2026

delphi care solutions

Forest View

Mock Inspection

Report and Improvement Plan

Date: 15th April 2026

Scope

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

Delphi completed the mock inspection on 15th April 2026, with all work carried out on a face-to-face/on-site basis.

During the mock inspection we identified good practice and potential areas for improvement. Throughout the day, we shared high level feedback relating to these findings with the service manager.

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

CQC KEY QUESTIONS					
Safe 21/32 = 69%	**Effective** 15/24 = 63%	**Caring** 15/20 = 75%	**Responsive** 21/28= 75%	**Well-Led** 19/28 = 68%	**Overall Rating**
Good ●	**Good** ●	**Good** ●	**Good** ●	**Good** ●	**Good** ●

Rating

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

We use these thresholds to convert percentages to scores:

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

R/A/G Rating

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: 3**	Safe Systems, Pathways and Transitions **SCORE: 3**	Safeguarding **SCORE: 3**	Involving People to Manage Risks **SCORE: 2**	Safe Environments **SCORE: 3**	Safe and Effective Staffing **SCORE: 3**	Infection Prevention and Control **SCORE: 2**	Medicines Optimisation **SCORE: 2**	**21/32** **69%**
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: 3**	Monitoring and Improving Outcomes **SCORE: 2**	Consent to Care and Treatment **SCORE: 3**			**15/24** **63%**
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 Peoples 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: 2**	Planning for the future **SCORE: 2**		**19/28** **68%**
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 announced on-site mock inspection at Forest View Care Home. The service was most recently inspected by the CQC in January 2022 where it received a rating of Requires Improvement.

The service is registered with the CQC to carry out the following legally regulated service for a maximum of 60 people: Accommodation for persons who require nursing and personal care.

At the time of our mock inspection there were 53 people living at the service. The service was set over two floors, and each floor was divided into different unites each which had a lounge and dining room. There were pleasant gardens outside which residents could make use of in the summer months.

Safe

Learning culture: Score 3

We found that the service had a positive and integrated culture of continuous improvement, with an appropriate focus on safety and learning lessons.

The service manager showed us how the provider's electronic platform (SHBS) was used to manage incidents, lessons learned, safeguarding, complaints, and other areas. This allowed the service and wider provider organisation to efficiently report, manage, investigate, and learn from incidents and concerns. We saw that learning was shared across the provider's service sites.

There was a comprehensive approach to assessing and managing incidents and risks, with events used as opportunities to share learning across the staff team. We reviewed dedicated lessons learned logs which included examples which demonstrated proper consideration, communication, investigation, recording, and discussion and dissemination of findings and suggested improvements.

We saw that the service had devised a system of walk-around checklists for team leaders working on both day and night shifts. These were live documents which were updated in real time to reflect current concerns, incidents, risks, lessons learned, and results from compliance audits.

Managers shared and described examples from the last 12 months which clearly demonstrated where process improvements had been made. This included where certain laundry tasks were outsourced which had led to demonstrable improvements in efficiency in the last 12 months.

We saw that lessons learned were discussed in staff meetings, including where discussions, actions and outcomes had been suitably documented. Where applicable, lessons learned were discussed in further detail in relevant staff forums, for example manager and senior carer meetings.

Comprehensive analysis of incidents was provided, leading to recommendations that we saw had been appropriately shared and carried out. Findings were used to drive staff training programmes and as part of staff supervision and appraisal.

We saw that incidents had been monitored and overseen regularly by managers and senior provider staff, with findings shared immediately with staff to support safe care and to manage risks.

Safe systems, pathways, and transitions: Score 3

People living at the service had their needs assessed and monitored. We could see throughout the care planning where people had been referred to different health professionals when required and this included speech and language therapists and tissue viability nurses.

The service had forged excellent relationships with visiting professionals including the local GP practise, District Nurses, psychiatric nurses, physiotherapists, and podiatrists. We could see in the care planning where people had been referred to medical professionals when people's needs had changed and they felt that they required specialist input.

We saw that there was a system of regular care plan audits completed by managers, which was explicitly linked with care planning and lessons learned processes.

Safeguarding: Score 3

We found that people were kept safe at the service.

We reviewed staff training logs and found that all staff had received suitable safeguarding training appropriate to their roles.

