2026

delphi care solutions

Orchard House Care Home

Mock Inspection

Report and Improvement Plan

Date: 28th & 29th May 2026

Scope

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

Delphi completed the mock inspection on 28th & 29th May 2026, with all work carried out on a face-to-face/on-site basis.

During the mock inspection, we identified good practices and potential areas for improvement. Throughout the two days, we shared high-level feedback relating to these findings with the home, deputy and local managers.

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

CQC KEY LINES OF ENQUIRY					
Safe 17/32 = 53%	**Effective** 13/24 =54%	**Caring** 14/20 = 70%	**Responsive** 18/28= 64%	**Well-Led** 19/28 = 68%	**Overall Rating**
RI	**RI**	**Good**	**Good**	**Good**	**Good**

Rating

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

We use these thresholds to convert percentages to scores:

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

R/A/G Rating

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

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: 2**	Safe Systems, Pathways and Transitions **SCORE: 2**	Safeguarding **SCORE: 2**	Involving People to Manage Risks **SCORE: 2**	Safe Environments **SCORE: 2**	Safe and Effective Staffing **SCORE: 2**	Infection Prevention and Control **SCORE: 2**	Medicines Optimisation **SCORE: 3**	**17/32** **53%**
EFFECTIVE: Score Range 1 – 4 per area (maximum Score 24)								
Assessing Need **SCORE: 2**	Delivering Evidence-Based Care and Treatment **SCORE: 2**	How Staff Teams and Services Work Together **SCORE: 3**	Supporting People to Live Healthier Lives **SCORE: 2**	Monitoring and Improving Outcomes **SCORE: 2**	Consent to Care and Treatment **SCORE: 2**			**13/24** **54%**
CARING: Score Range 1 – 4 per area (maximum Score 20)								
Kindness, Compassion, and Dignity **SCORE: 3**	Treating People as Individuals **SCORE: 3**	Independence Choice and Control **SCORE: 3**	Responding to People's Immediate Needs **SCORE: 2**	Workforce Wellbeing and Enablement **SCORE: 3**				**14/20** **70%**
RESPONSIVE: Score Range 1 – 4 per area (maximum Score 28)								
Person Centred Care **SCORE: 3**	Care Provision Integration and Continuity **SCORE: 2**	Providing Information **SCORE: 2**	Listening to and Involving People **SCORE: 3**	Equity in Access **SCORE: 3**	Equity in Experience and Outcomes **SCORE: 3**	Planning for the future **SCORE: 2**		**18/28** **64%**
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: 2**	Partnership and Communities **SCORE: 3**	Learning Improvement and Innovation **SCORE: 2**	Environmental Sustainability/ Sustainable Development **N/A**	**19/28** **68%**

Overview

We carried out an announced on-site mock inspection at Orchard House Care Home.
The home was last inspected in every domain on the 2nd February 2026 with an overall rating of "Inadequate" and a rating of "Inadequate" in the following domain(s):

- Safe
- Effective

The further three domain(s) were rated as "Requires Improvement":

- Caring
- Responsive
- Well-led

In respect of the above, the CQC found breaches against the following regulations set forth by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 9: Person-centred care
- Regulation 10: Dignity and respect
- Regulation 11: Need for consent
- Regulation 12: Safe care and treatment
- Regulation 13: Safeguarding service users from abuse and improper treatment
- Regulation 17: Good governance
- Regulation 18: Staffing

The home is registered with the CQC to provide the following regulated activities under the Regulated Activity Regulations 2014:

- Accommodation for persons who require nursing or personal care
- Treatment of disease, disorder or injury

With the following specialisms:

- Caring for adults over 65 yrs
- Caring for adults under 65 yrs
- Dementia
- Physical disabilities

The home was registered to provide the above regulated services for a maximum of 60 people. At the time of the mock inspection, 43 people were residing at the home, of whom 41 were receiving care and treatment within the service. Two people were in hospital at the time of the inspection.

This mock inspection was undertaken to assess the progress made since the previous CQC inspection and to identify any remaining areas requiring improvement to support sustained regulatory compliance and improved outcomes for people using the service.

Safe

Learning culture: Score 2.

The service had taken steps to develop a more positive learning culture following the previous CQC inspection, and there was evidence that leaders were seeking to strengthen oversight and quality assurance processes. Upon reviewing the clinical governance framework, we saw that clinical meetings, daily management meetings and other governance forums were established and covered a range of relevant topics, including incidents, clinical risks and service performance.

There was evidence that incidents, accidents and safeguarding concerns were being recorded and reviewed by the management team. However, the inspection identified inconsistencies in how learning from incidents was translated into care planning, risk management and wider service improvement. For example, where incidents had occurred, associated risk assessments had not always been reviewed or updated to reflect the changed risks. These included examples relating to behavioural incidents and skin integrity concerns. The provider had updated the care plan as part of the Resident of the Month review, although insufficient risk mitigation remained. As a result, opportunities to demonstrate organisational learning and reduce the likelihood of recurrence had not always been fully realised.

Consistent with regulation 12 (2) (a) Regulated Activities Regulations, providers must have regard to and assess "the risks to the health and safety of service users of receiving the care or treatment". Furthermore, the CQC guidance pertaining to this section suggests that "risk assessments relating to the health, safety and welfare of people using services must be completed and reviewed regularly…[*and]*…risk assessments should include plans for managing risks" (Regulation 12: Safe care and treatment - Care Quality Commission). During our inspection, we found that the Clinical Lead alongside the nursing staff had an excellent understanding of their service users and the risks associated with their daily care; however, the documentation of that, on a sustained and ongoing basis, was lacking.

The provider had implemented a range of audit and governance systems intended to identify areas for improvement. Whilst these arrangements demonstrated a commitment to monitoring quality and safety, they had not consistently identified the documentation and risk management concerns found during the inspection. We found examples where risks known to the service were not adequately reflected within risk assessments and where care records did not always evidence ongoing review following changes in people's needs. This indicated that learning from events and emerging risks was not always embedded into day-to-day practice.

Furthermore, some incidents and significant events discussed within governance forums were not consistently evidenced as being formally cascaded to frontline staff, creating a risk that lessons learned might not have been fully embedded across the workforce. For example, when discussing the dissemination of lessons learned with the clinical team, the team informed us that information from incidents was raised in the daily "flash" meeting to Heads of Departments, who then cascaded this to frontline staff. When we made further enquiries about how staff learned from incidents or stayed up to date with monthly care plan reviews, the team indicated that they relied on staff to read the care plan, with no mechanism for staff to sign to say they had read them. Although there was not a statutory obligation to ensure care plans were signed, it was important that a provider could evidence that the

care plan was being followed, reviewed, evaluated and monitored for trends and themes. Assurances were given that frontline staff were beginning to attend clinical meetings.

Despite these concerns, staff demonstrated a good understanding of safeguarding responsibilities and were able to describe how they would recognise and report abuse. One staff member reported that "I knew exactly who to go to if something was wrong (e.g. CQC, Local Authority, etc)." Whilst there was evidence that the service was working to create a culture of learning and improvement, governance systems had not yet matured sufficiently to ensure that learning from incidents, risks and regulatory requirements was consistently translated into practice. Further work was required to strengthen organisational learning, improve the effectiveness of quality assurance processes and ensure that lessons learned were embedded across all areas of the service.

Safe systems, pathways, and transitions: Score 2

Evidence reviewed during the inspection demonstrated that pre-admission assessments historically were not always undertaken to a high enough standard, aligning staffing capability, organisational risk tolerance and clinical need. However, recent pre-assessment documentation review outlined that full assessments were undertaken prior to people moving into the service, with consideration given to individuals' care needs, risks and the suitability of the placement. Management and clinical staff were able to describe the processes used to assess referrals and determine whether the service could safely meet people's needs.

Daily huddles involving nurses and departmental leads provided a structured forum to review care delivery, including incidents, hospital admissions and feedback. These discussions supported shared learning and ensured clinical staff were informed of outcomes and any required practice changes. The staffing team gave reassurance that frontline staff had started to attend clinical meetings to gain a wider understanding of clinical risk management and how this translated into operational care delivery.

