2026

delphi care solutions

Barchester Healthcare Homes Ltd:

Windmill Manor, Oxted, Surrey

Mock Inspection

Report and Improvement Plan

2 & 3 June 2026

Scope

Delphi Care Solutions was commissioned by Barchester Healthcare Homes Limited ('the provider') to complete an independent, evidence-based comprehensive mock inspection of Windmill Manor, Oxted, Surrey ('the home').

We completed the mock inspection on 2 and 3 June 2026. During the mock inspection we identified good practice, some exemplars, and some recommendations for improvement and development.

We shared feedback relating to these findings with the home's general manager and a senior regional provider lead both during and at the conclusion of the mock inspection process.

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

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

CQC KEY LINES OF ENQUIRY					
Safe 24/32 = 75%	**Effective** 18/24 = 75%	**Caring** 15/20 = 75%	**Responsive** 21/28= 75%	**Well-Led** 21/28 = 75%	**Overall Rating**
SCORE: Good	**SCORE: Good**	**SCORE: Good**	**SCORE: Good**	**SCORE: Good**	**SCORE: Good**

Rating

We work to the CQC Quality Statements scoring system, as follows:

4 = Evidence shows an exceptional standard.
3 = Evidence shows a good standard.
2 = Evidence shows some shortfalls.
1 = Evidence shows significant shortfalls.

We use these thresholds to convert percentages to scores:

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

R/A/G Rating

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

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

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

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

Overview

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

The home's most recent published CQC report followed a responsive assessment which took place in April 2025. The home received a GOOD rating overall; with good ratings for all five key questions 'Safe,' 'Effective,' 'Caring,' 'Responsive,' and 'Well-led.'

Prior to our mock inspection, managers told us that the CQC had completed a focused inspection in April 2026. The report writing and factual accuracy process for this inspection was in progress (with a draft CQC report submitted to the provider). We did not directly review this information as part of our mock inspection process, instead choosing to complete our findings report solely on the basis of our first-hand observations and review of evidence. However, it was inevitable that some of our discussions with managers and staff were framed within the context of the recent CQC inspection.

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

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

The service specialisms are:

- Caring for adults over 65 years of age.
- Caring for adults under 65 years of age.
- Dementia.
- Physical disabilities.

At the time of our mock inspection the home was registered with the CQC to accommodate a maximum of 60 people, and there were 48 people living at the home. Windmill Manor is one of 287 sites operated by the provider, and the home's local authority is Surrey.

Safe

Learning culture: Score 3.

From evidence we reviewed, we found that the home had well-developed and embedded effective systems and processes to promote a positive learning culture and to improve safety.

We found that the home had a proactive and positive culture of continuous improvement, with an appropriate focus on safety and learning lessons. Incidents and opportunities for improvement were discussed in daily 'stand up' meetings which were led by the general manager and attended by a range of staff from different departments (for example nursing, care provision, activity, maintenance, administration/management, and kitchen). We saw two separate examples of these meetings and in each case incidents, alerts, and lessons learned were discussed, with a suitable emphasis on people's

safety and care. Outstanding items and concerns from previous days' meetings were discussed with actions decided and allocated where required.

The general manager and/or other senior staff at the home completed daily documented 'walk arounds,' which were comprehensive and detailed in content. This included certain standing items for example consideration of building safety, provision and availability of information displayed about the home, communal areas, dining experiences, residents' rooms, clinical care delivery, and kitchen/laundry facilities. These were suitably documented and included comments, actions required, and planned work. Our reviews of the documented records indicated that this process had become more comprehensive and detailed from January 2026 to the dates of our mock inspection in June 2026. We recommend that the home could further improve this process by including evolving, dynamic risk factors as well as standing items as areas to consider and document as part of the walk arounds. This would allow for prompt and consistent consideration of emerging and evolving concerns and risk factors.

The home maintained dedicated lessons learned documentation. We reviewed 10 individual examples of lessons learned all from 2026, and saw that these had been handled appropriately. These examples all demonstrated proper consideration, communication, investigation, recording, and discussion and dissemination of findings and suggested improvements.

