Gold Standards Framework Accreditation/Reaccreditation Quality Hallmark Award Final Assessment Report			
Care Home Details			
Name of Home & Coordinator	Brook House Michelle Hood		
Address	15 Bell Lane, Husbands Bosworth, Lutterworth, Leicestershire LE17 5RP		
Telephone Number			
Name of Visitor/s	Annabel Foulger		
Date of visit	1/07/25		

Final Score - 75/75

The total score is 75 for Accreditation, 80 for Reaccreditation.
Scoring for Not achieved (Score 0), Working Towards (Score 1) and Achieved (Score 2)
To meet requirement for a visit they must reach a score of – 30/75 or 32/80 (40%) on the portfolio.
To meet requirement to obtain a pass award they must reach a score of - 60/75 or 64/80 (80%)– must also have to achieved on all the Must Dos.
Reaccreditation only – to be nominated for Care Home of the Year – you must achieve a score of 80/80 (100%)

Preliminary result – Please highlight the appropriate result for this care home.	**Pass**	**Defer**
FINAL PANEL RESULT	**Pass**	**Defer**

Panel Decision and comments	Congratulations to all staff on achieving full marks to gain your GSF Quality Mark in end of life care. We understand that this takes commitment and dedication from the whole team. Well done!

Must Do Key Tasks	Not Achieved	Working towards	Achieved
1.2			***Achieved***
2.1			***Achieved***
3.5			***Achieved***
4.1			***Achieved***
7.1			***Achieved***

Feedback to panel	A 41 bed family run home with a with a goal of running "outstanding care services". Priority is placed on ensuring that residents have a high quality of life including bespoke trips and meeting individual wishes. Care in the final days is carried out with confidence and sensitivity. Staff are valued and training and support is a priority.

Areas of Strength	*Relate to key tasks* Key Task 3 There is strong emphasis placed on home from home care and quality of life. Residents are enabled to live well in the care home. This includes enabling a good quality of life including physical, emotional, social and spiritual care. Robust measures in place help residents stay at home and reduce avoidable hospitalisation. Key Task 4 Care in the final days is of high quality, supporting residents to die well in their care home, if that is their wish. There is good after-death care for the resident and others. Key Task 5 There is awareness of the needs of relatives, friends and carers and proactive support is offered. Staff are imaginative and positive in providing support and care to relatives, during the final days and in bereavement. Key Task 6 Compassionate dignity-enhancing care is given by all staff, who are themselves supported and enabled through reflective practice and self-care, within a compassionate culture. Staff training and support is a priority. Key Task 7 High quality care is systematic and consistent for all residents.
Areas for Development	Key Task 2 Use the "Getting to know you" conversations with residents and families to establish their likes and dislikes, what is important to them in their lives as a starting point for the "What matters to me now?" discussions. This can help gather the details of the ACP which is then more about quality of life in final days. This should also help staff feel more confident about having these conversations.
Feedback from Staff, Relatives, and residents on assessment visit	The Manager /co-ordinator led the visit and two Deputy Managers were available throughout. They talked through all the GSF processes and how they are put into practice in the home. Staff discussed residents who they had cared for at end of life and the difference that having an ACP in place had made. The staff showed sensitivity, understanding and imagination in how they provided care for the residents and relatives. "Now that we have these systems in place we ensure that all staff are given the opportunity to discuss GSF and the coding in all staff meetings as there is always a special section on this", "the staff know that if they have any questions about this then they can discuss it as part of an open forum or they can come and speak to us in confidence." A long term resident of 5 years spoke very positively of the care that she has received at the home over that time. She had specifically requested to move

