Nottinghamshire County Council

Quality Monitoring Audit Form

Westdale Care Home

(Residential)

Service Name:	Westdale Care Home (residential)		
Manager: (Are they registered with the CQC?)	Ms Doris Bridget Irene Straun: (manager) CQC Registered Ms Doris Bridget Irene Straun: Nominated Individual (NI) Stuart Best: Director		
Provider:	Westdale Quaker Housing Association Limited		
Type of Service:	Residential		
Home Address:	129, Melton Road, West Bridgford, Nottingham, NG2 6FG		
Email Address:	d.straun@westdalecare.com stuart.best@westdalecare.com		
Date of Audit:	03 February 2026		
Band:	Band 5	Previous Band / Score:	Band 5 [53]
Score:	54	Action Plan Required?	Yes

Key:	**Excellent**	**Good**
	Improvement Required	**Does Not Meet**

What actions were identified during the last audit?

Previous audit date (14th November 2017)	What was identified?
Previous Recommendations:	Ensure PEEPs profiles are updated to include any residents that have critical medication and use flammable creams. Actioned. Ensure the International Dysphagia Diet Standardisation Initiative (IDDSI) information is displayed in the kitchen. It's good practice for some staff to have access to training for (IDDSI). In the process of addressing this. Ensure information about all resident's end of life care specifics are obtained and documented in more detail. Actioned. Ensure if attempts are made to glean end of life care specifics without success, make sure that these attempts are recorded to evidence staff involvement. Actioned. Ensure staff are reminded that signature gaps on (medication) MAR Charts are not acceptable and could place residents at risk. It is advised that medication refresher training is completed, and the individual/individuals have their medication competency assessments reviewed. Actioned.

What actions were identified during this audit?

Audit date (23rd January 2019)	What was identified?
Standard One:	1.4: Ensure all the International Dysphagia Diet Standardisation Initiative (IDDSI) modified diet information for each resident is updated and kept up to date in the kitchen and display information about (IDDSI) in the kitchen area.
Standard Two:	2.5: Ensure all medication creams are dated on opening. They need to have a date of opening and a date of discard recorded on tubes, dispensers and containers. Obtain stickers to be used for this purpose.
Standard Three:	3.2: Ensure any outstanding training and refresher training for the staffing team is arranged, attended and completed. Ensure all staff training is kept up to date.
Standard Four	None.
Standard Five	None.

Standard One: People who use the service experience outcome focussed person centred care: People who receive a care service receives outcome focussed person-centred care, which considers their choices and preferences. Care is provided in a positive risk-taking environment, which supports people to make decisions regarding their care.

1.1 Each service user has a personalised support plan which identifies patterns of daily living. Service users and / or families / advocates are involved in the process and are able to contribute their views.

Score	Recommendations:	Observed Evidence
Excellent	None.	Desktop evidence was requested, and the provider responded within the specified timeframe. We reviewed the records during this visit. We looked at five care and support plans and found that these were consistently maintained to a high standard. Each plan was person-centred, outcome-focused, reflective of the individual's current care and clinical needs, and aligned with their wishes and strengths. Reviews are completed within appropriate statutory and organisational timescales. We also noted that staff involved the person, their representatives, and relevant professionals in all planning and review activities, ensuring information remained accurate, meaningful, and supportive of wellbeing, safety, and independence. All care and support plans are held electronically they use the Care Control system. We also found that supplementary paper files are maintained alongside the electronic records, providing quick and easy access in the event of an emergency. These include completed documents such as Respect Forms and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders. All residents' documentation and care planning records were stored appropriately.