We saw that any staff member at the home could initiate the lessons learned process, with 'part A' of the lessons learned document being for staff to record and report, and 'part B' for managers to consider, analyse and action. We saw that incidents had been monitored and overseen regularly by managers, with findings shared as soon as possible with staff to support safe care and to manage risks. The home and wider provider had structured meeting, audit and governance processes which included proper consideration of incidents, risks and learning.

We saw documented evidence that lessons learned were discussed in team meetings, one-to-one meetings/supervision sessions, and as part of staff training sessions.

We saw evidence of where findings from incidents, analysis and outcomes had been shared with people living at the home, families, other healthcare professionals, and the wider provider organisation. There was evidence of appropriate candour in relation to lessons learned and associated findings.

Safe systems, pathways and transitions: Score 3.

We saw that people were supported through safe and well-coordinated systems, pathways and transitions that helped ensure continuity of care and positive outcomes. There were effective systems in place to share information promptly and accurately between home staff, healthcare professionals and other agencies.

There was evidence of appropriate continuity of care, including where people had moved between services. The home used the provider's 'Enable' care management platform, which was based on the 'Nourish Care' system and adapted for the provider's needs. This included detailed care plans, risk

assessments, and relevant supporting documentation. We reviewed four people's records and found that in each example there were regular reviews and updates which were sufficiently detailed and personalised.

We saw from care records and other documentation that the home had developed effective working relationships with the local GP practice. We saw evidence of ongoing engagement with healthcare professionals including GPs, paramedics, community nurses, dentists, opticians, audiologists, speech and language therapists, and physiotherapists. Professionals were contacted appropriately for advice, assessments and intervention, with outcomes documented.

We saw that there was a system of regular care plan audits which was explicitly linked with care planning and lessons learned processes, to support ongoing safe systems and pathways.

We saw that care and support pathways were planned with the involvement of people where they were assessed to have suitable capacity. Families and professionals had been suitably involved where this was applicable. Where people were deemed to lack capacity, Mental Capacity assessments were completed and best interest decisions documented appropriately.

Safeguarding: Score 3.

We found that people were kept safe at the home.

We reviewed staff training logs and found that 98% of staff (49 out of 50) had received suitable adult and children's safeguarding training and updates appropriate to their roles. The remaining staff member had safeguarding training scheduled to take place.

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

There was visual information throughout the home about raising concerns, whistleblowing, and processes to follow for reporting safeguarding concerns, including information aligned with local protocols and partners such as the Council and Police.

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

The home had clear, comprehensive written safeguarding policies and procedures which had been suitably reviewed and updated on an annual basis.

We reviewed 12 examples of where safeguarding incidents and risks had been correctly identified, properly reported, investigated, and the learning shared, including with the wider provider organisation and with partners from January to May 2026. This included proper communication with and provision of information to the local council and CQC.

We saw evidence of suitable Mental Capacity Assessments (MCAs), application of Deprivation of Safeguards (DoLS), and Best Interest (BI) decisions in people's records. We found that these were all properly documented, and managers and staff we spoke with demonstrated a clear understanding of these processes and principles.

We saw evidence of where safeguarding concerns and risks had been discussed and properly documented with people living at the home, and with families. All documentation and evidence we reviewed was appropriately mindful of human rights and discrimination factors.

The home maintained records of safeguarding incidents detailing the concerns raised, investigations conducted, outcomes, and relevant dates. These incidents were suitably integrated with lessons learned processes. We saw that safeguarding was discussed during various home and provider meetings.

Involving people to manage risks: Score 3.

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

All people living at the home had their care managed by the 'Enable' electronic platform. We reviewed four (of 46) people's records and found that care plans, risk assessments and notes were personalised and comprehensive.

We saw that the home supported people to effectively manage risks. All areas of risks identified for people were clearly assessed, planned for, properly documented, and subject to management oversight and governance. Care plans included comprehensive consideration of current best practice guidance for staff to follow. Risk documentation was frequently reviewed, at least every month or more often if needed or appropriate. Care records were subject to a programme of audits and quality checks to promote the use of suitably personalised information to help manage risks.

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

We saw evidence of where people and their families had provided information and feedback which managers and staff had listened to and used to improve care. People's care plans and risk assessments were suitably reviewed and updated in line with their evolving needs.

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

Safe environments: Score 3.

