparing a cake.

For one person who could not leave their room, staff engaged with their family and identified that they were a motorbike enthusiast and used to ride motorbikes regularly. Staff made a CD of audio recordings of motorbike engine sounds which the person could listen to in their room, and staff told us this had a demonstrable positive effect on the person, and they appeared to enjoy it.

One person was unable to attend their granddaughter's wedding as planned during 2025 due to their health, and the home worked with the family to enable the granddaughter to visit in her wedding dress with other family. The home held a showing of the couple's wedding video and photographs for the person and their family in the cinema area.

We consider these examples of person-centred care to be outstanding practice.

Care records we reviewed demonstrated clear evidence of person-centred care, including suitable assessment, planning and delivery for individual physical, mental, social and emotional needs. Care plans we saw were sufficiently detailed in their consideration of needs and how to best address these. People were empowered and supported to make their own choices as far as possible, including provision of reasonable adjustments relating to nutrition, hydration, activity, and the physical environment.

We saw evidence of activities provided for people, which were tailored to and assessed for their individual needs. This included for engagement with staff, exercise, offsite visits and activities, and creative pursuits such as art and music sessions. Staff told us they prioritised constructive and supportive activities to help promote people's engagement.

The layout of the home allowed people to spend time alone or with smaller groups in dedicated areas, including a cinema room, games room and a bistro which were suitably supported by staff.

Care provision, integration, and continuity: Score 4.

The home had a high level of understanding of the needs of its residents and the available provision within the local community, so care was joined-up, flexible and supported choice and continuity. Staff knew people at the service well, meaning they could provide support that responded to their needs and choices.

Continuity of care was supported by external visitors to the home, including GP staff, health visitors, and other professionals such as speech and language therapists.

The home was situated in a geographical area with a comparatively high number of military veterans and retired service personnel and was built on the site of an old Royal Air Force (RAF) base. Consequently, the home had a significant number of residents, families, and staff who were veterans. The home manager, who had served for 15 years in the Princess Mary's Royal Airforce Nursing Service,

championed veteran issues and had developed strong links with the local veteran community and associated groups, including the local Royal British Legion branch. The home provided evidence of engagement and events such as hosting regular veteran group events on-site, and by holding a 'week of remembrance' each November to honour and celebrate veterans.

The home applied for and was formally accredited as a 'Veteran Friendly Care Home' with the Veteran Friendly Framework (VFF) organisation in April 2025, which recognised commitment and best practice for care in the armed forces community. The home was the first care home in the region to achieve this official accreditation, and at the time of our mock inspection, one of only two having done so (the other being one of the provider's other sites). The documented requirements for achieving this status were robust and included demonstrating an understanding of and commitment to armed forces and veterans' issues; relevant staff training; supporting recruitment of veterans; partnerships with relevant local groups; and suitable awareness raising. The home's local GP practice was also recognised as being veteran friendly.

The home manager told us that, despite achieving and being proud of this recognition, they also prioritised avoiding becoming too focused on veterans issues to the extent that non-veteran residents, families and staff may feel excluded.

We consider the home's veteran friendly status, and the commensurate recognition of and alignment with local need, to be an example of outstanding practice for integrated care provision.

Providing information: Score 3.

The home supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs. There was comprehensive information available, including hard-copy information leaflets, in the reception area, bistro, and other areas throughout the home.

The home had established a small library in one communal area which it called the 'dementia corner,' which contained a wide range of information about dementia.

Information was provided in a variety of formats, including text, pictures, symbols, and by using objects of reference in line with the Accessible Information Standard (AIS). This is a legal requirement for organisations providing health or social care services which aims to ensure people with disabilities, impairments, or sensory loss receive information in formats they can understand.

Staff we spoke with were able to demonstrate examples of how they communicated with people based on their individual needs. This included how and where they spoke with people, and how they interpreted people's responses and requests including how these may evolve over time.

Information about people we reviewed followed data protection legislation and other legal requirements and was handled in accordance with these requirements.

Listening to and involving people: Score 3.

The home made it easy and convenient for people to share their views and ideas. There were dedicated policies and procedures for complaints, compliments and provision of feedback.