	to this home as it had a good reputation for care and her sister had lived here previously. She said that she felt all aspects of life were supported and has enjoyed the spiritual support of the regular services held in the home. The daughter of a previous resident spoke on the phone about the care that her mother received. She said that her mother had been a carer herself so had high expectations. “This home fulfilled the remit.” The daughter said that “nothing had been too much trouble “ and she felt that the leadership is compassionate and that everyone is treated as themselves, as individuals. She described how at the end stages of her mother’s life “They (the staff) took the fear away and cleverly took away the need for me to be my Mum’s carer so that I could be her daughter again.” “They made me feel that she was safe.” “Her final days were calm, peaceful and dignified.”	
Portfolio Feedback – i.e., content, presentation, easy to read, etc	Portfolio well organised and structured using 7 key tasks. Statements included in the portfolio document- fully detailed. All evidence provided. Trackers and action plans included. All ADAs seen on the visit.	3/3
Visit Assessment Feedback i.e., welcoming, organised, observations made, compassionate culture, team spirit, residents well-being observed, etc	The staff team were welcoming and well prepared for the visit. The electronic PCS care plans were available to view and a printed copy of the portfolio was also available. Staff were attentive and compassionate to residents. Staff had a good rapport with each other in the team and were also welcoming working well with external organisation in the building. On the tour of the home, it was clear to see that resident’s needs were being attended to and there was a choice of environments for them to enjoy, There were noticeboards introducing staff and also photos of activities and programmes of events. There was a staff area with information about training, wellbeing and support. There was a quiet area for relatives with useful and supportive information available.	3/3
Portfolio mark (7 key tasks)		48/48

1. Pen Picture – any comments	The pen picture describes the background, location and size of the home. It describes the facilities and services provide. It also describes the goals and ethos of the home. There is strong emphasis placed on home from home care and quality of life.	
2. Case Study	Detailed case study which gives the background to the resident's health and situation. Assessment and coding on admission. As her health condition and coding changed actions were triggered and care adapted. Assessment tools not mentioned but the tools used are mentioned in KT1 Resident and family discussed end of life wishes including DNACPR and no hospital admissions. GP involvement. Resident's social, emotional and spiritual care prioritised as well as comfort. Anticipatory meds in place. Resident died in preferred place of care with family around her. Resident had been very clear about funeral plans and wishes. No mention bereavement support to family although details of how bereavement support is provided in KTs 4 and 5 and seen on the visit No reflection from staff but arrangements for staff to see around funeral directors so that they know what happens when someone leaves their care- recognition that it can be like losing a member of the family.	Score 3 /3
	No evidence of coding triggering actions. No evidence of ACP/BI discussion. Resident did not die in PPC. No/little evidence of family being offered support. No evidence of staff support (0)	
	Coding evidenced but does not appear to trigger actions. ACP/BI discussions take place but does not appear to influence care. No evidence that person was not alone when they died (unless their choice). Some support for family but no evidence of staff support. (1)	
	Evidence of coding triggering actions and ACP/BI discussions influencing care & wishes being achieved. Residents emotional, social, and spiritual needs identified & supported. Other healthcare professionals involved as appropriate. Family supported at time of death. Resident dies in PPC, not alone unless their wish. Evidence of bereavement support to family and staff. No reflection from staff (2)	
	Evidence of coding triggering actions and ACP/BI discussions influencing care & wishes being achieved. Residents emotional, social, and spiritual needs identified & supported. Other healthcare professionals involved as appropriate. Needs of family carers identified from admission onwards until death of resident. Resident dies in PPC, not alone unless their wish. Evidence of bereavement support to family and staff. Reflection from staff with action points (3)	
Submitted in re/accreditation portfolio Y/N and comments to support quality of		**Score**