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

On the days of our mock inspection the home was undergoing refurbishment work. We saw that this was being managed appropriately, including keeping affected areas secure; suitable ventilation; provision of alternative access and routes; and warning signs and notices; and proper management of residents.

We reviewed documentation which showed us that staff and managers ensured the premises, equipment, facilities, and technology supported the proper delivery of safe care, including as part of a programme of daily, weekly and monthly checks.

We saw that the home had suitable processes for overseeing and managing areas including fire safety, electrical and personal appliances, water and legionella, heating and lighting, building maintenance, medical equipment, furniture, and waste. There were comprehensive records which provided evidence of suitable servicing, maintenance and audits. All required safety certificates were present and correct, and up to date. Managers and staff that we spoke with demonstrated that they understood the importance of maintaining a safe environment to support safe care.

The home carried out scheduled fire evacuation drills and weekly fire alarm checks which were all suitably documented. The home had designated Fire Marshalls, and information relating to this was prominently displayed in the home.

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

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

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

We saw that premises, facilities and maintenance matters were considered as part of the daily stand up meetings, whereby the maintenance lead attended and presented information relating to these areas, which was followed by discussion and planning to support safety.

There were suitable policies and procedures which had been regularly considered and updated to support the safe environment.

We saw that the home's general manager and maintenance lead held targeted meetings once a month to consider environmental issues and risks, and these meetings had been suitably documented including any actions. This facilitated proactive and pre-emptive consideration of environmental concerns, and we consider this to be an example of outstanding practice.

Safe and effective staffing: Score 3.

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

We reviewed six staff files and found that recruitment practices and activity were robust. This process was initially managed and overseen at provider level to support consistency across the organisation and the home sites, with further recruitment activity carried out by the home's general manager and other senior staff.

We saw there were effective checks to make sure staff were suitably qualified, competent and experienced to carry out their roles. Safe recruitment practices, for example employment history and Disclosure and Barring Service (DBS) checks, were consistently used. Checks for prospective new employees included right to work with the UK, references, experience and gaps in employment, and occupational health. Recruitment activity was subject to checklists and management oversight to promote consistency. There were suitable systems to ensure that professional revalidation was in place.

The general manager told us that staff levels and ratios were currently suitable for the home, and that these were subject to ongoing review with adjustments made in line with the number and needs of the people living at the home. The home used the provider's proprietary Dependency, Integrity, Care, and Evaluation (DICE) dedicated staff level dependency tool, which considers people's needs to identify staff levels.

The home used a majority of permanent staff, with occasional use of bank staff who worked at the home regularly. At the time of our mock inspection there were no agency staff being used.

We saw that compliance with staff training requirements was high, for example all training compliance at 96%. The home manager used a staff training matrix which provided effective oversight of staff training levels across the home. We found supervision, appraisal, performance management, and staff team meetings processes to be consistent and effective, including proper consideration of equality and protected characteristic factors.

Staff we spoke with told us they felt well-supported, including where they felt they had needed guidance and training to better understand their roles and requirements. We saw examples where any areas for concern, such as underperformance, had been addressed effectively and supportively. Managers and staff told us that staff wellbeing was properly considered, and we saw evidence to support this, for example in team meeting records.

Infection prevention and control: Score 3.

We observed the home to be visibly clean and odour free. There was information around the home with guidance on handwashing techniques and the correct use of PPE.

Cleaning tasks were carried out by dedicated housekeeping and cleaning staff who we saw had received training and updates relevant to their roles. There were documented daily cleaning schedules which were checked and audited by managers and senior staff.

The home had a head housekeeper who was also the infection prevention and control (IPC) lead. They were supported by the home's deputy manager in this function.

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

We observed the kitchen area to be clean, tidy, and organised, including during busy mealtimes. Fridge and freezer temperatures were monitored and logged. All opened food products in the fridge were appropriately dated. No food products or other items were stored on the floor. The kitchen had a detailed cleaning schedule and checklists in place and activity was suitably recorded.

There was evidence of a suitable process for handling and managing clean and soiled items and we observed that staff consistently followed this process. During the mock inspection process we observed managers and staff to be engaged in discussions relating to improving the processes for managing laundry, which demonstrated evidence of good practice and lessons learned.

The home had received and maintained the maximum food hygiene rating score of 5 in August 2025.

The home's kitchen maintained detailed records including of people's dietary requirements and any allergies and/or intolerances.