We found examples of effective multidisciplinary working and evidence that the service engaged with external healthcare professionals, including General Practitioners, community nursing teams and specialist services where required. Relatives spoken with during the inspection described improvements in the care provided to their family members and reported that staff were responsive when concerns were raised. One relative described significant improvement in their family member's wellbeing and independence since moving into the service, reflecting positively on the home's ability to support people's ongoing care needs.

The service was observed to use a "Transition Checklist" guiding staff on what documentation to complete on re-admission. This appeared to be well embedded. Staff described using the electronic care system (Nourish) to access and share up-to-date care information with external services during emergencies.

However, we found that incident recording processes remained largely paper-based and that opportunities to demonstrate how information was analysed, tracked and used to improve care pathways were limited. Although governance meetings considered clinical risks and incidents, evidence that learning was consistently embedded into care planning and operational practice was less robust.

Each person had a Personal Emergency Evacuation Plan (PEEP) in place. These were not stored in the emergency grab bag but held electronically; however, there is no legal requirement for PEEPs to be held in printed form. The requirement is that evacuation information is accurate, up to date and accessible to staff when needed, whether in digital or hard-copy format.

There was no evidence that the absence of printed PEEPs had impacted evacuation arrangements; however, the provider should ensure that whichever format is used, staff can access the information immediately during an emergency.

The contents of the emergency bag contained lights, hi-vis bibs, and the Business Continuity Plan and key contact information. There was evidence that these were maintained and routinely reviewed.

The service demonstrated a commitment to maintaining continuity of care, including during periods when people required admission to hospital. At the time of the inspection, two people were receiving treatment in hospital whilst remaining under the oversight of the service. However, the issues identified in relation to care planning, risk management and documentation reduced assurance that transitions between services and changing clinical needs were always supported by sufficiently robust systems.

The service had established processes to support admissions, ongoing care and multidisciplinary working. However, further work was required to ensure changes in people's needs were consistently identified, recorded and reflected throughout the care pathway.

Safeguarding: Score 2.

Safeguarding policies and procedures were available to staff, and safeguarding concerns were appropriately recognised and reported when required, as evidenced by the safeguarding log and a sample of the care notes. Records reviewed during the inspection demonstrated that safeguarding incidents were documented, investigated and monitored through the provider's safeguarding arrangements. Safeguarding formed part of the service's audit programme and was regularly discussed within management and clinical governance meetings.

While safeguarding policies and procedures were accessible via the electronic system and had been updated in line with legislation, not all staff were confident in locating or referencing them. In addition, safeguarding information was not consistently available in accessible formats for people using the service or their families, such as easy-read guidance or visual materials, which might have limited understanding of how to raise concerns independently.

Staff spoken with during the inspection demonstrated a good understanding of safeguarding responsibilities and were able to clearly explain the different types of abuse, potential indicators of harm and the actions they would take if concerns arose.

Feedback obtained from staff suggested that safeguarding culture within the home had improved significantly since the previous inspection. One member of staff reflected that there had previously been occasions when staffing pressures limited opportunities to provide the standard of care people deserved but reported that improvements in staffing levels and leadership oversight had resulted in more time being available to support people safely and effectively. Another staff member reported that there had previously been times where clients were subjected to abuse at the service due to poor culture but stated that this had since resolved. In this regard, a broad set of incident records indicated

that the required CQC notifications had been raised, and the required local authority safeguarding procedures had been followed. Staff consistently described feeling more supported and reported improved confidence in management's response to concerns.

Staff files reviewed contained the required pre-employment checks, including Disclosure and Barring Service (DBS) checks, identity verification, employment references and right-to-work documentation. Agency staff records also demonstrated appropriate checks had been undertaken and there was evidence that the service sought to maintain continuity using familiar agency personnel where possible. However, this was tempered by a serious governance concern identified during the inspection. Checks and oversight highlighted one set of interview notes that had been recorded as signed off; however, the named signatory denied having done so and stated that the registered manager had falsified her signature. This called into question the integrity of record-keeping, the reliability of internal oversight arrangements, and the provider's ability to demonstrate accurate and trustworthy governance processes, locally.

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-19-fit-proper-persons-employed

Relatives spoken with during the inspection expressed confidence in the safety of the service and described noticeable improvements in the quality of care being provided. One relative stated that their family member had experienced a significant improvement in wellbeing since admission and reported no concerns regarding abuse, neglect or poor treatment. Feedback from relatives consistently reflected a belief that people were treated kindly, respectfully and safely by staff.

Whilst safeguarding arrangements were generally effective, there remained opportunities to strengthen the service's approach to identifying and mitigating risks before concerns escalated. Some of the documentation issues identified elsewhere in this report, including inconsistencies in risk assessment reviews following incidents, demonstrate the need for continued focus on preventative safeguarding measures and proactive risk management. However, these issues did not detract from the overall finding that staff understood safeguarding responsibilities and that appropriate systems were in place to protect people from abuse and improper treatment.

Overall, safeguarding practice was embedded within the service and there was evidence of a positive culture in which concerns were recognised, reported and acted upon. Staff demonstrated good awareness of safeguarding responsibilities, relatives expressed confidence in the care provided, and governance arrangements supported oversight of safeguarding activity.

Involving people to manage risks: Score 2.

The service had some systems in place to involve people and those important to them in decisions about care and support, and there was evidence that leaders recognised the importance of seeking feedback from people, relatives and other stakeholders.

During the inspection, we saw examples of family feedback being gathered through surveys, care reviews and informal discussions, and some relatives spoke positively about the responsiveness of staff when concerns were raised. One relative told us the service had "taken things on board" and another said they were able to "go to sleep at night knowing he is safe and well cared for." These examples showed that the provider had made efforts to listen to feedback and maintain dialogue with families.

However, the inspection identified inconsistency in how people were supported to be meaningfully involved in identifying, understanding and managing risks associated with their care. Whilst some care records demonstrated good involvement for a small sample of people, as presented by the clinical lead, this was not reflected consistently across the records reviewed. There was limited evidence of people's engagement in the review of care and risk management over time, and care documentation did not always clearly show how people's views, wishes or lived experiences had informed changes to support arrangements.

The monthly care plan updates often stated, "remained relevant" or "no update", with insufficient evidence of people's experiences and feedback in relation to care and risk planning. The provider was required to have regard to Regulation 9 (1) (a) (b) (c), which states that "the care and treatment of service users must… (a) be appropriate, (b) meet their needs, and (c) reflect their preferences". In addition, the service did not consistently evidence that service users were enabled and supported to understand the care and treatment choices available to them, consistent with Regulation 9 (1) guidance.

For example, one communication plan lacked sufficient detail about alternative methods of communication for a person who was non-verbal, which reduced assurance that the service was consistently enabling the person to express their views and participate in decisions affecting their safety and wellbeing. When triangulated with care notes, there was limited evidence that the broader care and support plan was being followed.

The provider had not always ensured information was presented in a way people could easily understand in order to support informed involvement in risk-related decisions. During the inspection we found written information, including booklets and menus, was not always accessible, with some information presented in small or long-form text that was not suited to people's individual communication needs. The Accessible Information Standard was not being consistently met in practice, and this meant some people might not have been fully supported to understand information about their care, raise concerns, or contribute effectively to discussions about risks and how these should have been managed. This was particularly important where people might have been living with cognitive impairment, sensory needs or communication difficulties.

The inspection also found that when risks changed, records did not always demonstrate that people or their representatives had been appropriately involved in reviewing those risks and agreeing how they should be managed. We found examples where risk assessments had not been updated following accidents and incidents and a choking care plan identified risks but did not initially have corresponding risk notices and documentation in place. The provider did, however, correct this on the second day of our visit. There was also limited evidence of ongoing assessment of capacity where people's ability to make decisions may have fluctuated, despite initial assessments having been completed.

Although relatives gave largely positive feedback about the quality of care and told us staff were responsive when issues were raised, the overall evidence showed that the service's approach to involving people in managing risks was not yet embedded or consistently evidenced. Processes for seeking feedback were in place, and there were signs of improvement, but these had not translated into a consistently personalised and accessible approach to involving people in day-to-day risk assessment and review. Further work was required to ensure that all people, including those with

communication needs or fluctuating capacity, were fully involved in understanding risks, expressing preferences and shaping how their care was delivered.

