Nottinghamshire County Council

Quality Monitoring Audit Form

Radcliffe Manor House Residential Care Home

Home Name:	Radcliffe Manor House Care Home		
Manager: (Are they registered with the CQC?)	Mrs Melanie Gayle Barron (CQC Registered)		
Provider:	Home of Rest for Old People Also Known as Radcliffe Manor House		
Type of Service:	Residential Dementia Care		
Home Address:	52 Main Street, Radcliffe on Trent, Nottingham, NG12 2AD Telephone no: 0115 9110138		
Email Address:	melbarron@radcliffemanorhouse.co.uk		
Date of Audit:	25 October 2023		
Band:	5	Previous Band:	5
Score:	53/57	Action Plan Required?	Yes

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

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
Good	Ensure care plan reviews are documented in more detail. Review recordings should show what has been taken into consideration when completing the written review.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. All care plans are now electronic. We spoke with residents who reside at the home, they told us they were very pleased with the care they received. We looked at a sample of care plans and found these were person centred and were completed with the resident and relatives, (Where appropriate), upon admission and found they detailed the level of support required. We found the care plans are reviewed on a regular basis and the resident was involved unless they stated otherwise. Within the care plans we looked at [6] we found the reviews were taking place. However, we felt the documented review evaluations required more detail. For example, “No changes” is recorded most of the time. Management is aware the reviews require more written detail. We found that residents’ personal choices, preferences and equality and diversity needs were considered with in the care plans. Where decisions regarding changes to the support of residents, the resident was included in the decision-making process (wherever possible). Recordings seen show relatives are included where possible. We found likes, dislikes and preferences were recorded, and this also included what type of activities they would like to be involved with. Activities were taking place in the home at the time of this audit visit.

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.		
		This means each resident has a personalised assessment and care plan that identifies, through inclusion, the patterns of daily living in relation to their assessed needs, individual's wishes, choices, goals and sets out how the support, care and/or treatment is to be delivered. Review evaluations require a more detailed evaluation.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. All care and support plans are now electronic. We looked at a sample of care plans and found where a risk was identified a corresponding risk assessment was in place. We looked at the care plan for one resident who was identified as needing support with the use of a hoist. We looked at the daily records and found the risk assessment was documented as working as expected. We saw changes in needs were used to update the risk assessment. Where actions had been identified to minimise the risk, these actions were put in place. This means care plans include identified areas of risk and detail how these will be managed. They are reviewed within appropriate timescales. Resident's personal emergency evacuation plans (PEEP's) are completed and up to date.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. All care records are now electronic. We spoke with a resident regarding their involvement in their care and support. Residents told they are asked about their care needs. We looked at daily records regarding what residents are involved in each day. We found that these records were relatively detailed. Several things are documented. For example, relative visited, went out into the community. Other things such as the district nurse came in and movement to music. We found the daily records should where a task is identified and what action has been taken or to be taken. We found that all residents care plans and documentation is stored away safely when not in use. We didn't find any concerns about General data protection regulation (GDPR). We found the staff we spoke with had a good understanding and knowledge of the residents they care for. This means residents are telling us they are involved in the care planning process and can contribute their views, opinions and understanding. Confidentiality regarding protecting resident's details is upheld. Care staff have comprehensive details, understanding and knowledge about resident's care needs and regimes.