There was a dedicated hairdressing room which we observed to be visibly clean and tidy. This was in use during mock inspection, and we saw that appropriate health and safety and hygiene processes were being used.

The home was subject to monthly IPC short audits, with more comprehensive and detailed audits taking place twice a year.

The home had suitable, comprehensive policies and procedures relating to IPC which had been regularly reviewed and updated.

We saw from feedback submitted that people and relatives consistently described the home as clean, tidy and well maintained.

Medicines optimisation: Score 3.

We saw that medicines were managed safely, consistently and in line with current best practice guidance. The home had clear and robust systems and processes in place to support the safe receipt, storage, administration and disposal of medicines, helping to ensure people received their medicines as prescribed and in a timely way. This included flow charts and guidance within treatment rooms to guide staff in following correct procedures and reducing the risk of errors. Medicines were stored securely, and regular checks were completed to monitor stock levels, expiry dates and fridge and room storage temperatures.

We observed medicines rooms to be visibly clean and tidy, and each was equipped with functioning air conditioning to support effective temperature regulation. Records indicated that temperatures for each of the medicine fridges (used for items requiring storage between 2 and 8 degrees centigrade) and rooms were recorded twice daily, and we observed no gaps in the recording of these. All medicines and equipment were stored appropriately.

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

The home had suitable policies and procedures to support proper medicines optimisation, which were available to all staff on an electronic platform and in hard-copy form. These were created and updated at provider level and could be adapted to suit local, home-specific considerations if required.

We found no evidence of excessive medicine stock, and we found no evidence of any discrepancies between system and stock counts. Staff told us they prioritised avoiding keeping surplus medicine stock and that there was rarely any of this at the home. At the time of our mock inspection the home used paper Medication Administration Records (MARs) to support medicines administration and reporting

On the days of our mock inspection there were no people who administered their own medicines. For people receiving covert medicines there were appropriate processes and assessments in place.

CDs were suitably managed, including appropriate storage, security, recording, documentation, and destruction. Keys for CDs were kept separately and securely from other keys, with access strictly restricted to authorised staff only. We saw that the home's CD processes and practices was in line with guidance, regulations and laws (including the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 2001), for example policies and procedures, registers, storage, management, and disposal.

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

We saw evidence of staff being properly trained to administer medicines, with their competency to do so being checked and suitably documented.

The home had a comprehensive cycle of weekly and monthly audits including for medicines, clinic rooms, equipment, antibiotics, and CDs.

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

Effective

Assessing need: Score 3.

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

Initial pre-admission assessments were completed by the home's general manager and/or deputy manager and would involve the person and their family as much as possible. Other professionals were also involved where they were able to contribute to the assessment process. We recommend that the home considers involving more junior staff in the assessment process to provide a more holistic view and to support staff development.

Pre-admission assessments were comprehensive and included areas such as personal details, communication, preferences, social factors, spirituality, medical history, and comprehensive consideration of needs, requirements and risks.

Assessment of need was considered as part of an ongoing process. This was supported by a dedicated monthly "resident of the day" initiative, whereby people's assessments and care plans were subject to a comprehensive, holistic review. This included areas such as health, wellbeing, diet, communication, interests, aspirations, activities, visits, and any risks. Care records indicated that this was used as opportunity to fully engage with the respective person, and their family, to provide them with additional opportunities to contribute to assessment, planning and care delivery.

We saw that people had their plans, needs and risks updated frequently in line with evolving information. People's needs were considered and supported as part of daily stand up meetings.

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

Delivering evidence-based care and treatment: Score 3.

All aspects of the home's care delivery were supported by the provider's structured Care and Life Enrichment Framework (CLEF), which included areas such as 'person-centred care,' 'supporting and

involving residents, family and friends,' nutrition, activities, staffing, the home environment, and quality insurance/continuous improvement. There was a suitable focus on principles including personalisation, preferences, and positive well-being.

We reviewed the home's electronic care records. The home used the provider's own 'Enable' electronic platform, which was an adapted version of 'Nourish Care' tailored to the provider and home's own requirements and specific needs.

We saw that staff were able to access high-quality, detailed and personalised information relating to people to support the delivery of evidence-based care and treatment. Records indicated that people, and where applicable their families, were consistently and continually active in the delivery of care. Care was delivered in line with legislation and current, evidence-based practice.