1.2 Care / support plans include identified areas of risk and details how these will be managed and are reviewed, supporting service users to make informed choices.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we reviewed records during this visit. As part of our review, we examined a sample of care plans where risks had been identified. In every case, we found that an appropriate and relevant risk assessment had been completed and implemented. For example, where an individual required the use of specific equipment, a corresponding risk assessment was in place. All risk assessment reviews were clear, proportionate, and operating effectively in practice. We also confirmed that risk assessments are being reviewed within the required timescales, with prompt updates made when a person's needs change. We looked in more detail at the care plan for one resident who required support with continence care. We found a comprehensive assessment had been completed, with appropriate risk reduction measures identified and put in place. Care records demonstrated that the risk assessment was effective in practice. We also saw evidence that changes in the person's needs were reflected in timely updates to the assessment, and that required actions to minimise risk were consistently followed. Overall, the sample reviewed indicates that risk assessments are current, person-centred, and embedded in daily practice. We also reviewed staff training records and found that several staff members had completed training in risk assessment.

1.3 Accurate records relating to service users are completed in a timely way and stored in a safe place.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we reviewed records during this visit. Our review of care records showed that significant events were documented thoroughly, including occasions where residents declined elements of their care. Records also evidenced timely intervention from visiting health professionals. The documentation completed by the management team and care staff for GP and District Nursing visits was comprehensive, clear and informative. We also assessed how residents' records were stored and found that they were kept securely and handled with confidentiality. Staff could access the information they needed promptly, and records were organised in a way that supported the efficient delivery of care. Overall, this demonstrates that a live and accurate record of each person's significant life events is maintained, including any refusals of care. Staff clearly understand their responsibilities regarding confidentiality and adhere to General Data Protection Regulation (GDPR) requirements when managing residents' personal information.

1.4. Service users are afforded a choice of suitable nutritious food and in sufficient amounts in accordance with their identified needs and wishes.		
Score	**Recommendations:**	**Observed Evidence**

Good	Ensure all the International Dysphagia Diet Standardisation Initiative (IDDSI) modified diet information for each resident is updated and kept up to date in the kitchen and display information about (IDDSI) in the kitchen area.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we reviewed records during the visit. We spoke with residents about the quality and choice of food. They told us the meals were good and that a daily choice was offered. We reviewed relevant records and found the information provided to be accurate. During our observation of the lunchtime meal, we noted that it was a sociable occasion. Staff were seen assisting residents where required, and we observed them to be kind and respectful in their interactions. Meal and drink choices were promoted, and dignity and respect were consistently upheld throughout mealtimes. Menus were available, and staff were seen actively promoting these. We also reviewed nutritional assessments and found these had been completed where required. Training records confirmed staff had completed relevant training, such as hydration and nutrition. We spoke with the kitchen staff, who provided records and information relating to residents' likes, dislikes, preferences, special dietary needs, and allergies. We found that a review of these records was needed. For example, International Dysphagia Diet Standardisation Initiative (IDDSI) information requires updating for each resident. Also, details regarding (IDDSI) to be displayed in the kitchen area. We spoke with the chef/cook and they told us they would address this. We asked to look around the kitchen areas, and permission was granted. We viewed the fridges, freezers and pantry rooms and found all to be well stocked and well organised. Kitchen staff demonstrated good knowledge in their roles. We were told they have recently been assessed for food hygiene and have retained level rating 5. Records seen support this. The date of the inspection from Rushcliffe Borough Council is: 30 January 2026 with the next inspection planned to take place in January 2028.

		We saw completed MUST assessments, which were being used effectively to support residents. The Dietician and SALT teams are involved where required, and records supported this involvement. Overall, our findings demonstrate that residents are offered a choice of suitable and nutritious food in appropriate amounts, consistent with their needs, choices and wishes. Fluid charts viewed were up to date.

1.5. Service users are supported with dignity through individual stages of life, by staff respecting their choices and preferences.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also reviewed records during the visit. We found that improvements had been made in this area since the previous audit. Our review of several care and support plans showed that they were generally person-centred and, in many cases, included appropriate end-of-life care (EOLC) information. The manager informed us that they had been focusing on developing this area, and we found evidence of this through the establishment of advanced care plans and the completion of regular care reviews. We saw completed ReSPECT forms, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions, and documented records of Lasting Power of Attorney for both health and welfare, as well as property and finance. Our findings indicate that the provider ensures residents' confidential information is kept private and securely stored, in line with GDPR requirements. The provider has an up-to-date General Data Protection Regulation policy in place, and staff demonstrated a good level of understanding of this policy during our discussions. The care plans we reviewed also contained relevant information about residents' life histories, personal relationships, and religious or spiritual needs. In addition, our review of staff training records showed that staff had received appropriate training in end-of-life care and further training to take place.