Safe environments: Score 2.

The service environment was, in several respects, well maintained and presented in a way that promoted people's comfort and day-to-day safety. During the inspection, communal areas were observed to be clean, tidy and generally free from clutter, and fire exits were accessible, appropriately signed and allowed free egress. We also saw that the provider displayed relevant public information at the entrance, including liability insurance and the most recent Care Quality Commission rating. These findings indicated that some foundational environmental safety arrangements were in place and that leaders had given consideration to the overall presentation and basic safety of the premises.

However, the inspection identified several environmental safety concerns which reduced assurance that the premises were always managed in a consistently safe way. For example, in one cleaning cupboard there was no spill kit available, and there were no colour-coded mops in place despite signage indicating these should be used. This created a risk that cleaning processes may not always be carried out safely or in line with infection prevention and control expectations. In addition, call bells were not always found to be within people's reach.

Consistent with Regulation 12 (Safe care and treatment) and Regulation 15 (Premises and equipment) of the Regulated Activities Regulations 2014, providers must ensure premises and equipment are safe, secure, suitable for the purpose for which they are being used, and properly used. Whilst the home was visibly clean and some core environmental checks appeared to be in place, the issues identified during the inspection demonstrated that environmental safety systems were not always operating effectively in practice. For instance, over the two-day visit, we observed that in one communal lounge the carpet was missing part of the rubber edging, creating a clear trip hazard for people using the space. No warning signage, hazard tape or other visual control measures were in place to alert people, visitors or staff to the risk. This matter was raised with the provider during the inspection; however, no immediate action had been taken by the end of the visit, despite the area remaining in active communal use. The provider informed us that a request had been submitted to corporate procurement due to the cost of replacing the flooring. Whilst this demonstrated that the issue had been recognised, interim risk management arrangements were not sufficient to reduce the immediate risk of harm pending permanent repair.

The lack of some essential equipment, together with inconsistent oversight of call bell accessibility, health and safety risk and emergency documentation, meant the provider could not fully demonstrate that all aspects of the environment were being managed proactively to mitigate foreseeable risks.

The provider had a range of health and safety, maintenance and governance processes intended to monitor the safety of the premises. However, the inspection findings indicated that these systems had not consistently identified or addressed all the issues found on site. While the overall environment was orderly and there were positive aspects to the presentation of the home, further work was required to strengthen routine checks, improve assurance around emergency preparedness, and ensure all environmental risks were identified and acted upon promptly.

Safe and effective staffing: Score 2.

The clinical lead shared with us concerns about four residents whose needs she felt exceeded the skill set of the staff team. This was discussed with the peripatetic manager and the step-in Regional Director. It was recognised that not all staff were trained or competent to deliver delegated healthcare tasks, clinical monitoring, complex behavioural support or condition-specific interventions. Staff expressed that they had previously felt unsure or unsupported, and that this had begun to reduce with the arrival of the Peripatetic Manager, who had begun to address these placements in a more structured way. Without action, these issues would have risked breaching Regulation 9: Person-centred care; Regulation 12: Safe Care and Treatment; and Regulation 17: Governance.

Delphi assessors heard staff describe enhanced oversight through daily huddles, restriction of high-risk tasks, updated care plans and clearer escalation routes. Once embedded, this practice was expected to result in better outcomes, in line with the improvement pathway the service was working through. The Regional Director explained clearly the development of a full staff competency matrix, targeted clinical training and skill-based digital rota planning. This was intended to ensure staff followed care plans and only completed tasks they were trained and signed off to do.

This report was not about blame. Barchester demonstrated proactive leadership by identifying an approach that recognised risks early and understood how to put the right support in place. This, alongside current management approaches, was intended to support residents to be safe and staff to be confident, with care being person-centred and Orchard becoming inspection ready.

Infection prevention and control: Score 2.

Infection prevention and control (IPC) systems were in place and generally aligned with national guidance.

Although Barchester had robust systems and policies at organisational level, the inspection identified local environmental risks at Orchard that required action to ensure full compliance with Safe and Effective domains.

A walk-through of the environment and discussions with maintenance and management highlighted IPC-related concerns:

- Missing carpet strips in communal areas created surfaces that could not be effectively cleaned, increasing the risk of dirt accumulation and trip hazards.
- Dated and worn furniture in ten bedrooms was identified by the maintenance person as no longer fit for purpose. The condition of these items increased the risk of harbouring bacteria.
- Previous inconsistent local oversight evidenced environmental risks that had been identified by the maintenance operative but not escalated or addressed promptly through the governance route.

This indicated a previous gap between corporate IPC systems and local implementation, particularly in relation to environmental hygiene and maintenance responsiveness. The inspection found that the interim management team had begun to address these issues positively.

Medicines optimisation: Score 3

At the time of the inspection, medication administration and associated record keeping were found to be compliant. Medicines Administration Records (MAR) reviewed were completed appropriately, with no unexplained gaps, and storage, stock control and day-to-day administration processes gave assurance that medicines were being managed safely. Staff responsible for administering medicines demonstrated an appropriate understanding of their responsibilities, and records seen supported the view that medicines were administered as prescribed and documented accurately. This indicated that, at the point of inspection, medicines systems were operating in a sufficiently organised and reliable way.

Effective

Assessing need: Score 2.

The service had systems in place to assess people's needs before and after admission, and there was evidence of some thorough practice in parts of the assessment process. We saw examples of pre-admission assessments being completed, including one person being offered a respite stay prior to permanent admission in order to assess whether the service could appropriately meet their needs. Records reviewed also contained important background information such as full health details, contact information for relatives and professionals, and evidence of signed admission documentation. This demonstrated that the provider understood the importance of gathering relevant information at the point of admission and, in some cases, took a considered approach to determining whether placement at the home was suitable.

However, the inspection identified inconsistencies in how needs were reassessed and translated into clear, up-to-date care planning when people's circumstances changed. Although some initial assessments were completed well, records did not always show that ongoing reassessment had taken place in a timely or robust way.

In one example reviewed, a person had a planned operation for amputation of a toe, and the care plan gave a reasonable overview of the person's wider clinical complexity. However, the provider's ongoing assessment and response to deterioration were not sufficiently robust. Three days before the person's hospital admission, a routine "Resident of the Month" physical assessment recorded no wounds or skin concerns. Two days before admission, concerns regarding poor circulation were evident and a staff member told us, in regard to the client, "we all knew she was losing feeling in her legs"; however, although clinical observations were offered and declined, there was insufficient evidence of a fuller reassessment, repeat examination later in the day, or timely escalation in response to these soft signs of deterioration. Necrosis of the toe was only identified subsequently at a routine chiropody appointment, following which photographs were sent to the GP and urgent hospital admission was requested. This raised concern that, had that external appointment not taken place, the provider might not have identified the seriousness of the deterioration in a timely way.

The provider recorded that the person "had the capacity to refuse" when declining their observations; however, we found no contemporaneous documentation of a decision- and time-specific capacity assessment in relation to the refusal of assessment or treatment, despite the apparent concerns about physical deterioration and altered sensation. Whilst the Mental Capacity Act 2005 requires staff to

begin with a presumption of capacity and not to treat a person as lacking capacity merely because they make an unwise decision, both the MCA Code of Practice (Mental-capacity-act-code-of-practice.pdf) and NICE guideline NG108 (Overview | Decision-making and mental capacity | Guidance | NICE) make clear that where there is reason to doubt a person's ability to make a particular decision, practitioners must undertake and record a decision-specific assessment, take all practicable steps to support the person to decide, and document the process proportionately. There was little recorded evidence to show how the nurse, in this case, had concluded that the person could understand, retain, use or weigh the relevant information about the risks of declining assessment, or that the risks and benefits had been revisited later when concerns persisted.