We saw that people's hydration and nutrition needs were properly met, with relevant information, interventions and care properly recorded and shared. There was proper consideration of people's needs, food allergies and intolerances, whether adapted cutlery was required, and Malnutrition Universal Screening Tool (MUST) score (MUST is a validated five-step screening tool used by healthcare professionals to identify adults at risk of malnutrition or obesity in care settings). Although there was comprehensive consideration of people's nutritional needs and associated factors (for example medicines), we recommend that the home focuses further on considering people's individual likes and preferences in relation to nutrition.

How staff teams and services work together: Score 3.

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

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

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

The home had a dedicated GP practice, and the GP conducted weekly ward rounds at the home. We saw that other professionals were engaged and involved with delivering care for people at the home, for example dentists, opticians, and physiotherapists. Specialist external teams and agencies were also involved including speech and language therapists and wheelchair services.

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

Supporting people to live healthier lives: Score 3.

We saw that the home prioritised people's empowerment and engagement where possible, for example by planning and reviewing meal choices and choosing activities.

We saw from care records we reviewed that changes in people's presentation, emotional state or distress which may indicate deterioration to their health or wellbeing were recognised by staff; and concerns shared with relatives, partners and/or other services as appropriate.

Activities and entertainment were provided by the home's staff and external visitors to the home, for example exercise, art, and animal/pet therapy.

We saw that people had suitable and timely access to GPs, nurses, and other healthcare professionals. We saw that staff escalated any changes to people's health to the relevant healthcare professionals and made sure people's health needs were reviewed if needed.

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

We saw from care records that people received monthly oral health checks, with dentist input where assessed as required.

Monitoring and improving outcomes: Score 3.

We reviewed four people's care records and found that there were comprehensive arrangements for planning, coordinating, delivering, and measuring care and improvements. Care records, assessments and plans were of a consistently high quality with sufficient detail provided, and we noted a high level of personalisation in the examples we reviewed.

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

We saw examples of how the home supported people to improve their outcomes. For example, during 2026 a person had experienced a wound healing following the home's staff implementing a tissue viability and wound support plan.

Consent to care and treatment: Score 3.

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

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

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

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

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

Caring

Kindness, compassion, and dignity: Score 3.

We saw that the provider and home prioritised the delivery of kind, compassionate and respectful care, and throughout our mock inspection we saw consistent demonstration of care provision in line with these values and principles.

All interactions we observed were natural and evidenced knowledge and understanding of each person and their needs. This included in one-to-one and group settings. We saw that people were supported and encouraged to interact with each other in productive ways where appropriate, for example during activities and mealtimes.

We observed people receiving care and support without delay when needed. We saw staff proactively engaging with and supporting people, for example to meet their mobility and hydration needs.

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

We saw that visitors to the home were treated respectfully and courteously. Feedback from relatives demonstrated that they were satisfied with and complementary about the kindness and compassion they had received when visiting the home

We saw that staff treated each other, and colleagues from other organisations (for example contractors) with professionalism, respect and kindness.

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

Treating people as individuals: Score 3.

We observed staff at the home to be demonstrating understanding of each person, including their personal needs, strengths, backgrounds, and preferences.

Managers and staff that we spoke with, and documented care records, demonstrated a high level of understanding of people's backgrounds and lives, as well as their personal situations and circumstances. For example, in one person's care records there was detailed guidance relating to how best to provide care, including that the person was known to "respond positively to staff smiling" and that they responded better when care staff sat on their right hand side when supporting them with food and hygiene tasks.

Care records clearly differentiated between first-hand staff observations and information, and where information had been received from other sources for example family members and other healthcare professionals. For example, one person's care records contained detailed information relating to epilepsy seizure antecedents, and made it clear that this information came from family. This information was used to support the provision of PRN (pro re nata, or as needed) medicines.

We saw that the home appropriately used opportunities to engage with people and to improve their quality of life. For example, one person's care records and assessment documentation indicated that they had previously been an active gardener but were now unable to do so. Staff had supported this person to sit in the home's garden and observe others engaged in gardening activity, which had reportedly had a positive impact on the person.