Standard Two: Keeping People Safe: People are protected from abuse or the risk of abuse, including financial abuse and the safe handling of their medication. People are supported and needs are met in line with MCA and DoLs / DoLiC requirements.

2.1 Service users are protected from abuse or risk of abuse. Their human rights are upheld through the effective operation of safeguarding arrangements. These identify and prevent abuse and are responded to appropriately.

Score	Recommendations:	Observed Evidence
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. Our review of the service's safeguarding procedures found them to be comprehensive and clearly documented, including the contact details for Nottinghamshire County Council's Adult Safeguarding Team (MASH). Staff we spoke with demonstrated a strong understanding of what constitutes abuse and the correct process for reporting concerns in line with local safeguarding requirements. Training records confirmed that all staff had completed the necessary safeguarding training. We examined the safeguarding folder, which contained all referral information and investigation outcomes. It was well organised, clearly indexed, and divided into logical sections to support ease of navigation. Through discussion, the manager demonstrated a thorough understanding of safeguarding pathways, referral procedures, and the principles of Making Safeguarding Personal, as well as the processes for managing concerns that do not meet the threshold for safeguarding (None Safeguarding). Records also showed that the provider consistently submits statutory notifications to the Care Quality Commission (CQC), including notifications relating to deaths and other reportable incidents. The safeguarding policy is current and up to date.

2.2 Where the service user lacks capacity to make decisions, the requirements of the Mental Capacity Act 2005 are met.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested, and the provider responded within the required timeframe. Additional records were reviewed during the visit. Our review of a sample of care and support plans showed that individuals who lacked the mental capacity to make decisions about their care and treatment had been appropriately assessed. We found clear improvements in the completion of Mental Capacity Act (MCA) assessments and best interests decision records. All MCA/Best Interests documentation is now subject to ongoing review. The provider has an up-to-date and comprehensive Mental Capacity Act policy and procedure, reviewed in line with statutory and organisational requirements to ensure continued compliance with current legislation and best practice. We also reviewed staff training records and found that staff had completed MCA training within the past 12 months, with evidence of refresher training being undertaken. Overall, we found that the requirements of the Mental Capacity Act are being met.

2.3 Service users are protected and supported to live with the least restrictions to their liberties. Where the service user is subject to restrictions and restraint, they must be authorised under the Deprivation of Liberty Safeguards (DoLS) and Deprivation of Liberty in Community referred to in Nottinghamshire as (DoLiC).		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested, and the provider responded within the required timeframe. Additional records were also reviewed during the visit. Documentation relating to the Deprivation of Liberty Safeguards (DoLS) showed that all referrals sampled had been submitted appropriately and were being managed effectively, for example, any conditions attached to authorisations were clearly considered, transferred into, and reflected within the resident's care plan. Required actions were appropriately followed up, and statutory notifications were completed and submitted to the Care Quality Commission (CQC) as required. Documentation reviewed confirmed that the DoLS policy and procedure are current and subject to timely review in line with required standards. Training records evidenced that staff have completed DoLS training. The manager has also implemented a comprehensive DoLS matrix that clearly outlines application dates, acknowledgements, assessment dates, outcomes, and dates of CQC notifications.