CQC's guidance under Regulation 12 states that risk assessments must be completed and reviewed regularly, include plans for managing risk, and contain arrangements to respond appropriately and in good time to people's changing needs. National deterioration guidance for care homes (RESTORE2™ official: NHS Hampshire and Isle of Wight) also emphasises that early changes in condition, including "soft signs" of deterioration, should prompt timely review, escalation and use of deterioration tools such as NEWS2/RESTORE2 where appropriate. In this case, the provider's assessment, documentation and escalation did not provide sufficient assurance that deterioration had been recognised and managed at the earliest opportunity.

Furthermore, one care plan stated that capacity would be continually assessed, but there was no evidence this had occurred in practice. We did, however, find good initial capacity assessments had been completed, but not been supported by sufficient ongoing review where decision-making ability may have fluctuated. This reduced assurance that the provider was consistently reviewing people's changing needs and adapting care accordingly.

Although the provider had established processes for assessment and there were examples of thoughtful admission practice, the overall evidence showed that reassessment and review were not consistently robust, particularly where people's needs changed over time or where clinical deterioration required prompt recognition and response. Further work was required to ensure assessments were dynamic, regularly reviewed, clearly linked to risk management, and consistently reflective of people's current needs and wishes.

Delivering evidence-based care and treatment: Score 2.

The service had some appropriate clinical systems in place, including care planning processes, physical health monitoring and governance oversight. Staff spoken with, including nursing staff and the clinical lead, showed a good understanding of people's needs and could describe the support required to manage complex conditions. This gave some assurance that people's needs were known by staff delivering care.

However, records did not consistently demonstrate that recognised guidance and clinical judgement were being translated into robust assessment, review and escalation. We found examples where care plans identified risk without the supporting risk assessment being in place. Other records showed that needs within care plans relied on a "multifactorial risk assessment" to mitigate risk and control care need. However, this area of the risk planning system had little functionality to record mitigation, calculate risk, evaluate mitigation effectiveness, and incorporate the views and wishes of the clients being assessed. In response, local managers reported that they had been instructed to remove risk

mitigations embedded within the care planning documentation. Furthermore, associated documentation had not always been updated to reflect the changed presentation. CQC guidance under Regulation 12 asserts that risk assessments must be reviewed regularly, include plans for managing risk, and respond appropriately to changing needs.

Conversely, we also reviewed evidence of some appropriate, evidence-based care and treatment being delivered. For example, following a series of falls in which one person sustained injuries, the service had made an appropriate referral to the local safeguarding adults' team for review. The relevant CQC notification had also been submitted in line with statutory notification requirements. In this case, associated risk assessments were reviewed and updated regularly, and care plans had been updated monthly, consistent with several other records sampled during the inspection, although there remained limited evidence of direct input from people using the service. We spoke with the person concerned, who was able to describe their recent incidents in a way that aligned with the records reviewed, and they told us staff were "wonderful". This provided some assurance that, in this instance, staff had taken a proactive and responsive approach to managing risk and supporting the person following repeated incidents.

Staff used recognised assessment tools to monitor key areas of care, including nutrition, hydration, mobility, and skin integrity. For example, MUST (Malnutrition Universal Screening Tool) assessments were completed and generally up to date, supporting safe nutritional management. Where required, referrals to external professionals such as Speech and Language Therapy (SALT) and physiotherapy were appropriately made and reflected in care planning.

Staff demonstrated a good understanding of their roles and responsibilities and were able to describe how they applied best practice guidance in day-to-day care delivery. This included awareness of relevant legislative frameworks and a generally consistent approach to safe and effective care.

People's nutritional and hydration needs were regularly assessed and monitored, with evidence of ongoing review and adjustment where required. Care records showed that assessments were generally accurate and reflected current needs, with appropriate professional input where required.

There was evidence of staff engagement with learning and development to support evidence-based practice. Care delivery was observed to be consistent with policies and recognised standards, contributing to safe and effective outcomes for people.

How staff teams and services work together: Score 3

The service demonstrated a generally coordinated approach to joint working, both within the home and with external professionals. We saw evidence that people's needs were considered before admission, including an example where the deputy manager had undertaken an assessment in hospital, and records contained contact details for relatives, professionals and wider support networks. This indicated that the service was working with others involved in people's care to help determine suitability and support continuity.

Internal team working was also supported through regular management and departmental communication. During the inspection, we reviewed the content of the daily "flash" meeting, which covered a broad range of operational and clinical matters, including staffing, new starters, residents of concern, planned assessments, maintenance, housekeeping, activities, catering, service user

feedback, fluid monitoring, tissue viability and accidents and incidents. This gave assurance that leaders had created forums where different parts of the service could come together, share information and maintain oversight of emerging issues across the home.

There was also evidence of partnership working with external services when risks escalated or specialist input was required. For example, during an outbreak the service had notified UKHSA and environmental health, and in another case a person was urgently admitted to hospital following review by an external professional and GP escalation. We also reviewed an example where repeated falls and injuries resulted in an appropriate safeguarding referral and the relevant CQC notification being submitted. These examples showed the provider was able to work with partner agencies when people required additional oversight or intervention.

Feedback from relatives further supported this picture of coordinated care. Family members described staff as responsive and told us concerns they had raised had been acted on. One relative said the service had "taken things on board," while another told us they could "go to sleep at night knowing he is safe and well cared for." This suggested that communication between the service and those close to people was generally open and helped contribute to joined-up care.

However, the quality of multidisciplinary working was not fully consistent in all areas. Although governance and flash meetings covered relevant topics, it was not always clear how learning and decisions were formally cascaded to frontline staff beyond heads of department. We also observed one meeting where the clinical lead briefly raised a concern about a person's suitability, but this was not explored in detail before the meeting moved on. In a further discussion, a comment made about a staff member not knowing how to complete a funding form, with local leaders referring to it as "just a form" risked minimising the importance of external processes and collaborative planning.

Systems for internal communication were established, external referrals were made where needed, and relatives were generally positive about the service's responsiveness. While there was room to improve how decisions were explored, recorded and cascaded, the evidence showed a reasonable level of teamwork and coordination.

Supporting people to live healthier lives: Score 2.

The service showed an understanding of the importance of supporting people to maintain their health and wellbeing, and there were examples where people's quality of life had improved following admission. Records contained relevant health information, including details of people's medical conditions, professional contacts and wider support networks. Relatives also described positive outcomes for some people living at the service. One family member told us their relative had previously spent long periods in bed but was now "up and about playing bingo," which suggested staff had supported improved engagement and day-to-day wellbeing. Another relative described the person as a "different person from when she came," indicating some people had benefited from the care and support provided.

There was also evidence that the service monitored aspects of people's physical health and discussed emerging concerns through internal clinical processes. During the inspection, we saw reference to routine observations, blood glucose monitoring, fluid monitoring and tissue viability being considered as part of care delivery and discussed at management level. The daily flash meeting included discussion

of 12 fluid warnings on one unit, which had prompted review, indicating that some oversight systems were in place to identify risks to people's health.

A varied activity programme was in place, including colouring, arts and crafts, painting, sing-along sessions, and movement-based activities. Activities were delivered in accessible communal areas, supporting participation for people with reduced mobility. Where people were unable to access communal spaces, one-to-one activities were also provided in their rooms, supporting inclusion and reducing the risk of isolation.

Opportunities to access the wider community were also promoted, supporting social engagement and overall wellbeing. Private spaces were available for people and their families to spend time together, supporting emotional wellbeing and maintaining relationships.

However, this was not consistently translated into proactive clinical practice. For example, concerns were identified regarding one person's unstable blood glucose levels, which staff linked to dietary non-concordance. During discussion, staff explained that the person was supported to obtain takeaway food, including staff collecting items from reception and taking them to the person's room due to their mobility needs. Whilst this approach promoted choice and independence, it also raised concern that support to maintain healthier living was not always being balanced effectively with the management of long-term health conditions, including diabetes.

This approach was not fully aligned with recognised good practice for the management of long-term health conditions. NICE guidance on diabetes management (Overview | Type 2 diabetes in adults: management | Guidance | NICE) emphasises the importance of supporting people to make informed choices about diet and lifestyle whilst ensuring that risks associated with poor glycaemic control are appropriately assessed, monitored and managed. In this case, the provider was aware that dietary choices were contributing to unstable blood glucose levels, with good evidence of multidisciplinary review.