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

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

Staff and managers that we spoke with, and care records, demonstrated a suitable understanding of people's cultural, social and religious needs, including proper consideration of any applicable protected characteristics.

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

People were encouraged to display photographs, keepsakes, mementos, and other personal items of significance to them. Staff told us that these items had been chosen by people and their relatives.

Independence, choice and control: Score 3.

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

We saw evidence of suitable and detailed risk assessments and care plans to promote and encourage maintenance of independence in relation to activities within and outside of the home. There were adequate supplies of suitable equipment to support and maximise outcomes and independence, and records indicated that these were properly maintained and checked for safety. The home had a large, accessible outside areas which staff told us were well-used when the weather was suitable. These areas were subject to appropriate maintenance, checks and risk assessments by staff.

We saw that people were able to meet with others who were important to them (including family members and friends), both inside and outside the home environment. This included visitors to the home, including for special events such as birthdays.

The home had a café/bistro area which people and their visitors were encouraged and supported to use. We observed positive, meaningful and supportive conversations and engagement there throughout our mock inspection days.

Responding to people's immediate needs: Score 3.

We observed throughout the day of our visit that people's needs were responded to in a timely manner. Staff knew people well and we saw where staff managed people and their needs in a proactive as well as reactive way. This included during mealtimes, where we saw staff focusing on people's comfort in a patient and kind manner.

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

People's care needs and associated risks were clearly identified in their care records, and we saw that these had been regularly reviewed and updated to ensure information was current and relevant, and aligned with people's circumstances and aspirations.

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

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

Workforce wellbeing and enablement: Score 3.

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

We saw evidence that staff views were addressed as part of supervision sessions and appraisals, and as part of staff meetings. We saw that the provider administered annual staff surveys at the home, with the most recent being completed during January 2026. Findings from this most recent survey included positive feedback relating to the home's general manager (who had been in post since November 2025), provision of training and guidance, and support when this was needed. There were some comments relating to there sometimes being low staffing levels, and we recommend that the home systematically reviews staff levels and deployment of staff to identify if there is potential for improvement, and to provide reassurance for staff.

Staff files showed examples where staff were provided with targeted support to increase their skills and confidence, including for new staff and where areas of underperformance or other concerns had been identified.

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

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

Responsive

Person centred care: Score 3.

During our visit we observed staff to be consistently following a person-centred approach in their interactions with people, including provision of reasonable adjustments relating to nutrition, hydration, activity, and the physical environment.

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

We saw evidence of activities provided for people, which were tailored to and assessed for their individual needs. This included engagement with staff, exercise, offsite visits and activities, and creative pursuits such as art and music.

The supported activities timetable for the week of our mock inspection included offsite visits, crossword club, creative activities, and music. Managers told us they prioritised constructive and supportive activities to help promote people's engagement.

The layout of the home allowed people to spend time alone or with smaller groups in dedicated areas, including the bistro area.

Care provision, integration, and continuity: Score 3.

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

Continuity of care was supported by external visitors to the home, including GP staff, social workers, and other health and care professionals. Staff communicated effectively within the team and with families, ensuring changes in care were shared promptly. This helped maintain smooth transitions and integrated care.

Providing information: Score 3.

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

Information was provided in a variety of formats, including text, pictures, symbols, and by using objects of reference in line with the Accessible Information Standard (AIS). This is a legal requirement for organisations providing health or social care services which aims to ensure people with disabilities, impairments, or sensory loss receive information in formats they can understand. Care records indicated that people's communication abilities and preferences were assessed as part of pre-admission processes and continually reviewed during their time at the home

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

Care records and feedback indicated that people and relatives were kept informed about care and any changes. Information was shared in accessible ways, including phone calls, emails, and face-to-face discussions during visits.

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

Listening to and involving people: Score 3.

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

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

Managers and staff recognised and could describe the distinction between requests for action or improvement (designated as 'concerns' by the home), and formal complaints. Information about how to provide feedback, including how to complain, was accessible, clear, and easy to understand.

The home operated separate residents and family meetings processes to discuss people's experiences, feedback and concerns, and to suggest improvements. We saw that this led to suitable actions and outcomes, for example in relation to food provision, the home environment, and activities.