2.4 Service users are protected from financial or material abuse.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested, and the provider responded within the specified timeframe. This criterion was not fully assessed during the 2026/2027 Contract Compliance Quality Monitoring audit. However, based on the information reviewed, no concerns were identified in relation to residents' finances during 2025/2026. We did check one resident's money pockets on this visit and found the counted money totals matched with the recorded amounts and totals, for example, [JS] £72.73p all correct and receipts for money deposits and purchased all matched. Should anything change over the coming months, the Quality Market Management Team (QMMT) will oversee the situation and take appropriate action if any concerns arise. We reviewed the finance policy provided and found it to be a comprehensive and detailed document covering finances and billable extras. The policy has been reviewed and updated, and it is easily accessible. We found any money held by the provider is secured away appropriately. Told they do not keep any credit or debit cards, pin numbers for residents.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure all medication creams are dated on opening. They need to have a date of opening and a date of discard recorded on tubes, dispensers and containers. Obtain stickers to be used for this purpose.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. We did not speak with residents or relatives about medication. Instead, we requested that the provider share their medication policies and procedures, and they complied. This included policies on the administration of covert medication, all of which were in date and recently reviewed. We reviewed the care plans for [5] residents and found that each contained clear information about their medication needs. Care plans had been updated to reflect any changes in prescribed medicines, and they described how residents preferred to receive their medication. Our observations confirmed that staff followed these preferences. Where residents lacked mental capacity to make decisions about their medication, we found that assessments had been completed and best-interest decisions were recorded. We reviewed the storage of medicines and found this met the provider's policies and procedures. Medication trolley was found to be locked and secured to the wall in clinic room when not in use. Daily records of clinic room and medication fridge temperatures were completed, up to date and aligned with best practice guidelines. The system for ordering medicines ensured adequate stock levels to meet residents' needs in line with their prescriptions. Homely remedies were managed safely and in accordance with the provider's procedures. We reviewed the process for disposing of medicines and found that records

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

accurately reflected the quantities awaiting return. Staff were able to clearly describe this process in line with the provider's expectations.

Medication administration records (MARs) for [3] residents matched the medicines documented in their care plans. Where medicines had not been administered, the reasons were clearly recorded. During our observations of a medication round, staff administered medicines safely and in accordance with prescribing instructions. Residents were informed about what was happening prior to administration, and staff ensured the medication trolley was locked and secure when unattended.

For residents prescribed 'as required' (PRN) medication, we found this was managed appropriately. Staff demonstrated good understanding of relevant policies and procedures, and PRN reviews were taking place regularly. Records of prescriptions were retained, and a current copy of the British National Formulary (BNF) was accessible.

Records relating to Controlled Medication (CDs) were accurate and matched the quantities held. Storage and administration of CDs followed the provider's policies, and appropriate consideration had been given to the placement of pain patches to avoid double dosing. All samples reviewed were correct, and all CDs were stored securely. Systems for safe disposal of CDs were also in place. Staff we spoke with described appropriate processes for administering and disposing of CDs. We observed safe administration of medicines by a senior care worker during lunchtime in the dining room and other areas of the home. Staff were able to explain how they would respond to an adverse medication incident, consistent with the provider's policies.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.

The provider had appropriate systems in place for residents assessed as able to self-administer medication. These included processes for assessment, safe storage, and monitoring, supporting residents' independence.

Training records showed that staff had received recent education in the safe handling of medicines. Competency assessments were completed before staff undertook medication administration duties. We saw evidence of regular medication audits. Documentation relating to topical medicines, including body maps, are being completed appropriately. Medication creams seen had a date of opening on. However, no date of discard. We spoke with the manager and senior care workers [2] and explained it is good practice to records both dates. Advised the manager and senior care workers to obtain date stickers for recording both dates. They told us they would do this.

Procedures were in place for any resident who required covert administration of medication. This process involved the GP, pharmacist, and relevant others, and included Mental Capacity Act (MCA) assessments and best-interest decisions. We were informed that there are no residents receiving their medication covertly at the time of this visit.

We found the clinic room to be clean, tidy and well organised. We asked about the Pharmacy used and they told us they find them helpful and supportive.

Standard Three: People who use services are supported by competent staff: People are supported and cared for by sufficient numbers of staff who are suitably recruited and sufficiently inducted and trained to provide them with the knowledge, skills and experience to be competent and professional.