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**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with residents regarding the quality and choice of food. They said, “We do get a daily choice and they do review meal options” and “Plenty to eat and drink” and “I don’t have a problem with the meals” and “They do offer my relative a meal when they visit as well”. We observed the lunchtime meal and found this was a very sociable occasion. Staff were seen assisting residents where needed. We found the staff to be kind and respectful to the people they care for. Plate guards are used (where needed) and residents have a choice of where to sit in the dining room and if they wish they can have their meals in their bedroom. We saw the staff offering a choice of hot and cold drinks to residents throughout this visit. One relative said “My [residents name] never complains about not having enough food and drink”. We found Nutritional assessments had been completed where required. We looked at the training records and found staff have competed any relevant training. For example, hydration and nutrition. We spoke with staff, and they provided us with records and information to support residents likes, dislikes, preferences, special dietary needs, and any allergies. We spoke with the chef and chef assistant in the kitchen, and they were able to provide us with a good knowledge and understanding of their working area and residents’ food and drink requirements. Records relating to resident’s special dietary needs are kept in the kitchen and we found they were up to date. Records seen evidence the involvement of the dietician and SALT team. This means residents are afforded a choice of suitable nutritious food and in enough amounts for their needs in accordance with their identified needs and wishes. Relevant professionals are involved where required.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at [5] care plans found some care plans that documented person-centred end of life care specifics. They included considerations of the residents' preferences and wishes regarding care, support, and treatment. We also found that residents have a completed RESPECT form in place. We looked at the care plan for one resident who had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) in place. We found this had been completed appropriately and was in line with the MCA requirements. We looked at the associated care plan and found this had been documented. We saw the resident had been included in the decision regarding the DNACPR. Staff have received end of life care (EOLC) training. This means residents are supported with dignity through individual stages of life, by staff respecting their choices and preferences. Staff have received end of life care and dignity training.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at the safeguarding procedures and found this to be detailed and included the contact details for Nottinghamshire County Council's adult safeguarding team (MASH). We spoke with staff regarding their understanding of adult safeguarding and found they knew what abuse is and how to report this, using the local reporting requirements. We looked at the training records and found staff had completed safeguarding training. We looked at the safeguarding folder which contained the safeguarding information for all referrals, investigations, and outcomes. We found this folder to be well organised, divided into sections (for easy use) and indexed. On discussion with the manager, they were able to provide a good knowledge and understanding of the safeguarding pathway and referral procedures for making safeguarding personal. There is a whistle-blowing policy and procedure and staff we spoke with were able to provide details about this policy and procedure. We saw evidence to support the completion of the Care quality commission (CQC) statutory notifications and completed accident and incident records. This means residents are protected from abuse or risk of abuse. Staff have completed the training they require regarding safeguarding procedures.

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**
Good	Ensure Mental capacity act assessments (MCA/BI) are completed for residents that lack the capacity to make decisions about the use of equipment.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at a sample of care plans and found people that lack capacity around their care and treatment are assessed. We found Mental capacity and best interests'(MCA/BI) assessments had been completed for several areas of care and support. We also, found MCA/BI assessments that needed completing. For example, for residents that lack capacity around the use of equipment. We spoke with the management about this, and they told us they would action any gaps in assessments sooner rather than later. We looked at staff training records and found that staff had received Mental capacity act (MCA) training, within the last 12 months and this included any refresher training needed. This means the requirements of the mental capacity act (MCA) are mostly met. A review of MCA/BI assessments for equipment use is required. Staff have received the appropriate training.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. Records seen show that any DoLs referrals have been submitted and have been and are being managed appropriately. For example, any conditions are looked at and transferred and used in the respective care plan for the resident. Any actions are addressed. Findings indicate that statutory notifications are completed and forwarded to the Care quality commission (CQC) by the management. We found several referrals are awaiting assessment from the DoLs team. Evidence seen shows the provider keeps in touch and communicates with the DoLs team regularly about these referrals. Training records seen show that the staffing team have received DoLs training and evidence seen supports the completion of refresher training as well. This means the requirements of Deprivation of Liberty Safeguards (DoLs) are met. Staff have received Deprivation of liberty safeguards (DoLS) training. All documentation relating to DoLs is in good order.

2.4 Service users are protected from financial or material abuse.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	There have not been any recent concerns about the provider managing residents' finances ineffectively, therefore this has not been assessed during this audit review for 2023/2024. If any concerns or other intelligence regarding this in the future is bought to our attention, then we will get back involved to review. This means that residents are protected from financial abuse.