We saw evidence of how the home had used feedback and complaints information and findings to drive improvement, including through staff meetings, supervisions and appraisals, and staff training. Findings had been integrated with incidents, accidents and risk processes where applicable. Complaints had been subject to thorough, comprehensive investigations where findings and recommendations had been shared with all staff, with the wider provider, and with partners where appropriate.

The home operated a 'you said, we did' approach, with details and outcomes displayed within the home. For example, during 2026 the home had used feedback from people and relatives to establish greater links with local garden centres, including providing transport for increased numbers of trips there.

Equity in access: Score 3.

We saw evidence that the home made sure that people could access the personalised care, treatment and support they needed, when they needed it. The home premises and outside areas were suitably accessible for people living there and their visitors. People were encouraged and supported to attend events outside of the home.

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

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

Equity in experience and outcomes: Score 3.

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

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

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

Planning for the future: Score 3.

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

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

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

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

Well-led

Shared direction and culture: Score 3.

We found there to be a collaborative team approach across the senior management team, with good communication channels observed between the senior provider regional staff, the home's general manager and deputy manager, and team leads.

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

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

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

Capable, compassionate, and inclusive leaders: Score 3.

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

All managers and staff that we spoke with displayed a passion for the home and for what they were aspiring to achieve, which was to provide high quality and personalised care. Managers and senior staff were able to demonstrate inclusivity and an understanding and appreciation of suitable care delivery and associated risks to this, for example risk of exclusion.

We saw examples of where supportive performance management processes had been used. This included formal disciplinary processes where needed. Managers were able to demonstrate a structured and evidence-based approach to managing poor culture or poor performance and there was evidence of high quality, detailed recording where this applied, including setting actions and targets for improvement, and working with staff in a supportive way to achieve mutually beneficial outcomes.

Staff were encouraged in their development. We saw examples where staff (including recruited recently) were supported with training, guidance and mentoring to enhance their skills, performance and confidence.

Freedom to speak up: Score 3.

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

The general manager told us they had an 'open door policy' and we saw evidence of this throughout our mock inspection. We observed managers and other senior staff to be highly visible and frequently engaged with staff, relatives, people living at the home, and visitors.

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

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

The provider had suitable approaches to support whistleblowing and speaking up in line with the UK National Guardian's Office recommendations, which was supported by there being three dedicated freedom to speak up guardians at the home. We saw that information relating to this was available to staff, residents and visitors to the home.

Workforce equality, diversity, and inclusion: Score 3.

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

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

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

Governance, management, and sustainability: Score 3.

We saw evidence of accountability and proper governance. Managers and senior staff used information to promote and deliver safe, high-quality care. This included acting on and sharing the best available information about risk, performance and outcomes in relation to for example personalised care provision, risk assessment and management, and medicines optimisation.

The home's governance framework ensured the home operated effectively and to a set of prescribed standards. This included a comprehensive programme of regular quality audits, incident and risk management processes, effective use of evidence-based action planning, and a systematic approach to learning and improvement. Risks, learning points and actions were shared across the provider's home sites to support learning and improvement. This work was documented using the provider's dedicated Clinical Governance System.

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

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

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

Partnership and communities: Score 3.

We saw evidence that the home had engaged with the wider community, including participation in local events and groups.

The home held monthly Community Choir sessions where anyone from the local area was welcome to attend, as well as residents and family members.

At the time of our mock inspection the provider was engaging in, or had recently held, a wide range of events including fetes, quizzes, music performances, pup-up shops, and parties. Information about these events was shared as part of monthly newsletters.

The home had established links with a local garden centre company and its two nearby sites, and residents attended these frequently. The home had links with the Pets As Therapy national charity, which included a therapy dog visiting the home regularly (we saw this take place on both days of our mock inspection).

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

Learning, improvement, and innovation: Score 3.

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

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

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

Managers and staff that we spoke with demonstrated a willingness to learn and improve and could cite examples of where this had taken place, for example in relation people's risk management.

At the time of our mock inspection the home was engaging with a research project facilitated by a relative of one of the people living at the home, who was in the process of designing a compact assistive 'sit to stand' device to support people with mobility impairments. This initiative formed part of a mechanical engineering course at a nearby university, and we saw that staff had contributed to the work by completing a questionnaire relating to their work at the home.

Environmental sustainability / sustainable development: Score N/A.

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

Improvement Plan