We reviewed feedback submitted to the home, and we found the overwhelming majority to be extremely complimentary. This included feedback from people living at the home and their families. The home had a consistent approach for managing feedback, compliments and complaints, and this were overseen by managers and provider quality leads to promote consistency and thoroughness.

The home manager and staff recognised and could describe the distinction between requests for action or improvement, and complaints. Information about how to provide feedback, including how to complain, was accessible, clear, and easy to understand.

The home operated a 'residents' committee' which consisted of five people (at the time of our mock inspection) who met with the home manager monthly to discuss people's experiences, feedback and concerns, and suggested improvements. We saw that this led to suitable actions and outcomes, for example in relation to food provision, the home environment, and activities.

We saw evidence of how the home had used feedback and complaints information and findings to drive improvement, including through staff meetings, supervisions and appraisals, and staff training. Findings had been integrated with incidents, accidents and risk processes where applicable. Complaints had been subject to thorough, comprehensive investigations where findings and recommendations had been shared with all staff. Complaint investigations were aligned with Care Quality Commission (CQC) lines of enquiry to support improvement.

Equity in access: Score 3.

We saw evidence that the home made sure that people could access the care, treatment and support they needed, when they needed it.

We saw that the home had a productive relationship with the local GP practice who supported the home with scheduled weekly ward round visits and ad hoc visits as needed. Staff told us they worked in partnership with other health and social care professionals, and we saw evidence of this in care records.

The home premises and outside areas were suitably accessible for people living there and their visitors. People were supported to attend events outside of the home.

We saw that people's needs were comprehensively assessed before they moved into the home and care plans reflected any reasonable adjustments the person needed to ensure their needs were met.

Equity in experience and outcomes: Score 3.

We saw that managers and staff actively listened to information about people who were most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this. This included for example people who were most at risk of exclusion and isolation due to their personal circumstances.

We saw evidence that staff reviewed and acted upon information about people in a way which supported equity in experience and outcomes. This included addressing any potential barriers to inclusion (such as communication difficulties) with the aim of ensuring people felt valued and a part of the home's community. Staff included and considered personal goals and outcomes as part of care planning and care delivery.

We saw that staff consistently worked to provide an inclusive, engaging environment for people whilst respecting when people chose to spend time alone, or privately with their families.

Planning for the future: Score 3.

We saw that people were given proper support to plan for important life changes, so they could make informed decisions about their future, including at the end of their life.

The home demonstrated a commitment to supporting people and their families in planning for the future, ensuring everyone was empowered, informed, and treated with dignity and compassion throughout their journey. People were supported to understand how to legally prepare for times when they might no longer be able to make decisions for themselves.

We saw evidence of Do Not Attempt Cardiopulmonary Resuscitations (DNACPRs) documented and in place. We saw that specific sections within the care records were completed in relation to End-of-Life plans, hopes, goals, and preferences.

We saw that staff had received suitable training in relation to end of life care.

Well-led

Shared direction and culture: Score 3.

The home and wider provider organisation had an overarching vision, which was to be the leading provider of high quality, personalised care. The associated values included dignity, commitment, creativity, empowerment, collaboration, and innovation.

We saw that the home manager and other senior staff consistently worked to promote these principles through, for example, staff meeting minutes, policies and procedures, and supervision records. There was evidence of where strategic provider engagement provided support for the home, for example in relation to quality assurance and governance of activity.

We saw examples where the home had used mechanisms to ensure people who lived there, families, staff, and partners could collaborate and contribute to the home's direction. This included residents' committee meetings.

Staff we spoke with demonstrated pride in working at the home and were able to describe the principles and priorities they worked towards. Staff also told us they felt supported and that there was an open, collaborative culture.

Training records we reviewed and staff we spoke with demonstrated that staff had a suitable understanding of equality, diversity and human rights, and evidenced how they prioritised safe, high quality and compassionate care.

Capable, compassionate, and inclusive leaders: Score 3.

Managers at home and provider level demonstrated suitable experience, capacity, capability and integrity to properly understand the context in which they delivered care, treatment and support whilst embodying the culture and values of the home.

All managers and staff we spoke with displayed a passion for the home and for what they were aspiring to achieve, which was to provide empowering, dignified and person-centred care to the best of their ability. We found from staff feedback that the home manager was considered to be a capable, credible and knowledgeable leader who staff respected and felt comfortable approaching with any questions or concerns. We saw that the home manager had received numerous thank you cards and letters from staff since commencing in post 15 months prior to our mock inspection, which set out their appreciation for the support and encouragement they had received.