Although there were positive examples of people experiencing improved wellbeing and staff showed a good working knowledge of individual needs, the overall evidence indicated that support for healthier lives was not yet consistently proactive or well evidenced. The service had some systems for monitoring health and involving external professionals, but these were not always effective in identifying deterioration early, managing long-term health conditions, or demonstrating how people were being supported to achieve the best possible health outcomes.

Monitoring and improving outcomes: Score 2

The service had systems in place intended to monitor people's outcomes, including regular care plan reviews, governance meetings and daily management oversight. Records showed that care plans were reviewed routinely, and the provider had established forums where incidents, clinical concerns and service pressures were discussed. During the flash meeting we reviewed, staff considered issues such as fluid warnings, tissue viability, accidents and incidents, which demonstrated that some monitoring processes were in place at management level.

However, these systems were not sufficiently robust or effective in consistently identifying, analysing and responding to areas of concern. Incident forms remained paper based, and Delphi assessors observed that this created difficulty in ordering, tracking and reviewing information. This reduced

assurance that the provider could undertake effective thematic analysis, identify patterns and trends over time, or reliably use incident data to drive improvement across the service.

We also found a gap between the assurance provided through audits and governance systems and the reality of operational practice. Although meetings and audit arrangements covered relevant topics, they had not consistently identified the concerns found during the inspection. For example, known risks and changes in presentation were not always clearly reflected in associated care records or risk assessments, including after falls, behavioural incidents and skin integrity concerns. In one example, a mobility care plan had been updated to state that no falls had occurred despite the person having experienced several falls in practice. This meant the provider could not fully demonstrate that outcome monitoring arrangements were translating into accurate records, effective review or timely action.

The service was monitoring a range of health indicators, such as nutrition, blood glucose levels, NEWS2 observations, fluid intake and tissue viability. However, the quality of oversight was inconsistent. In some cases, concerns were noted but there was limited evaluation of whether interventions were effective or whether care had changed as a result. For example, wellbeing referred to hourly wellbeing checks, but records did not clearly show how these had been reviewed for impact or whether they remained the most appropriate response. This reduced assurance that monitoring was being used proactively to improve individual outcomes rather than simply record tasks completed.

Feedback from relatives suggested that some people had experienced positive changes since moving into the home, and one person told us staff were “wonderful.” While this indicated that people could experience good support on an individual level, it did not outweigh the wider concerns about the provider’s ability to consistently monitor outcomes, analyse emerging themes and convert oversight into reliable operational improvement. Overall, further work was required to strengthen the provider’s approach to reviewing outcomes, improve the quality and usability of incident data, and close the gap between governance assurance and day-to-day practice.

Consent to care and treatment: Score 2.

The provider had systems in place to obtain and record consent, and there was evidence that staff understood the importance of involving people in decisions about their care. Most records contained initial mental capacity assessments, with good content and clear delineation of the decision being made. Staff spoken with were able to describe the principles of the Mental Capacity Act 2005 (MCA) and the need to seek consent before providing care. We also saw examples where people’s choices were respected in day-to-day practice and where relatives were involved appropriately in discussions about care and support. This indicated that the service recognised consent as an important part of care delivery. The Clinical Lead provided good assurance that “mental capacity” was a key theme and responsibility of the service, and stated that the provider was undertaking capacity workshops with nurses relating to practice development in this area.

However, the inspection found that the provider’s application of the MCA and consent processes was not always consistent in practice. While initial capacity assessments were completed to a high standard, often completed by the Clinical Lead, there was limited evidence of ongoing review where people’s decision-making ability may have fluctuated. For example, one care plan stated that capacity would be continually assessed, but this was not evidenced in the records reviewed. Delphi assessors also found examples where capacity had been assumed without a clearly documented, decision-

specific assessment, despite the context indicating that a more robust consideration may have been required. This reduced assurance that consent decisions were always being made and recorded in line with the principles of the MCA.

One example raised particular concern. A person with known clinical complexity declined observations when staff had concerns about their physical deterioration, and the nurse recorded that the person "had the capacity to refuse." However, there was no contemporaneous evidence of a decision- and time-specific capacity assessment in relation to refusing assessment or treatment. The Mental Capacity Act Code of Practice (Mental-capacity-act-code-of-practice.pdf) and NICE guideline NG108 (Overview | Decision-making and mental capacity | Guidance | NICE) make clear that capacity must be considered in relation to the specific decision at the time it needs to be made, and that practitioners should take all practicable steps to support the person to make the decision before concluding that they have, or lack, capacity. In this case, records did not show how the person had been supported to understand the risks of refusing observations, how staff had satisfied themselves that the person could understand, retain, use and weigh the relevant information, or whether the discussion was revisited later as concerns continued.

We also identified gaps in the oversight of deprivation of liberty safeguards. In one case, a DoLS authorisation had expired in September 2025, and although a further application had been submitted, there was no evidence this had been actively chased. While records stated the person remained subject to DoLS in practice and care plans had been reviewed monthly, this did not provide full assurance that legal safeguards were being robustly monitored and progressed. This oversight was observed on the first page in the second DoLS tracking folder, limiting assurance of effective oversight mechanisms. CQC guidance under Regulation 9 states providers must take account of people's capacity and ability to consent and work within the requirements of the MCA 2005 when planning, managing and reviewing care and treatment. Further work was needed to strengthen documentation, improve the application of MCA principles in complex situations, and ensure legal frameworks such as DoLS were monitored effectively.

Caring

Kindness, compassion and dignity: Score 3

The service demonstrated a caring approach in the way people were supported, and feedback from relatives indicated that people were treated with kindness and consideration. Family members described staff as attentive and responsive, with one relative telling us their family member had become a "different person from when she came," and another explaining that staff had "taken things on board" when concerns were raised and had supported the person to become more active and engaged. These comments suggested people were receiving care from staff who knew them well and responded to them in a compassionate way.

Relatives were also positive about the overall standard of care and the reassurance this gave them. One relative told us they could "go to sleep at night knowing he is safe and well cared for," while another said the home was "immaculate" and that staff took "great care" of their family member's needs. This feedback supported a picture of a service where people were generally cared for with warmth, respect and attention to their comfort and wellbeing.

Staff feedback was also consistent with a more positive and respectful culture developing within the home. One staff member told us people were “feeling more positive about things” and described there being more consistency in the service. The same staff member also said they now felt there was more time to care for people properly, adding that previously they had not always had the opportunity to do so. This suggested staffing culture and support had improved in a way that helped staff provide more person-centred and compassionate care.

The evidence reviewed did not indicate widespread concerns about how people were treated, and we did not receive feedback suggesting people were routinely deprived of privacy, dignity or respect. However, there remained some areas where the provider could strengthen people’s overall experience, particularly in relation to accessible information and the consistency with which people’s views were reflected in records and review processes. While these issues were more closely linked to involvement and communication, they had the potential to affect how fully people were empowered in decisions about their care.

Treating people as individuals: Score 3

Staff were observed engaging warmly and respectfully with people, demonstrating a good understanding of them as individuals. Interactions were person-centred and responsive, with staff adapting their approach to reflect people’s routines, preferences, and communication needs. People appeared comfortable and relaxed in staff presence, and relationships were positive and familiar.

The service demonstrated a generally personalised approach to care, and there was evidence that staff knew people well and understood important aspects of their individual needs, preferences and routines. Care records included personal information about people’s health conditions, support needs, family networks and, in some cases, end of life wishes and wider life history. Pre-admission assessments also showed that consideration had been given to whether the service was suitable for the person, including an example where a respite stay was used to help determine whether the home could meet the individual’s needs safely and appropriately. This indicated that the provider took steps to understand people as individuals from the point of admission.

Feedback from relatives also supported the view that care was often tailored around the person. One relative told us their family member was a “different person from when she came,” while another said staff had taken concerns on board and supported their relative to become more active. Such comments suggested staff adapted support in response to people’s presentation and wellbeing, rather than delivering care in a wholly task-led way. Relatives also described staff as responsive when concerns were raised, which gave assurance that the service was listening to feedback and adjusting when needed.