We spoke with managers and staff at the service, 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 service'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 service 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 service manager and other senior staff told us they had strong, positive, and supportive relationships and engagement with the local council's safeguarding team and we saw written documentation to substantiate this. The service operated a hard-copy signing in and out procedure for visitors, and had secure areas protected by numerical codes or locked doors.

The service had clear, comprehensive written safeguarding policies and procedures. These were consistent across the provider's sites, and we saw they had been suitably reviewed and updated on an annual basis, including during the last 12 months. Policies and procedures were available to all staff on the provider's electronic staff portal.

We saw examples of where safeguarding incidents and risks had been correctly identified, properly reported, investigated, and the learning shared, including with the wider provider organisation and with partners. We saw further evidence of where safeguarding concerns and risks had been discussed and properly documented with people living at the service, and with families.

The service maintained comprehensive digital records of safeguarding incidents detailing the concerns raised, investigations conducted, outcomes, and relevant dates. These incidents were suitably integrated with lessons learned processes using the provider's electronic platform. The service manager was able to demonstrate a comprehensive approach to monitoring and tracking safeguarding incidents at suitable stages and could evidence how this was shared with and actioned by the senior provider staff. We saw that safeguarding was discussed during service and wider provider meetings.

Safeguarding incidents were included as part of quarterly operational audits, and we saw that safeguarding was discussed as part of monthly quality improvement management meetings.

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

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

Involving people to manage risks: Score 2

We spoke with residents and relatives, and they told us that they had their care needs discussed with them and any risk elements. People told us that they were well supported and looked after and if they wanted anything changed then it would be done. People and their families were spoken to regarding risk where this was necessary but there was not a significant risk to the care and support needs and interventions throughout the service.

This did not translate into the care planning and there was no documented evidence where people or their relatives had been engaged and involved in their own risk.

Safe environments: Score 3

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

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

We saw that the service had suitable processes for properly 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.

Where remedial actions were identified as part of environmental checks, we saw that these were properly addressed in a timely manner. For example, a fire door was repaired in November 2025 following a fire safety inspection in October 2025. The service carried out scheduled fire evacuation drills and weekly fire alarm checks which were all suitably documented. A weekly, scheduled fire alarm test took place on the day of our mock inspection. The service had designated fire marshals (who were all team leaders), and information relating to this was prominently displayed in the service.

Each person living at the service 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 and securely in the service's reception area.

We found the service 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 service and on all floors. There were policies and procedures which had been regularly considered and updated to support the safe environment. The service had a suitable business continuity plan which had been reviewed and updated in the last 12 months.

Safe and effective staffing: Score 3

We found that the service had processes and systems to ensure there were enough qualified, skilled, and experienced people who were subject to appropriate support and supervision. We reviewed four 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 service sites, with further recruitment activity carried out by the service's manager and other local 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, with a minimum of three references (two employment/education and one personal), experience and gaps in employment, and occupational health.

Managers told us that staff levels and ratios were currently suitable for the service, and that these were subject to ongoing review with adjustments made in line with the number and needs of the people living at the service. The service used a dedicated care management dependency tool alongside the provider's electronic rota system. The service manager told us the service operated a rota system where there would be a 'floating' member of staff on day shifts, who was used to provide support where required and as a dynamic response to changing needs, for example where people required additional support, where visits were taking place, or where there was a new admission. The service used two agencies when additional staff were required to support consistency.

We saw that compliance with staff training requirements was high, for example mandatory training at 98% and where this was not complete there were suitable reasons for this (for example staff having

very recently started in post). The service manager used the provider's electronic staff training matrix which provided effective oversight of staff training levels across the service.

We found supervision, appraisal, performance management, and staff team meetings processes to be consistent and effective, including proper consideration of equality and protected characteristic factors.

Staff received four supervision sessions per year (quarterly), of which two were designated as formal appraisals. The service followed a suitable staff hierarchy process for this. The four supervision records that we considered as part of our review of staff files all contained detailed records of supportive supervision conversations, and this were linked with evidence based actions and targets for improvement and development. We saw that staff improvement and development was approached in a supportive, collaborative way. Staff inductions included suitable periods of shadowing and buddying.

Staff told us that they felt supported and that training was excellent. One staff member had been promoted to team leader and was engaged in completing an NVQ level 4. The deputy manager showed us that they had developed training for staff stepping up to more senior roles to better equip them to support and manage staff in their charge.