Managers and senior staff were able to demonstrate inclusivity and an understanding and appreciation of suitable care delivery and associated risks to this.

We saw examples of where supportive performance management processes had been used. This included formal disciplinary processes where needed. Managers were able to demonstrate a structured and evidence-based approach to managing poor culture or poor performance, and to improve and further develop high-achieving staff.

Staff were encouraged in their development. We saw examples where staff (including recruited recently) were supported with training, guidance and mentoring to enhance their skills, performance and confidence. There were examples of where staff, such as homemaker leads, were allocated additional responsibilities to support their growth and development.

We saw that senior provider staff, including those responsible for quality, visited the home to provide support, guidance, and constructive challenge to drive improvement.

Freedom to speak up: Score 3.

We saw that the home had a culture and accompanying processes which supported and encouraged staff, people living at the home and others to speak up.

Managers told us they had an 'open door policy' and we saw evidence of this throughout our mock inspection. We observed managers and senior staff (including those from the provider organisation who worked across home sites) to be highly visible and frequently engaged with staff, people living at the home, and visitors.

We saw examples of where meetings and one-to-one sessions had taken place where staff were encouraged to provide their views. We also saw evidence of where staff views had been documented and acted on, including as part of incident and risk review processes.

Staff we spoke with told us they would feel able and comfortable in raising any concerns they had. The home had a suitable whistleblowing policy in place with information around the home referring to this and which all staff we spoke with were aware of.

The home had a dedicated Freedom To Speak Up Guardian who was based on site, and who was not a member of the management team. We saw that they had been suitably trained and had commenced in this role in September 2025.

Workforce equality, diversity, and inclusion: Score 3.

We saw evidence that the home valued diversity in its workforce. This included by working towards an inclusive, fair culture for people working there. Managers told us there were fair and equitable recruitment and promotion policies and we saw documents to support this.

We saw evidence of where staff members' personal circumstances had been considered when shift patterns had been allocated, for example for those with caring responsibilities and other personal commitments.

Staff we spoke with demonstrated suitable awareness of equality, diversity and inclusion principles, and told us they were treated fairly. We reviewed staff files and saw evidence that the home had understood and considered relevant factors including protected characteristics and reasonable adjustments as part of recruitment and supervision arrangements.

Governance, management, and sustainability: Score 3.

We saw evidence of accountability and proper governance. Managers and senior staff used information to promote and deliver safe, high-quality care. This included acting on and sharing the best available information about risk, performance and outcomes.

We saw that managers and senior staff took a proactive approach to governance, for example by upskilling staff and assessing their competence, and by carrying out detailed audits and preventative actions in relation to premises safety and infection prevention and control.

The home's governance framework ensured the home operated effectively and to a set of prescribed standards. This included a programme of audits, incident and risk management processes, effective use of evidence-based action planning, and a systematic approach to learning and improvement. Risks, learning points and actions were shared across the provider's home sites.

We found all policies, procedures, risk assessments, action plans and other associated documentation to be suitable and being used appropriately to drive improvements.

We saw evidence that managers were continually checking that people were supported appropriately, staff were carrying out their roles properly, and that the premises and equipment were safe and fit for purpose. We saw that any issues or concerns identified were addressed within a suitable time frame. Staff told us they were clear about their roles and told us they had regular supervision and opportunities to discuss any concerns with managers.

Managers and senior provider staff demonstrated a clear understanding of their responsibilities and were knowledgeable about how to comply with notification requirements and legal regulations.

Managers and staff demonstrated openness and honesty with people living at the home and their families when things went wrong with their care and provided them with a suitable apology following investigation. Complaints and feedback were continually reviewed and used as an opportunity to drive improvements throughout the home, including being considered as part of ongoing lessons learned processes.

Partnership and communities: Score 4.

We found that the home was actively integrated and engaged with the wider community to an exceptional standard.

This included the veterans initiative as described above, plus a large number of events, activities and partnerships which meant that the home demonstrated a high level of interaction and involvement with partners.