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 handwritten medication administration records (MAR) charts always contain two witness signatures.	Robust evidence was gathered and assessed relating to this standard during audit process 2023/2024. We did not speak with residents or relatives about medication. We requested that the provider show us their medication policies and procedures, they complied with our request. This also included policies regarding the administration of covert medication. We looked at the care plans for [6] residents and found that these included considerations of their medication. We saw that where changes in medication had been made, care plans were updated accordingly. We found care plans described how residents preferred to receive their medication, and our observations demonstrated this to be true. We found where people were identified as lacking the mental capacity to make decisions regarding their medication, best interest decisions are appropriately completed (as and when needed). There is one resident currently receiving their medication covertly. All relevant documentation is completed and

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reviewed. We looked at the storage of medicines and found that this was in line with the provider's policies and procedures. We saw medication trolleys used are secured to a wall in the clinic room, when not in use. We saw there was a daily record of medication fridge and clinic room temperature measurements, and these were in line with best practice guidelines. All up to date.

We looked at the system for ordering residents' medicines. We found the system ensured there was enough quantities in stock to meet individual residents' needs and in line with their prescriptions. We looked at the homely remedies and found these were being managed appropriately and safely and in line with the provider's procedures.

We looked at the system used for the disposing of medicines, and found the records matched the quantities of medicines held awaiting return. We spoke with staff and their description of the process for returning medicines matched the provider's policies and procedures. We looked at the medication administration records (MAR) for eight residents. We found that records of medicines being administered matched those identified in in the care plans. No signature gaps evident for the ones we looked at. Some handwritten MAR charts didn't contain two initials when being checked (details obtained for evidence). On discussion with the manager, they told us they would investigate this with staff and correct this.

We saw where medicines were not administered; the records indicated the reasons for this. Our observations of staff during the medication round found that they were administering medicines safely and in line with prescribing instructions. We found residents were informed by staff of what was happening prior to administration, and we saw that staff ensured the medication trolley was locked and safe when not being attended.

We saw where residents have been identified as requiring their medicines 'as and when required' or PRN; we found these to be managed appropriately. Our discussions with staff assured us they understood the provider's policies and

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

procedures in this area. We looked at the residents' care plans and found that reviews of PRN medicines were taking place on a regular basis. We saw that records of resident's prescriptions are kept, and a current copy of the British National Formula (BNF) was accessible.

We found that the records for Controlled medication (Controlled Drugs CD) were accurate and reflected the quantities of medicines held. The storage and administration of controlled drugs was in line with the provider's policies and procedures. We found consideration had been given to the placing of patches, to ensure residents did not receive double doses. The sample of controlled medication we looked at were correct. We found all controlled medication was stored and locked away appropriately.

We found systems in place for the safe disposal of controlled drugs. We spoke with staff regarding their understanding of how to administer and safely dispose of controlled drugs. Their description assured us they were ensuring residents medicines were being administered safely. We saw the senior care worker administering residents' medication safely at lunchtime in the dining room and in other parts of the home.

We spoke with staff regarding how they would deal with an adverse medication incident. Their description of the actions they would take matched the provider's policies and procedures. We found for those residents who were responsible for their own medication, we found appropriate systems in place for the assessment, safe storage, and handling, whilst maintain the residents' independence.

We looked at the provider's records of training and found that all staff that require this have received recent training in the safe handling of medicines. We saw that prior to staff undertaking medication administration, their competency was checked and evidence to support this has been obtained. We saw copies of completed medication audits documentation that have been completed. We looked at documentation relating to the application of medication creams.