3.1 Robust recruitment processes are completed with structured probation, supervision and appraisal arrangements in place for staff in line with Policies and Procedures

Score	Recommendations:	Observed Evidence
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. We reviewed a sample of staff files for employees recently appointed by the manager and found robust recruitment procedures in place. Application forms had been fully completed, providing comprehensive employment histories. All relevant pre-employment checks had been carried out, including verification of qualifications, right to work documentation, and Disclosure and Barring Service (DBS) checks. Adequate references had been obtained prior to the start date and had been appropriately verified. We also found evidence of signed contracts of employment and copies of identification documents. There are clear induction processes in place, and a defined probationary period, including a probation review within the specified timeframe. Staff received regular supervision sessions that provided opportunities to discuss professional matters as well as personal development needs. Annual appraisals are completed, and staff reported feeling well supported. The manager operates an open-door policy, and staff confirmed they could approach the manager at any time.

3.1 Robust recruitment processes are completed with structured probation, supervision and appraisal arrangements in place for staff in line with Policies and Procedures		
		We reviewed minutes from recent staff meetings and saw that structured meetings are taking place. A supervision and annual appraisal planner are also in place. Examination of the recruitment policy showed that it is comprehensive, up to date and subject to timely review in line with required standards. Overall, the findings demonstrate that residents can be assured that structured supervision and appraisal processes are firmly in place, supporting staff to deliver safe and effective care. Regular staff meetings are also held to promote clear communication and continuous service improvement.

3.2 Staff have the knowledge, experience, qualifications and skills to support the service users.		
Score	**Recommendations:**	**Observed Evidence**
Good	Ensure any outstanding training and refresher training for the staffing team is arranged, attended and completed. Ensure all staff training is kept up to date.	Desktop evidence was requested, and the provider responded within the required timeframe. Additional records were reviewed during the visit. We observed staff care practices and found they demonstrated a clear understanding of residents' needs. Their interactions were responsive, person-centred, and supportive. We spoke with two care staff members about the specific needs of residents; they were able to accurately describe each person's identified needs and the ways in which they provide support. Our observations also showed positive relationships between staff and residents. Residents we spoke with praised individual staff members. Staff reported that they receive extensive training and regular updates. Training records for staff provided by the manager indicates that training processes are working. However, there are some gaps for some staff where refresher training has expired (obtained details of these). The manager told us they are working hard to address this. Overall, this demonstrates that residents can be assured their care is delivered by staff who have the necessary knowledge, skills, and experience to provide safe and effective support. Refresher training is to be arranged, attended, and completed by some staff in line with the service's training plan.

3.3 Staffing levels for the service are determined and deployed according to people's assessed needs.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. We spoke with the home manager about how they determine the number of staff required. They explained that staffing levels are based on dependency assessments. We reviewed a sample of these assessments and found them to be an accurate reflection of each resident's needs, consistent with our own observations. We reviewed the staff rota and confirmed that the staff scheduled to be on duty on the day of our visit were present. We also looked at how staff were deployed throughout the home and found that they were appropriately distributed. Staff rotas showed consistent staffing levels across weekdays and weekends. We found activities were scheduled, and staff were available to facilitate them. Residents told us there is usually something happening in the home each day, and they can choose whether to take part. Overall, staffing levels at the service are determined and deployed in line with people's assessed needs. Rotas are effectively organised, and social activities are planned and delivered. Dependencies are used to calculate required staffing hours, and records show that actual staffing hours generally exceed these requirements. Staff reported that staffing levels are adequate.

Standard Four: Services are managed effectively: People receive high quality care through an effectively managed service. The provider/manager takes responsibility, is accountable for their actions, and has an effective system for identifying, assessing and monitoring the quality of the service provision.

4.1 People receive high quality care through an effectively managed service.

Score	Recommendations:	Observed Evidence
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. We looked at the provider's CQC registration on our visit and found that care was delivered in line with the registered regulated activities. We found that the home manager was registered with the CQC. We looked at the manager's qualifications, experience and training and found this to be appropriate, up to date, and suitable to lead the team. The staff we spoke with told us the manager is very approachable and supportive. Our observations of the home manager found they were able to lead the team.