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 2

We observed the service to be visibly clean, and odour free. There was information around the service with guidance on handwashing techniques and the correct use of PPE. We observed there to be no plugs in the sinks in the communal toilet and handwashing areas that we saw, meaning that water was free-flowing (sink plugs in communal areas can be a source of infection and cross-contamination).

Some communal areas had braided/corded light pulls, which can be a source of infection. We identified this to the service manager who told us they would address this by obtaining smooth plastic coverings for them.

We saw that uncovered baskets were being used to store laundry in the service's bathroom areas, which can be a source of infection and cross-contamination. We raised this with the service manager, who told us they would acquire additional, suitable segregated storage for soiled items.

The service employed dedicated housekeeping and cleaning staff who we saw had received training and updates relevant to their roles. The service's senior housekeeper was the designated infection prevention and control (IPC) lead.

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.

The kitchen was clean including food storage, fridges, and freezers. The chef showed us the cleaning rotas and staff were in the process of cleaning down after lunch. The chef told us that the was a full deep clean of the kitchen annually and there was a rota for different areas to ensure that every space was cleaned regularly.

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

We saw that all staff had received suitable training relating to IPC, and dedicated IPC audits were conducted quarterly. The most recent IPC audit had been completed in March 2026, with an overall compliance score of 98%. There was an associated action plan for improvements, for example to deep clean two chairs.

The service had suitable, comprehensive policies and procedures relating to IPC which had been regularly reviewed and updated, including within the last 12 months.

The service was clean with no malodours throughout. There were some remedial works required in bathrooms as some of the flooring was no longer effectively sealed and we saw that one of the toilet seats was wooden and required replacing as the paint had worn off over time. There were no sheaths on pull cords in the bathrooms which posed a risk of cross contamination. Some of the laundry had been placed in plastic laundry bins in bathrooms and although they had a laundry bag inside, the bins had no lids which we discussed with the registered manager who told us that the lids were available and that this would be addressed.

Medicines optimisation: Score 2

We saw that medicines were monitored and administered on an electronic system. We were told that night staff carried out a count of the medication each evening, however, when we saw how the information was collated it was difficult to discover the benefit of the additional audit as there was no overall stock number on the sheet so although the medication was being counted they were unable to see if the stock was correct without knowing how many tablets there should be in each box.

PRN protocols were stored on the electronic system and there was no information on if a person was able to tell staff if they were in pain and required pain relief. There was also no information regarding people who were either nonverbal or unable to state that they required PRN medication to relieve symptoms. We spoke to the registered manager regarding this and were told that this would be implemented. There were risk assessments throughout the support planning regarding flammable emollients and medication did have regular monthly audits.

The medicines fridge had a key, but this was left in the fridge when it should be locked and the key removed. There was a small freezer box in the fridge, and the door had been taken off. We spoke with the registered manager about this and advised that they could not be assured of the temperature as at times we saw that the recording was below the required temperature and noticed recordings of

1.1°C and 1.2°C we could not see where any action had been taken when the fridge had dropped below the required temperature of 2°C.

Effective

Assessing need: Score 3

People's needs were assessed and then monitored throughout their stay at the service. Staff knew people well and reported through anything which they felt may need further attention. Staff could tell us about people living at the service and how they liked to receive their support. We spoke with two relatives, and they told us that staff were wonderful and fully understood the needs of people. One relative told us that they were fully engaged and involved in the support planning, associated risks, and any ongoing intervention from medical professionals.

We did not always see evidence of people's involvement throughout the support planning which would benefit from mentioning who had been engaged and involved in the decision making when people lacked capacity regarding their care and treatment.

Delivering evidence-based care and treatment: Score 2

Not all care plans were comprehensive and detailed. We saw where documents were updated regularly and reflected the person's needs, how they liked their care delivered and information on their health needs. The registered manager and staff had worked to give people good outcomes and improve their health and wellbeing. There was not sufficient information in the oral health care planning, and we found that apart from the service having a dedicated oral health champion who change toothbrushes regularly and ensured that people had toothpaste. The plans lacked information on checking people's mouths to ensure that there were no emerging issues.

One person's care plan stated, '[name] is living with dementia and requires support to get in touch with relevant healthcare professional.' We spoke with the deputy manager about this as the person would not have the capacity to know that they may require a healthcare professional and the information did not accurately reflect their needs. We talked about the language used and giving accurate information.