There was also limited evidence in some records of direct input from people themselves during review processes. Although the Clinical Lead had provided good evidence that, for a small number of clients, a more person-centred review had taken place, these issues meant the provider could strengthen how consistently people’s voices were captured and reflected in care planning. However, they did not outweigh the broader evidence that staff generally knew people well and sought to respond to them as individuals.

The evidence showed that people were usually treated as individuals and that staff understood key aspects of their preferences, histories and support needs. Although documentation and

communication arrangements could be improved in places, the service demonstrated a sufficiently personalised approach to care.

Independence Choice and Control: Score 3

People were generally supported to maintain choice and control over important aspects of their daily lives. The service had processes in place to consider whether placements were suitable before admission, including the use of a respite stay in one case to help determine whether the home could meet the person's needs appropriately. This approach supported a more individualised transition into the service and showed some regard for the person's circumstances and longer-term preferences.

There was also evidence that people were offered opportunities to make choices about how they spent their time and how they maintained relationships with others. During the inspection, we saw that activities were planned across different parts of the home, including group events and visits from external organisations such as Age UK. Relatives told us they were able to visit freely, and one described attending a recent event at the home, which suggested the service was enabling people to sustain family involvement and participate in social opportunities.

Feedback from relatives indicated that the service was usually responsive when preferences or concerns were raised. One relative told us they had raised an issue and were "very satisfied" with how staff responded, while another said staff had acted on concerns and made changes. This gave assurance that people close to those using the service were able to influence care and that the provider was prepared to adjust support when needed.

The provider also had forums through which people's views could be heard, including surveys, feedback opportunities and service user discussion within meetings. Daily oversight arrangements included consideration of service user feedback alongside wider operational and clinical matters, showing that people's experiences formed part of the running of the home.

There were, however, some limits to how consistently choice and control were evidenced in records. Documentation did not always show clear input from people during care reviews, and some information available to people was not presented in the most accessible format. While this did not outweigh the wider evidence of responsive support, it meant the provider could strengthen how consistently it demonstrated that all people were enabled to exercise maximum control over decisions affecting their care and daily life.

Responding to people's immediate needs: Score 2.

Daily oversight arrangements were in place through the 11am "flash" meeting, where staff and managers reviewed issues such as residents of concern, staffing, new assessments, maintenance matters, service user feedback, fluid warnings, tissue viability, and accidents and incidents. This gave assurance that emerging needs were being identified and discussed routinely across the home, allowing staff to prioritise support and respond to issues as they arose.

However, the inspection identified inconsistency in how promptly and effectively people's immediate needs were recognised and acted upon in practice. In one example, a person was later admitted to hospital with necrosis affecting a toe, but records from the preceding days did not clearly demonstrate what communication had taken place from the provider, what the clinical response had been, or whether timely reassessment, repeat examination or escalation had occurred when concerns about

circulation and reduced sensation had already been noted. The seriousness of the deterioration was identified during a routine external appointment, which reduced assurance that the provider would always recognise urgent clinical need at the earliest opportunity.

In one example reviewed, a mobility care plan had been updated to state that no falls had occurred, despite the person having experienced several falls in practice, all of which had appropriately been managed through safeguarding procedures. This discrepancy reduced assurance that the care record audit accurately reflected the person's current presentation and support needs. We were informed that this entry had been made by an agency nurse; however, although the service advised that reliance on agency staff was limited, the provider remained responsible for ensuring the accuracy and quality of all care documentation.

We also found environmental and practical issues which could affect people's ability to obtain timely support. During the inspection, call bells were not always within people's reach, and some clients were slumped in their chairs, with staff walking past. On one occasion we spoke to a client in her room who looked visibly distressed. The client suggested that they felt dizzy and unwell and had not alerted staff because "they are often so busy, they don't always come, I understand why though", which meant some people may not always have been able to summon help promptly when needed. In addition, concerns raised during the inspection about a trip hazard in a communal area had not been addressed by the end of the visit, despite the risk remaining present in an area used by people living at the home.

Although there were examples of staff responding appropriately in some cases, including making safeguarding referrals and involving external professionals when risks escalated, this was not consistent enough across the service to give full assurance that people's immediate needs were always met without delay. Relatives were generally positive about staff responsiveness, but the records and observations reviewed showed that prompt action was not always well evidenced where people's presentation changed or where immediate risks were identified.

Workforce wellbeing and enablement: Score 3

Staff feedback indicated that the workforce felt increasingly reassured by the governance arrangements introduced following the recent change in local management. Staff described a more settled and consistent service, with improved day-to-day oversight and stronger scrutiny of care and support. They told us this had created greater confidence in how concerns were identified, discussed and acted upon, and that there were now more time and capacity to focus on people's care in a responsive and person-centred way. Staff also demonstrated awareness of escalation routes and safeguarding responsibilities, with one member of staff telling us they knew exactly who to approach if something was wrong. Overall, feedback suggested that recent leadership changes had begun to create a more supportive and accountable environment for staff, with a clearer emphasis on quality, oversight and safe care delivery.

Responsive

Person-centred care: Score 3.

The service demonstrated a generally personalised approach to planning and delivering care. Pre-admission processes showed that consideration was given to whether the service could meet people's

needs safely and appropriately, including one example where a respite stay was used before permanent admission to test suitability due to previous concerns about complexity and fit within the home. Records we reviewed also contained detailed information about people's health conditions, important relationships and wider support networks, which helped provide a fuller picture of the individual rather than focusing solely on tasks or diagnoses.

There was also evidence that care was adjusted around the person's circumstances and reviewed over time. Admission paperwork was completed and signed, end of life considerations were recorded where relevant, and monthly review processes were in place across several care records sampled. In one example, although a person had experienced repeated falls, the service had followed safeguarding procedures appropriately and continued to review associated documentation, showing some responsiveness to changes in presentation. This indicated that care was not entirely static and that the provider was taking steps to reflect people's changing needs within care planning arrangements.

Feedback from relatives supported the view that care was often experienced as individual and responsive. One relative described their family member as a "different person from when she came," while another said the service had taken concerns on board and responded positively. Family members also spoke warmly about the standard of care and the attentiveness of staff, suggesting people were supported by a workforce that knew them and adapted support when concerns were raised. We also spoke with one person using the service who described staff as "wonderful," and their account was consistent with records reviewed about their recent care.

The service also showed some recognition of the importance of coordinating care around people's broader wellbeing and preferences. Daily flash meetings included discussion of assessments, residents of concern, activities, service user feedback and clinical issues, which meant information about people's needs was being shared across departments rather than held in isolation.

Care provision, integration, and continuity: Score 2.

The service had arrangements in place to support continuity of care, including pre-admission assessment, routine review processes and regular liaison with external professionals where required. Records contained details of relatives, GPs and other agencies involved in people's care, and there were examples of referrals to safeguarding, communication with hospital teams and requests for GP input when concerns escalated. This demonstrated that the provider recognised the importance of working collaboratively with others to support people through changes in health and circumstances.

Care records also reflected clear commissioning and funding arrangements, including the involvement of the Local Authority and Integrated Care Board where applicable. Funding streams such as Funded Nursing Care and Continuing Healthcare were appropriately documented, and care delivery appeared to be aligned with these arrangements.

The provider also had internal systems intended to promote joined-up working. Daily "flash" meetings brought together operational and clinical information, including residents of concern, planned assessments, fluid warnings, tissue viability, accidents and incidents, staffing, activities and service user feedback. This provided a structured forum through which different departments could share updates, maintain oversight of emerging issues and support coordinated care across the home.

However, these arrangements were not consistently effective in ensuring safe and coordinated continuity of care. Information was held across both paper and electronic systems, and incident forms remained paper based, which limited the provider's ability to track, review and act on information in a timely and reliable way. We found examples where care plans and risk assessments had not been updated promptly following incidents or changes in people's needs, reducing assurance that staff were always working from accurate and current information. In addition, four people's placements were identified as a concern because the complexity of their assessed needs was not matched by the staff skill mix and level of clinical competence required to meet those needs safely. The provider advised that this had arisen, in part, from pressure to accept people who were medically optimised for discharge from hospital, but whose needs had not been sufficiently triaged against the service's capacity and competence to provide safe and appropriate care.