2.5 There are systems in place to ensure medication is obtained, stored, and administered, reviewed documented and disposed of effectively and safely.		
		We found that these were being applied, signed for, and recorded appropriately. We looked at a sample of medication cream dispensers and tubes and we found these have a date of opening and date of discard recorded on them. This means that there are systems in place to manage, store, administer and document resident's medication to ensure residents are protected. There are times when handwritten (MAR) charts do not have two witness signatures evident and this is to be reviewed by management. A review of Topical medication administration records (TMAR) charts is to be completed.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at a sample of staffing files [5] and we found that all appropriate checks have been completed. For example, obtaining 4 forms of identification, Disclosure barring service (DBS) checks. We found completed copies of staff induction programmes. Also, references from past employers. There are identification photographs on the staffing files. We spoke with care staff, and they told us they do feel supported by the management. We spoke with the management about supervision and appraisals for the staffing team. Asking how they provide support. They told us they received formal supervision every 2 months. We looked at supervision records [4]. We found that the timescales for completion of supervision sessions is approximately every 2 months. We found that staff do receive an annual appraisal. We also found that staff meetings are held on a regular basis. Care staff told us the management have an open-door policy, so they can speak with a member of the management as and when needed. During our visit to this service, we saw evidence to suggest the open-door policy works well. This means structured supervision and appraisal arrangements are in place for staff. Staff meetings are held. Staff can meet with the management when they wish (the management has an open-door policy).

3.2 Staff have the knowledge, experience, qualifications and skills to support the service users.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None. Note: All staff to receive Oliver McGowan training.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We observed the care practices of staff. We found they understood the needs of residents, and we found they were responsive and person-centred in their actions. We spoke with [2] care staff about the specific needs of residents. They were able to describe to us the resident's identified needs and how they support them. We looked at the training records and statistics provided by the manager and found staff had completed compulsory and appropriate training needed within the last 12 months. Evidence obtained for reference. All staff to receive Oliver McGowan training. Management have told us they will arrange this training. This means residents can be assured that the staff team delivering their care has all the relevant knowledge and experience they need to provide safe care and effective care. All staff to complete Oliver McGowan training.

3.3 Staffing levels for the service are determined and deployed according to people's assessed needs.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with the home manager regarding how they determined the number of staff and skill mix required. They told us they use dependency assessments. We looked at the dependency assessments for residents and found these to be an assessment of the needs of each person. We looked at the staff rota and found the staff planned to be working on the day of our visit matched those who were at work. We looked at how staff were deployed around the care home and found staff were well distributed and an allocation record is kept and used. Staff rotas documented the same staffing levels at weekends. We obtained sample copies of the completed dependencies for this month and found these are a calculation of the staffing hours needed to manage the care needs of all residents who reside at the home. Recorded staffing hours seen evidence that hours are over the required amount needed. We looked at how meaningful group and individual activities were planned. We found activities were planned and the staff were available to facilitate these activities. We spoke with residents regarding how they spent their time. They told us there is something happening in the home each day if you wish to get involved. This means staffing levels for the service are determined and deployed according to people's assessed needs. Staffing rotas devised and social activities for residents are planned and provided.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with residents and asked them if they knew who the home manager was. They told us they were aware of who the manager was and spoke with them most days. 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 Care quality commission (CQC). We looked at the manager's qualifications, experience and training and found this to be appropriate, and suitable to lead the team. The staff we spoke with told us the manager was very supportive. Our observations of the home manager found they were able to lead the team well. We saw a copy of the completed business continuity plan (BCP). This means the service and the manager is registered with the care quality commission (CQC). A business continuity plan is in place.

4.2 There is an effective system for identifying, assessing, monitoring the quality of service delivery.		
Score	**Recommendations:**	**Observed Evidence**
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We found evidence of comprehensive auditing processes in place to monitor quality of service delivery. We found the manager use 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 produce reports to inform the owner of the service. We found evidence that audits had been completed on a regular basis, with overarching annual review to inform the organisation. Example, we saw are: Infection prevention and control audits, Medication audits and many others. We asked the provider to comment on how residents are consulted about the running of the service. They told us they hold meetings. We looked at the minutes of resident's, relative's and staff meetings and found these had been held regularly. Quality assurance surveys are completed (questionnaires). We were provided with the documentation following the most recent assessment. There is also a company used called: Swift and they support with quality assurance and the service improvement plan. This means there is a system for identifying, assessing, monitoring the quality of service delivery and risks to health, welfare, and safety of residents. Quality assurance questionnaire surveys are completed and evaluated.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with residents and asked them whether they knew who they would make complaints to or raise their concerns if they weren't happy with the care they received. Resident's spoken with were able to identify correctly who they would escalate any concerns, worries or niggles to. We looked at the provider's complaints procedure and found this contained timescales, the responsible person and contact details for Care quality commission (CQC). We saw copies of the complaint's procedure on display in the care home. We looked at residents, relatives and staff minutes of meetings and found there were opportunities to raise concerns. We found records relating to any complaints had been addressed appropriately and stored away safely and confidentially. This means there is an effective system for identifying, receiving, handling, and responding to and learning from complaints. Records are up to date and safely stored.