How staff teams and services work together: Score 3

Staff were very kind and caring and interactions with residents were very positive and encouraging. We saw evidence where people were referred to health professionals when required and in more severe cases admitted to hospital. Staff knew when people's needs changed and reacted by contacting health professionals to ensure that people received health intervention in a timely manner.

Management and staff had forged good relationships with professionals involved in peoples care and worked to improve the health and wellbeing of residents. We could see in the care planning where people had been supported by dieticians and speech and language therapists where this was felt necessary to effectively support and improve people's outcomes.

We saw evidence of where meetings had taken place to support effective information sharing, including with families and other health professionals. Where appropriate, people living at the service were also involved in these meetings. We saw evidence of where meetings had been used to communicate care and treatment information between staff. This included as part of handover sessions, team meetings, and training sessions.

The service's electronic care management system facilitated the alerting and communicating of any concerns or emerging risks across the staff team, and we saw examples of where this had taken place to support safe and effective care. We saw evidence of engagement and meetings for people living at the service, including some where families had been engaged and involved. The service 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

People were supported to live healthier lives, and this was through all aspects of care and support. Food was cooked freshly each day and presented in the dining room. The activities co-ordinator and staff provided a variety of activities including exercise which people really enjoyed, and it supported people's mobility. The activities included some exercises and engaging with people.

On the afternoon of our visit we saw that they had a singer come into the service. Staff told us that they went to each lounge to entertain the residents, and we observed that some people were getting up and dancing and others were moving in their chairs and tapping their feet.

Monitoring and improving outcomes: Score 2

Within the care planning we could see that there was no information on outcomes or how outcomes could be achieved. We did have a conversation with the registered manager regarding outcomes and talked through some of the achievements they had within improving people's mobility or supporting people to manage their diabetes to reduce their likelihood of going onto medication.

We suggested that the narrative in the care planning was changed to reflect people's desired outcomes and also how the service would work to support people to achieve them. The registered manager was keen to make the improvements suggested so that people's outcomes could be effectively recorded to reflect people's achievements with support from the staff.

Consent to care and treatment: Score 3

Consent to care and treatment was sought from the residents and where they lacked capacity relatives had been involved in support plans and associated risk assessments. Where people lacked capacity, they had DoL's in place. We saw evidence that best interest meetings had taken place and decisions were made in people's best interest where they lacked the capacity to consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best

interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care services, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

Caring

Kindness, compassion, and dignity: Score 3

Staff were kind, caring and compassionate, on staff member told us, *'It's like a family, we really do care.'* We could see within the care interventions that people were happy with the staff and felt safe with them.

Staff ensured that doors were closed when delivering personal care and asked if people needed support with what they were doing, some declined and others welcomed a little help. This was evident when people had their lunch, staff were asking some people if they wanted food items cutting up or if they would like a spoon instead of a fork. We observed one person being supported to eat their lunch. The staff member was engaged in conversation with them, laughing and interacting while remaining kind and patient throughout.

All interactions we observed were natural and evidenced knowledge and understanding of each person and their needs. 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 service had a wide range of large and small rooms, including quiet areas, which supported privacy and calm. We saw that visitors to the service were treated respectfully and courteously. Feedback from relatives demonstrated that visitors were satisfied with and complementary about the kindness and compassion they had received.

We saw that staff treated each other 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 that people were treated as individuals and staff knew them well. One relative told us that they trusted the service and the staff implicitly and that their relative was supported in a way that they wanted to be and although the person had advanced dementia and didn't recognise the relative; staff ensured that they knew people's needs and preferences and ensured that they were treated as individuals. We asked one relative if people were able to have their own things in their rooms such as duvet covers and furniture. They told us that they could have what they wanted to have in there and they had taken various things in including bedding and personal items, but this had all been removed by the relative as they preferred the interior as provided by the service.

Managers and staff that we spoke with demonstrated a high level of understanding of people's backgrounds and lives, as well as their personal situations and circumstances.

Staff demonstrated patience and understanding whilst promoting independence, for example encouraging people to move around areas of the service 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.

The service promoted flexible visiting times.

The service had a process where people could use an area outside their room which could be used to display photographs, keepsakes, mementos, and other personal items of significance to them. Staff told us that these items had been chosen by people and their relatives.