There were also occasions where coordination between assessment, review and follow-up action was not sufficiently robust. Although the service engaged external professionals where required, systems did not consistently ensure that identified concerns were translated into timely review, updated care planning and effective onward action. This reduced assurance that discharge decisions and subsequent placements were always subject to appropriate professional challenge, safe triage and clear consideration of whether the service could continue to meet people's needs safely and appropriately.

The quality of communication supporting continuity was similarly inconsistent. While some oversight systems were in place, it was not always evident how updated information, care changes or lessons learned were reliably cascaded to frontline staff. We also identified gaps in accessible communication, including one care record that did not provide sufficient detail about alternative methods of communication for a person who was non-verbal. This reduced assurance that staff would always have access to the information needed to provide consistent, person-centred and safe care across shifts.

There was evidence that the service did engage external agencies when concerns arose. For example, during a norovirus outbreak the provider had notified UKHSA and environmental health. Importantly, the service did not notify the CQC of this outbreak (Notifications - Care Quality Commission).

Where people's needs changed or concerns escalated there was evidence of contact with GPs, hospital teams and safeguarding services. Internal communication structures were also in place, with the daily flash meeting covering planned assessments, residents of concern, service user feedback and clinical issues such as fluid warnings and tissue viability.

Further work was required to strengthen record integration, ensure changes in need were reflected promptly in care documentation, and improve the reliability with which information was shared and acted upon across the service.

Providing information: Score 2.

The service had information available for people living at the home, including resident folders and standard written materials about the service. However, these were largely standard corporate documents presented in long-form text and were not consistently adapted to meet people's individual communication needs. We did not see sufficient evidence of accessible or easy-read information about key aspects of people's care and rights, such as menus, complaints processes, safeguarding, what safeguarding might mean to the individual, copies or summaries of their care plan, or clear information about identified risks and how these were being managed.

While there may not be an absolute requirement for every person to hold a paper copy of their care plan, risk assessment or safeguarding policy, CQC guidance under Regulation 9 (Regulation 9: Person-centred care - Care Quality Commission) is clear that people must be involved in the planning and review of their care and provided with the information they reasonably need in a way they can understand. NHS England guidance (NHS England » Personalised care and support planning) on personalised care and support planning further states that care plans should record decisions and agreed outcomes in a way that makes sense to the person, and the Accessible Information Standard requires providers to ensure people can access and understand information about their care and treatment. In this service, information was not always presented in a sufficiently personalised or accessible way to support understanding, choice and meaningful involvement.

This reduced assurance that people were being given information in a way that supported understanding, involvement and choice. For example, there was limited evidence of accessible or easy-read information about key topics such as complaints, safeguarding, what safeguarding means to the individual, copies of care plans, or risks associated with their care and support. While information existed, it was not always presented in a way that enabled people to engage meaningfully with it or use it to make informed decisions about their daily lives and care.

Although the service had some systems for sharing information internally and with relatives, the information made available directly to people using the service was not sufficiently personalised or accessible. Further work was required to ensure people had access to clear, easy-read and individualised information about their care, their rights, how to raise concerns, and how risks were managed.

Listening to and involving people: Score 3

People, relatives and staff described a service where feedback was encouraged and valued. Most individuals spoken with understood how to share their views and who to approach, including the registered manager, who was described as visible and accessible. Relatives highlighted regular opportunities to contribute.

The service had several ways of seeking people's views and involving them, and there was evidence that feedback from people and relatives was listened to and, at times, acted upon. During the inspection, we saw that satisfaction surveys were used, relatives described being asked for feedback, and service user feedback was included as a standing item within daily oversight arrangements. The provider also had meetings and review processes in place through which people's experiences could be discussed.

Feedback from relatives suggested that the service was usually open to hearing concerns and responding to them. One relative told us they had raised an issue and were "very satisfied" with the response, while another said staff had "taken things on board." A further relative described having completed an online survey, which demonstrated that the provider was using more than one route to gather people's views about the quality of care.

There was also evidence that people and those close to them were involved in discussions about care to some extent. Records included family and professional contacts, and relatives told us they had been involved in pre-admission assessment or had opportunities to discuss care once the person had moved into the home. Daily communication within the service also included discussion of residents of

concern, assessments and service user feedback, which supported a more responsive approach to people's changing experiences.

However, the provider was not fully consistent in evidencing how people's direct views shaped all aspects of care planning and review. In some care records, there was limited evidence of the person's own input during review, and accessible information was not always well developed, which may have reduced some people's ability to engage fully in decisions about their care. These issues meant the provider could have strengthened how it recorded involvement and ensured everyone could participate as fully as possible.

Overall, people, relatives and staff had routes through which views could be shared, and there was positive evidence that concerns were heard and responses made. Although recording of direct involvement could be improved in some areas, the wider evidence showed that the service usually listened to people and involved them in a meaningful way.

Equity in Access: Score 3.

The service generally supported equitable access to care and support by completing pre-admission assessments, considering whether it could safely meet people's needs, and involving relevant professionals and relatives where appropriate. In one example, a person was offered a respite stay before a longer-term placement decision was made, which demonstrated a more considered approach to assessing suitability and avoiding inappropriate admission. Records also contained details of people's professional contacts, family networks and support arrangements, which helped promote access to the right support at the right time.

There was evidence that people could access a range of support within the home, including nursing input, activities, mealtime support and external healthcare involvement when needed. Daily oversight arrangements included discussion of assessments taking place that day, occupancy, residents of concern, activities across the home, and service user feedback, which suggested the provider was maintaining operational oversight of who needed support and how this was being organised. Relatives also told us they were able to visit and remain involved, which helped support equitable access to family relationships and advocacy.

For people who lacked capacity and had no appropriate family member or representative to support them, the provider fulfilled its obligations by ensuring referral to an Independent Mental Capacity Advocate (IMCA) where required, in line with the Mental Capacity Act 2005.

The provider also showed some willingness to respond to individual circumstances. For example, relatives described staff adapting support where needed, and feedback suggested some people had experienced improved wellbeing and engagement since moving into the service. This indicated that access was not limited purely to placement or basic care but extended to social opportunities and wider wellbeing support.

The evidence showed that people were usually able to access the care, support and involvement they needed, and the service took some steps to tailor access around individual circumstances. While improvements were needed in relation to accessible communication and information, these shortfalls did not outweigh the broader evidence that people generally had fair access to support, relationships and day-to-day opportunities.

Equity in experience and outcomes: Score 3.

The service generally promoted equitable experiences and outcomes for people by providing support across different areas of the home and adapting care to a range of needs, including nursing provision and support for people living with dementia. Records showed that people's health needs, family networks and professional involvement were considered as part of care planning, which helped create a more tailored approach to support rather than a one-size-fits-all model of care.

There was evidence that some people had experienced positive outcomes since moving into the service. Relatives described meaningful improvements in presentation, wellbeing and day-to-day quality of life. One family member told us their relative was a "different person from when she came," while another described their relative as being more active and engaged than previously. These comments suggested that, for some people, the service had supported improved emotional wellbeing, increased participation and a more positive daily experience.

The service also appeared to make efforts to ensure people had access to social opportunities and meaningful occupation across different parts of the home. During the flash meeting, staff discussed activities that had taken place and those planned throughout the service by the activity lead, including larger group events and external visits. This indicated that the provider was considering people's opportunities for engagement and not limiting positive experiences to one group or area of the home. Relatives also described being able to attend events and remain involved in the life of the service, which supported inclusion and continuity of important relationships.

Feedback from relatives was broadly positive and suggested that people usually received a comparable standard of care, attention and reassurance. Family members described staff as responsive, caring and attentive, and one relative said they could "go to sleep at night knowing he is safe and well cared for." This gave assurance that most people were experiencing support that was both consistent and reassuring, and that relatives felt confident in the care being provided.

Planning for the future: Score 2

The service demonstrated a generally forward-looking approach to planning for people's future care and support needs. Records sampled during the inspection showed that end of life considerations, advance care planning and funeral wishes had been documented where relevant, and in the examples reviewed these arrangements were recorded as being in place and up to date. This indicated that the provider had recognised the importance of discussing future wishes and making plans in advance so that people's care could continue in a way that reflected their preferences as their needs changed.