For example, the home held annual 'Care Home Open Week' events for the wider community. The home hosted the local Women's Institute (WI) on a monthly basis, which included afternoon tea, presentations from partners (such as the local air ambulance), and singers. Some of the people living at the home were previous members of the WI. We saw feedback from the WI group which said, "we are lucky to have such a caring home in our village."

The home held a 'Inclusion and Diversity' week each year, which included staff who were originally from overseas contributing to a fashion show at the home, where they showed clothing reflecting their cultural heritage and conducting interactive presentations to people and their families.

The home held monthly 'blue light breakfasts' with complimentary food, drink and gifts for local blue light workers to encourage wider community engagement for people and their families. (Blue light workers are professionals in certain critical public services, for example emergency responders, NHS staff, social care workers, teachers, and armed forces personnel.)

Since 2024 the home held annual 'Christmas Fayres', which were open to the public and included local market and craft stall holders. We saw feedback from one stall holder from the Christmas 2025 fayre which said the event was "the best they had ever done."

The home put on a free event in April 2025 for people, their families and the local community to celebrate the recruitment of a new head chef. This was called "a taste of Montague" and provided canapes and a tasting menu for over 80 people.

We saw that proceeds from events had been donated to local and charities, for example Alzheimer's UK.

During summer 2025 the home worked with a local school and a local estate agent to host a "connecting generations" event at a nearby golf course, where people, their families, children, and the local community engaged in conversation and activities.

The home's community events often attracted positive coverage in the local and regional press. For example, the Peterborough Telegraph covered the home's Easter 2025 celebration event which was attended by over 100 people.

The home sponsored the local cricket club at the time of our mock inspection and had done so for four years. We saw an example from 2025 where one person living at the home, who was a keen cricket fan, spent a day as a guest of the cricket club, including speaking with the players and watching a match. This was facilitated by one of the home's homemaker leads, who played for the cricket team.

We consider the home's ongoing and successful programme of partnership and engagement with the community to be an example of outstanding practice.

We recommend that the home shares its examples of positive partnership and community engagement (and how it achieves these) with the provider's other homes as evidence of best practice, to support their ongoing development and improvement.

In terms of care provision, staff told us they could make referrals to health and social care professionals. Staff and family members we spoke with confirmed that relevant health and social care professionals were involved with people's care, and people's care records and documentation supported this.

Learning, improvement, and innovation: Score 4.

We found that the home was consistently focused on learning and improvement, including by working to dedicated improvement and action plans.

We saw that people living at the home and their families were involved in providing feedback and making suggestions from surveys, submitted feedback forms and meetings. This information was collated and considered as part of driving improvement and lessons learned processes.

We saw from meeting notes and staff supervision sessions that the home identified and used information as opportunities to address concerns and support improvement. This was supported by documented action and improvement plans.

Managers and staff that we spoke with demonstrated a willingness to learn and improve and could cite examples of where this had taken place, for example in relation to more detailed and personalised care records.

The home provided evidence of a range of innovative approaches, including the pioneering and creative use of technology. For example, the home had worked with a UK virtual reality headset company twice in 2025 to provide interactive experiences for people living at the home. This included providing experiences such as virtually touring cities and university sites where people used to live. This work was suitably risk assessed and used as part of reminiscence therapy, and we saw that family members had provided positive feedback about their relative's experience and the outcomes.

The home had used Bluetooth technology to adapt equipment to alert a person with sight and hearing loss when someone was at their room door. This meant they could wear a device on their belt and attach a device to their mattress which vibrated when required.

All managers and staff that we spoke with demonstrated a willingness to think creatively and to try new things to support improvements to people's quality of life.

Environmental sustainability / sustainable development: Score N/A

In line with current CQC methodology, we do not currently assess this area. We did not consider evidence relating to this area as part of our mock inspection.

Improvement Plan

The following actions highlight the areas for improvement and recommendations for further development from the mock inspection carried out during January 2026. This can be used alongside any existing action plans or improvement plans for the home.

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
The home was engaging in enhanced processes to support assurance relating to the home environment. We recommend that the home's manager and maintenance lead could support further improvement across the provider's other sites by sharing the home's enhanced processes and activities relating to environmental safety.				
We recommend that the home seeks opportunities to further develop its nursing and medicines-related information sharing, engagement and networking to maximise support, learning and continuous improvement across the provider's home sites.				