Independence, choice and control: Score 3

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

We saw evidence of suitable and detailed risk assessments and care plans to promote and encourage maintenance of independence in relation to activities within and outside of the service. 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.

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 service environment. This included visitors to the home.

Responding to people's immediate needs: Score 3

The service had many examples of where people had their needs met and staff responded immediately to any distress or discomfort. We saw staff supporting people and ensuring that they were kept safe and well. We saw many examples of where people had healthcare professionals involved where staff had felt that they required further medical intervention in order to make them comfortable and meet their needs.

We observed throughout the day of our visit that people's needs were responded to in a timely manner. Staff appeared to know people well and we saw where staff managed people and their needs in a proactive as well as reactive way.

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 service.

Workforce wellbeing and enablement: Score 3

Managers and staff that we spoke with told us there was a positive, supportive culture at the service and that their wellbeing and support were properly considered.

Throughout the day we observed staff to be working collaboratively and in a mutually supportive way. We saw evidence of supervision sessions, appraisals and team meetings which included a focus on staff wellbeing and support. Staff views were addressed as part of supervision sessions and appraisals, as part of staff meetings, and as part of formal survey and feedback processes.

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

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

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

The service provided an anonymous food bank service for staff. The service manager told us this was because they and other senior colleagues recognised current and recent financial pressures and wanted to try and support staff where they could.

Responsive

Person centred care: Score 3

People were treated in a person-centred way and staff knew people well and how to support them in a way that they wanted to be supported. Residents and relatives could not praise the service and the staff team more. One relative told us, “Staff are consistent, the same staff supported [name] throughout the time they lived at the service, and the continuity was the best thing.” Staff took their time to understand people’s needs and knew residents well; they took time to ensure that people were encouraged gently when carrying out tasks and did not jump in to offer assistance so that they retained their independence even if it took longer to achieve.

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.

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.

Care provision, integration, and continuity: Score 3

People had good care from a regular team of staff, and the service employed more staff than the dependency tool calculated to ensure that people had genuine interactions from staff who had time and really cared about their health and welfare. Relatives told us that they were updated regularly on things which were important to them and that they had a good relationship with staff and management.

The relationship with external healthcare professionals was excellent and ensured that people had timely care interventions as their needs changed. The GP carried out a surgery every Monday for people who required it and when the Monday was a bank holiday, they moved the surgery to the Friday before to ensure that they saw people who needed to have further assessments or health interventions carried out.

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

Continuity of care was supported by external visitors to the service, including a GP, the local mental health team, district nurses, and other professionals such as speech and language therapists and falls prevention professionals.

Providing information: Score 3

The service 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 service.

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). The AIS is a legal requirement for organisations providing health or social care services which aims to ensure people with disabilities, impairments, or sensory loss receive information in formats they can understand.

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

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

Information was provided in a variety of formats and displayed on notice boards throughout the service. We did not see a pictorial menu and so asked staff how people were consulted on what meals they wanted to choose that day. We were shown laminated cards with all of the meals for that season displayed and were told that in the morning the staff took the cards around to people with that day's choices on and people could choose what they would like from the pictures.

Listening to and involving people: Score 3

People were listened to and involved in all aspects of their care and support. Relatives told us that they had regular discussions with staff and management and felt that they were kept informed, and they were involved in decision making and best interest meetings where this was required. We could see staff listening to what people wanted and they were patient and caring throughout. Relatives told us that they had a good relationship with staff and management.

The service made it easy and convenient for people to share their views and ideas in ways that suited them. There were dedicated provider policies and procedures for complaints, compliments, and provision of feedback.

We reviewed feedback and complaints submitted to the service, and we found the majority to be complimentary. This included feedback from people living at the service and their families. The service-maintained records for complaints, compliments, and other feedback and these were overseen by service and provider managers to promote consistency and thoroughness.

The service used its SHBS electronic platform to log and manage feedback (including complaints and compliments). At the time of our mock inspection, the service had received one formal complaint within the last 12 months which we saw had been appropriately addressed and managed.
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Equity in access: Score 3

People had equity in access and received holistic care which supported them in ways that they wanted to be supported and to ensure that their outcomes were being met. People were referred to healthcare specialists when required and we saw evidence of this throughout the care planning.

Relatives told us that staff and management were proactive in speaking to healthcare professionals and referring on as health care needs changed and were confident that their loved ones received the best care from dedicated professionals who were able to observe when people needed specialist support, assistance, or medical intervention.