There was also evidence that the service considered future planning at earlier stages of the care pathway. Pre-admission assessment processes included gathering background information from professionals and relatives, and in one case a respite stay had been used prior to admission to help determine whether the service would be a suitable longer-term option for the person. This showed some regard for planning ahead and trying to ensure that transitions into the service were appropriate and sustainable.

Care records included documentation of people's wishes for later life, including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and ReSPECT decisions where appropriate. Staff demonstrated awareness of these preferences and aimed to ensure they were respected in practice.

Where individuals chose not to engage in end-of-life discussions, this was respected and recorded appropriately.

The provider had systems for routine review which supported ongoing consideration of people's future needs. Care plans were reviewed regularly, and daily and clinical governance meetings provided forums in which people's changing health needs, risks and service pressures could be discussed. This gave some assurance that future planning was not treated as a one-off exercise but was considered alongside people's developing needs and circumstances. https://cqc.org.uk/guidance-regulations-service-providers-and-managersd/health-social-care-act/regulation-17

Relatives' feedback also suggested that the service was responsive to longer-term changes in people's wellbeing and presentation. Family members described improvements in how people were being supported and indicated they were able to remain involved in discussions about care. This supported the view that future planning was usually carried out with some regard to the views of those important to the person.

There were, however, some limitations in how consistently future planning was evidenced. In particular, records did not always clearly demonstrate ongoing involvement from people themselves in reviews of care, and accessible information was not always available in a format that would support everyone to engage fully in planning ahead. There were also isolated examples where associated risk assessments were not updated promptly when needs changed, which reduced assurance that forward planning was always matched by equally robust review of current and emerging risks.

Well-led

Shared direction and culture: Score 3

Barchester reported that they felt the CQC inspection did not reflect the standard they consistently aimed for. Some immediate improvements around governance had already been put in place, and Delphi Delphi assessors felt that this was the moment for Barchester to align around the required improvements and strive for outstanding services.

Delphi assessors had lengthy discussions with leaders around the need to reconnect with the team and focus on why service quality mattered, in order to align with the Barchester imperative that a 'Quality First' culture was embedded. The service's core values were clearly displayed in the reception area and reflected an open and inclusive culture. Staff spoke positively about the management team, leadership and direction of the service, reporting that they felt valued, supported and listened to. We observed a respectful and compassionate environment, with staff demonstrating a commitment to treating people with dignity and empathy. Team meetings and training sessions reinforced these values, providing opportunities for shared learning, reflection and alignment with service objectives.

The Peripatetic Manager prioritised building trusting relationships between staff and people using the service. Regular meetings with residents and relatives ensured that views, choices and concerns were actively sought and considered. This approach helped create an open atmosphere where people felt comfortable expressing their preferences. Staff described feeling well supported and equipped to

deliver effective care, highlighting the provider's focus on staff wellbeing and a positive workplace culture.

Capable, compassionate, and inclusive leaders: Score 3

Leaders acted with honesty and transparency in recognising that under previous management the service had been inadequate. They avoided defensiveness and expressed a desire for continuous improvement. Their approach was to embrace overarching systems and treat the situation as a cultural opportunity. Whilst there were current difficulties relating to the past, the leadership group was aligned around a one-time continuous improvement plan. Their ambition was to deliver a great service consistently.

Managers and leaders were visible, approachable, and responsive. Staff described them as fostering an environment of equality, diversity, and respect through inclusive behaviour. Leaders remained well-informed about quality and service priorities and actively sought support and professional development to enhance their leadership effectiveness.

The Peripatetic and Deputy Manager had defined roles and responsibilities and promoted accountability, ensuring care tasks were completed efficiently and consistently. This structured framework supported continuity of care and helped staff feel confident in their duties.

Staff feedback reflected a positive view of leadership, with comments such as, "The interim registered manager is very friendly and approachable," "Management listens and provides support," and "The doors are always open management is always helpful."

Freedom to Speak Up: Score 3

There was a culture within the service where residents and their families, along with staff, felt safe, heard and free from detriment when raising concerns. The current approach from the local leadership was modelled on openness, honesty and transparency. Concerns were investigated sensitively and confidentially with shared learning. This aligned with the national 'Freedom to Speak Up' policy, which emphasised inclusive, consistent arrangements and learning through listening. Residents' and relatives' approaches were both enthusiastic and complimentary about the current service levels.

The service fostered an open and supportive environment where people felt comfortable expressing themselves, confident that their views would be listened to. Staff reported easy access to the manager, who was approachable and receptive to any concerns. They trusted that feedback and issues raised would be acknowledged and respected. A designated 'Freedom to Speak Up' champion was available to support both staff and service users in raising concerns. Whistleblowing and safeguarding procedures were well communicated and regularly reinforced during inductions and team meetings.

Systems encouraging open communication included clear whistleblowing and complaints procedures, alongside staff and service user surveys that provided opportunities for feedback. Regular one-to-one meetings with senior staff and team meetings also offered platforms for staff to raise important matters.

Workforce equality, diversity, and inclusion: Score 3

Barchester Healthcare demonstrated a clear organisational commitment to workforce equality, diversity and inclusion, supported by visible leadership, an improving curve of structured governance and practical actions to move beyond requiring improvement. The current service improvement plan promoted a fair, respectful and inclusive working environment. The organisation recognised that an inclusive workforce directly contributed to safer, more personalised and higher quality care.

The staff team reflected a variety of cultures and backgrounds, supported by recruitment practices that were open and free from bias. The service valued workforce diversity, recognising that a range of experiences, perspectives, and skills strengthened the quality of care provided. Managers and leaders were committed to fostering an inclusive and fair culture where every staff member felt respected and valued.

By promoting diversity and inclusion, the manager aimed to create a supportive environment that enhanced empathy and effectiveness, ensuring the service was well placed to meet the diverse needs of those using it.

Governance, management, and sustainability: Score 2

Governance systems were in place and leaders had access to a range of established corporate oversight, audit and assurance processes. These appeared, in principle, to provide a strong framework through which quality, safety and performance could be monitored.

However, the inspection found that these systems were not being consistently or effectively utilised at local level. As a result, concerns identified during the inspection had not been reliably identified, escalated or resolved through the home's own governance arrangements. This indicated that the shortfall was primarily a localised failure in the application and execution of governance rather than an absence of governance structures themselves.

The impact of this was significant, as the service could not demonstrate that local leaders were using available governance and audit systems to maintain accurate oversight, ensure the integrity of records, or drive timely improvement. This was illustrated by a serious governance concern in which interview notes had been recorded as signed off, but the named signatory denied having done so and stated that the registered manager had falsified her signature. This undermined confidence in the integrity of records, the reliability of internal oversight arrangements and the provider's ability to demonstrate accurate, transparent and trustworthy governance processes. https://cqc.org.uk/guidance-regulations-service-providers-and-managersd/health-social-care-act/regulation-17

Taken together, these issues reduced assurance that the service was operating in line with the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as systems were not sufficiently effective in assessing, monitoring and improving the quality and safety of the service at local level.

Partnership and communities: Score 3

Orchard Nursing Home actively fostered strong, effective partnerships and community relationships. There was evidence of integrated working, shared priorities, and a culture of collaboration across

health, social care, voluntary organisations and the local community in Newport. The island's geography supported close-knit working, while formal governance ensured consistency, accountability and improvement. The inadequate rating was felt sharply by stakeholders and there was a strong sense of resilience to maintain the improvements witnessed in the home.

Learning, improvement, and innovation: Score 2

Barchester's Regional Director articulated clearly the commitment to maintain a culture where learning, improvement and innovation became embedded at a local level. Local services were encouraged and supported to identify what worked well, learn from what did not, and contribute actively to Barchester's wider improvement journey for this service. It was felt within the service that Barchester's corporate ambitions for excellence were being translated into meaningful, practical action at Orchard Nursing Home.

Environmental sustainability / sustainable development: Score N/A

We do not assess this quality statement