4.2 There is an effective system for identifying, assessing, monitoring the quality-of-service delivery.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. We found evidence of comprehensive auditing processes in place to monitor quality of service delivery. We found the manager uses findings from audits to form an action plan with measurable outcomes, realistic timescales and who is responsible to drive completion, we found the results from findings within the audits are used to make improvements. The manager provided a sample of completed audit documentation. For example, weekly kitchen audit: 19/01/2026 and monthly medication audit: 16/01/2026. We found actions plans are generated if required. We looked at documentation and found residents and relatives surveys are completed regularly and evaluated. Told actions plans are compiled to address any shortfalls. Findings are generated and used to measure effectiveness and manage risk. Overall, there is an effective system in place for identifying, assessing, and monitoring both the quality-of-service delivery and any risks to the health, welfare, and safety of residents. Quality assurance assessments are carried out regularly. All evidence seen supports this.

4.3 There is an effective system for identifying, receiving, handling and responding to and learning from complaints and concerns raised.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. We reviewed the provider's complaints procedure and found it clearly outlined the expected timescales for responding, identified the responsible person, and included contact details for the Care Quality Commission (CQC). We found copies of the complaint's procedure were visible throughout the care home. We saw the complaints policy and found this was reviewed appropriately and up to date. We also viewed a folder containing written compliments from relatives, friends, family members and people using the service. These records demonstrated appreciation for the care and support provided. Several thank-you and greeting cards were displayed, expressing gratitude to the staff team for their kindness and support. A complaints matrix is used and kept up to date. We found this document provides all details and actions taken for any complaints received. We examined minutes from residents', relatives', and staff meetings and saw that people were given regular opportunities to raise concerns. Staff members told us there was a whistleblowing policy in place, and those we spoke with demonstrated a clear understanding of how to report concerns appropriately. We reviewed the complaints folder and saw that all complaints received had been fully investigated, recorded, and resolved appropriately. Some staff have received training in managing complaints. The complaints and the whistleblowing policies are reviewed and kept up to date and relevant.

4.4 How is technology used to enhance the delivery of effective care and support?

Score	Recommendations:	Observed Evidence
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. We spoke with the manager about the use of technology within the service. They explained that residents have access to a computer and Wi-Fi should they wish to use them for activities such as internet shopping, Facebook, FaceTime, and other social media platforms. We saw and found Smart TVs are also in use throughout the home. The provider has a Facebook page and was told this is very popular for residents, relatives and the staffing team. An electronic call bell system is in place, and the electronic care planning system is currently being used. Additional devices, including Alexa's and iPads are available for residents to use. Manager told us they are continually exploring further ways to enhance the use of technology within the service. Several residents also make use of sensor-based equipment to support their needs and safety. There is a policy relating to technology and found this to be reviewed appropriately and kept up to date. Overall, the findings show residents have appropriate access to technology whenever required, and electronic systems and processes are in place to support the effective and efficient running of the home.

Standard Five: Environment is safe and homely: People live in an environment which is clean, safe and personalised.

5.1 The accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. There are effective cleaning and maintenance schedules in place which ensure suitable standards of living are maintained.

Score	Recommendations:	Observed Evidence
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during the visit. During the audit we toured the home and found that individual living spaces were personalised to reflect residents' preferences. The home is maintained to a good standard, and any issues identified were addressed promptly and records seen support this. We looked at the garden areas and found these are also well maintained, offering several pleasant seating areas for residents to enjoy. Records seen indicate times when resident do access the garden spaces and these records have detail showing how the residents who go out are kept warm in colder weather and are being kept safe while outside in the garden or trips out into the community. We found the care home environment to be clean and well presented. We looked at completed cleaning schedules and records that support effective cleaning systems and processes. We reviewed maintenance records provided to us, which showed evidence of ongoing work around the home. Clear maintenance schedules are in place, including tasks such as wall redecoration and equipment servicing. We found communal areas are arranged effectively to support residents' care and comfort.