Equity in experience and outcomes: Score 2

The service worked to ensure good outcomes for people and supported them in a way that promoted good health and wellbeing. People told us that the care was good and they had a say in all aspects of their care and staff supported what they wanted to do and how they wanted to achieve outcomes.

The outcomes focus did not translate into the care planning and although there was considered work on people having good outcomes and staff supporting them to achieve their desired outcomes. The support plans did not reflect this.

Planning for the future: Score 2

People had end of life care planning some plans were more comprehensive than others depending on if people were prepared to talk about their wishes to plan for the end of their lives. There was information on where people wanted to be and family members who they wished to be there. However, this was not consistent throughout the care planning, and some people had very little information apart from the desire not to be resuscitated. We talked to the registered manager regarding this and there was an intention to improve the overall care planning and incorporate more information regarding advanced directives.

Well-led

Shared direction and culture: Score 3

The service and wider provider organisation had an overarching vision, which was to “deliver the quality of care that we would want for our loved ones in a safe and caring service at the heart of the community.” There was an accompanying set of values - wellness, happiness, and kindness – which were used to underpin interactions with residents, employees, and the wider community.

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

We saw examples where the service had used mechanisms to ensure people who lived there, families, staff, and partners could collaborate and contribute to the service's direction. This included residents' meetings and mechanisms for gathering feedback as described above.

Managers and staff that we spoke with demonstrated pride in working at the service 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 service demonstrated suitable experience, capacity, capability, and integrity to properly understand the context in which they delivered care, treatment and support whilst embodying the vision and values of the service and provider organisation.

All managers and staff that we spoke with displayed commitment to the service, the residents, and their colleagues. Managers and senior staff were able to demonstrate inclusivity and an understanding and appreciation of suitable care delivery and associated risks to this.

We saw examples of where supportive performance management processes had been used. This included informal and formal performance management 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.

Staff were encouraged in their development. We saw examples where staff (including those recruited recently) were supported with training, guidance and mentoring to enhance their skills, performance, and confidence. Staff were allocated 'champion' status across a range of areas which managers told us promoted learning, development, accountability, and confidence.

There was evidence of the service and provider demonstrating appreciation to staff, including an employee of the month initiative.

The service manager and other senior staff told us that the provider's senior staff were approachable, knowledgeable, and supportive.

Freedom to Speak up: Score 3

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

The service manager told us they had an 'open door policy' and we saw evidence of this throughout our mock inspection. We observed managers and senior staff to be highly visible and frequently engaged with staff, people living at the service, 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 service had a suitable whistleblowing policy in place with information around the service referring to this and which all staff we spoke with were aware of.

The service had a designated Freedom to Speak Up (FTSU) guardian representative and a dedicated mental health first aider.

Workforce equality, diversity, and inclusion: Score 3

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

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. Staff files and other documentation demonstrated that the service 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 areas including care provision, risk assessment and management, and medicines optimisation.

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

The service's governance framework ensured the service operated effectively and to a set of prescribed standards. This included a programme of meetings (including those dedicated to quality improvement), 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 service sites to support learning and improvement.

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, with evidence of proper version control, approval and sign-off.

We saw evidence that managers and senior staff were continually checking that people were supported appropriately, staff were carrying out their roles properly, and that the premises and equipment were safe and fit for purpose. We saw that any issues or concerns identified were addressed within a suitable time frame.

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 service 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 service, including being considered as part of ongoing lessons learned processes.

Partnership and communities: Score 3

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

We observed that the service provided a wide range of activities and events for people and their relatives, including monthly 'markets' held on-site. We saw that there was ongoing engagement with a local school and a local children's nursery.

Other local organisations and bodies we saw the service had engaged with during the last 12 months included a local church, veterans' groups, the Women's Institute (WI), and the local branch of the Salvation Army.

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 service was focused on learning and improvement, including by working to dedicated and comprehensive improvement and action plans.

We saw that people living at the service 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 service 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.

Each of the provider's services had a staff representative who attended meetings with the provider's Chief Executive and other senior colleagues, with the aim of identifying and driving improvements.

Environmental sustainability / sustainable development: Score N/A

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

Sign Off

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

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

Manager's Name: _____

Date: _____

Delphi Executives Client Lead: Sallyann Robinson
Delphi Executive: Adrian Cavendish

Date: 22 April 2024