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

Score	Recommendations:	Observed Evidence
Excellent	None.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. Computers are used to send emails by the manager and care staff. There is a new electronic care planning system in place. The staff have worked extremely hard over recent months to transfer all the data over to this new system. We spoke with the manager. We asked them whether they use any other technology. They told us residents use Skype/Zoom and FaceTime for contacting relatives, family, and friends if they wish too. We were told that I-pads are available. Evidence seen supports this. We looked at one and found that these are also used by residents and for taking and storing photographs. Staff told us residents sometimes use them for playing games. The home has an electronic call bell system in place. This means residents do have access to technology as and when needed.

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
Good	Continue to ensure the care home improvement plan is implemented. Note: there has been a new passenger lift installed and we were told this is working very well and a resident told us, "Having the new lift has improved things for us enormously".	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We spoke with residents [3] regarding the physical environment of the care home. They told us they liked the home and felt decorative improvements have been happening recently. For example, landings and corridors. We found what we had been told was true. There is a service improvement plan in place. Told the fire officer has requested all woodchip wall covering on the corridors is to be removed and replaced with more suitable wallpaper. Evidenced the programme for removal has commenced. The manager told us it is being completed as per the improvement plans and in stages for least disruption to residents and the running of the home. We looked around the care home, at communal spaces, residents' rooms, bathrooms, and toilets. We found the premises to be maintained to a good standard. We looked at the exterior and grounds and gardens of the care home, and we found these to be maintained to a good standard. We found that resident can access the garden when they wish. We saw suitable garden furniture and seating available. We found the garden to be a pleasant space for residents. We looked at a sample of cleaning schedules and found these show details of how to clean effectively. Cleaning schedules also show that night staff carry out cleaning tasks. We looked and found that staff have access to hand washing, toileting and/or bathroom facilities. Records show that each resident's room is deep cleaned on a regular basis. Staff told us if a resident moves out or passes the room is deep

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.		
		cleaned and decorated. We saw a sample of completed maintenance schedules. The maintenance staff member attended at the time of this visit. This means the accommodation is safe, comfortable, and suitable for the service delivery and promotes well-being. Decorating in the home is being completed as per the fire officer's recommendations.

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.	Robust evidence was gathered and assessed relating to this standard during the audit process 2023/2024. We looked at systems in place and found there is a system for managing and monitoring health and safety within the service. We found staff adequately were informed and educated about general health and safety and infection control policies, procedures, and government guidance within the home, and this also includes Coronavirus (Cvd19). We checked the training completed by staff and found staff had completed training in these areas. For example, Infection prevention and control (IPC), COSHH and RIDDOR training and training about Coronavirus (Cvd19). We were told by the manager that they keep in close contact with the NHS Infection prevention and control team and Public Health. We looked at equipment and found these had been regularly checked and maintained. Staff are aware of how to report any maintenance issues. We found where issues are identified all measures are followed to rectify them with clear actions being documented. The person responsible for maintenance attended the home at the time of our visit. We found fire assessments had been completed and fire equipment checks had been completed as required. We saw records regarding the completion of Infection prevention and control (IPC) audits and action plans are generated when required. Fire risk assessment is dated: 25/07/2023 with a review date of: July 2024. Also, Legionella Certificate is dated: 11/08/2023 with a review date of: August 2024. This means there are systems in place to help prevent and control any health associated infections. The premises are clean, well maintained and smell pleasant. The staffing team have received the appropriate training.