5.1 The accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. There are effective cleaning and maintenance schedules in place which ensure suitable standards of living are maintained.		
		The maintenance workers were in the care home at the time of this visit. They were making changes to a door in a downstairs unoccupied resident's room. The manager told us they have plans to upgrade rooms as they become available and to add an on-suite facility to several rooms (overtime). Records seen evidenced comprehensive and detailed documentation are kept for maintenance jobs and repairs. We saw staff using Personal protective equipment (PPE) correctly and effectively. We found the provider has sufficient stocks of PPE that is in date and a choice of varied sizes. Staff we spoke with were able to provide a good knowledge and understanding about PPE. Found the care home smelt fresh and free from any unpleasant odours. We also found that several improvements are currently planned or underway by the provider. Findings show there is an ongoing redecoration plan in place and has been for a while and new furniture has been purchased for some rooms and communal areas. The manager told us there is continued improvements being identified, for example, looking at the layout of the conservatory and where best to place items of furniture and declutter. The manager told us they do involve ideas from people who reside at the service. We looked at all resident's Personal emergency evacuation plans (PEEPs), and we found these to be detailed and individualised to each resident. We found these are being reviewed within appropriate timescales and are easily accessible for staff in an emergency. Found all the (PEEPs) documents are

5.1 The accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. There are effective cleaning and maintenance schedules in place which ensure suitable standards of living are maintained.		
		stored away securely and General data protection regulation (GDPR) is upheld. Overall, findings evidence the accommodation is safe, comfortable, and suitable for the care delivery and the service being provided is contributing positively to residents' health and well-being.

5.2 Infection Prevention Control, risks to health, welfare and safety of service users including fire safety and management.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Desktop evidence was requested and the provider responded to this request within the timeframe given and we also looked at records during this visit. We reviewed the systems in place for managing and monitoring health and safety within the service and found them to be robust and effective. Staff were well informed and appropriately trained in general health and safety and infection control policies, procedures, and relevant government guidance. Our review of training records confirmed that staff had completed all required training, including Infection Prevention and Control (IPC), COSHH, RIDDOR, Moving and Handling, and Fire Safety. A comprehensive training matrix is in place, clearly outlining completion dates and scheduled refresher dates for all mandatory training linked to this criterion. Management informed us that they maintain close communication with the NHS Infection Prevention and Control team, and the records we reviewed supported this. Equipment checks showed that items were regularly inspected, cleaned, and well maintained. Staff were able to clearly describe the process for reporting maintenance concerns, and we found that identified issues were appropriately addressed with clear documentation of actions taken.

5.2 Infection Prevention Control, risks to health, welfare and safety of service users including fire safety and management.

We looked at the laundry area found this to be clean and well organised. The COSHH storage cupboard was well stocked with cleaning products, gloves, aprons, and other materials. Through discussion with the housekeeping staff, we found they had a strong understanding of their responsibilities and systems. They explained that all incoming stock is stored in date order, rotated effectively, and accurately recorded in inventory documentation. Records reviewed supported this practice. Additional documentation reviewed included fire safety, environmental safety, water safety, food safety, and general health and safety and maintenance checks. Legionella records were in date and appropriately maintained.

Overall, the findings demonstrate that detailed and effective systems are in place to prevent and control healthcare-associated infections. The premises presented as clean, well maintained, and free from unpleasant odours. Staff received appropriate IPC training, and equipment was clean, well serviced, and fit for purpose.

What was observed in relation to innovation or creative ways of working whilst visiting? Did you have any conversations with staff, service users, and family members?

This section can be used to demonstrate innovative practice highlighting where provider / staff have gone above and beyond and to document good practice and the lived experience of the people living within each home / service.

Observed / Conversational Evidence:

We spoke with residents and they told us:
“It’s a pleasant place to live”.
“Really well looked after by the carers”.
“I do feel safe here”.
“My room is cleaned each day”.
“I would recommend this home”.
“Staff are kind and friendly”.

We spoke with relatives and they told us:
“I don’t have any concerns or issues here”.
“The manager does communicate with me about any changes to [residents name]”.
“I would say my [residents name] has progressed well since being placed here”.
“I can go away from the home and feel confident my [residents name] is being well looked after”.
“Very pleased with everything”.