<table>
<tr><td>3. Key Outcome Ratios (KOR)</td><td>Over 80% residents died at home, with an ACP in place, had a DNACPR in place, had anticipatory drugs in place, and a personalised care of the final days of life plan in place and achieved PPC. Bereavement support and bereavement leaflet provided for all. Questionnaire not used.</td><td>3/3</td></tr>
<tr><td colspan="3">Scoring is out of 3 on the KOR.
0/3 No KOR submitted or a higher proportion of deaths in hospital rather than at home with no evidence of proactive planning in place.
1/3 Less than 60% of residents died at home and inconsistency with ACP s. Less than 60% had a DNACPR in place, had anticipatory drugs in place, and a personalised care of the final days of life plan in place, and achieved their preferred place of death, have a bereavement leaflet, and offer support and gather feedback from families.
2/3 Less than 80% of residents died at home with ACP. Less than 80% , had a DNACPR in place, had anticipatory drugs in place, and a personalised care of the final days of life plan in place, and achieved their preferred place of death, have a bereavement leaflet, and offer support and feedback from families being in place.
3/3 80% or over – residents died at home, with an ACP in place, had a DNACPR in place, had anticipatory drugs in place, and a personalised care of the final days of life plan in place, and achieved their preferred place of death, have a bereavement leaflet, offer support and gather feedback from families.</td></tr>
<tr><td>4. 5 ADAs, required</td><td>Each individual ADA needs to be scored out of 3.
0/3 – No ADAs submitted.
1/3 – Inconsistency of GSF embedded in practice.
2/3 - Evidence of GSF embedded in practice, but SEA does not demonstrate reflective practice.
3/3 Evidence of GSF embedded in practice and evidence of open and honest reflective practice and actions identified according to need.</td><td>Score 15/15</td></tr>
<tr><td>5. Reaccreditation only – sustained improvement in standards</td><td><table>
<tr><td>Home has not been able to demonstrate that they have maintained the expected level of Gold Standards Framework</td><td>0/5</td></tr>
<tr><td>Home has maintained the expected level of Gold Standards Framework</td><td>1/5</td></tr>
<tr><td>Home has maintained the expected level of Gold Standards Framework
Home has demonstrated that areas of development highlighted from last accreditation round have been met and introduced within the home.</td><td>2/5</td></tr>
<tr><td>Home has maintained the expected level of Gold Standards Framework
Home has demonstrated areas of development highlighted from last</td><td>3/5</td></tr>
</table></td><td>Score /5</td></tr>
</table>

	accreditation round have been met and introduced within the home • Home has demonstrated areas for development that they highlighted within their action plan from last round have been introduced and met		
	• Home has maintained the expected level of Gold Standards Framework • Home has demonstrated areas of development highlighted from last accreditation round have been met and introduced within the home • Home has demonstrated areas for development that they highlighted within their action plan from last round have been introduced and met • Home has demonstrated further areas of development and innovation within the home	4/5	
	• Home has maintained the expected level of Gold Standards Framework • Home has demonstrated areas of development highlighted from last accreditation round have been met and introduced within the home • Home has demonstrated areas for development that they highlighted within their action plan from last round have been introduced and met • Home has demonstrated further areas of development and innovation within the home. • Home has demonstrated working with outside organisations to improve practice e.g. working with local end of life care forums, dementia steering and support groups, contributing to research etc.	5/5	
Statement from Clinical Associate to support why the home is being nominated for Care Home of the Year?			

(Reaccreditation only)	

Assessment document and scoring criteria. Each section scores 0, 1, 2,				
Key Task	**Details for accreditation**	**Not Achieved (0)**	**Working Towards (1)**	**Achieved (2)**
1. Residents identified early Early recognition of resident's phase of illness and level of need is identified, enabling more proactive supportive care.	1.1 All residents are Needs-based coded (RAG-B/ABCD) *(see evidence 1a, incl., information gathered from statement and visit)*			2
	1.2 **Needs Based Coding triggers appropriate actions for each phase - use of needs support matrix/core care plan to trigger the right care is given at the right time (*see evidence 1b incl., information gathered from statement and visit)***			2
	1.3 Residents are assessed for frailty (see evidence 1c incl., information gathered from statement and visit)			2
	1.4 There is effective communication, awareness, and processes to ensure that key staff are involved in coding, and all staff are aware of it. Coding is communicated in different ways and shared with others, e.g., GPs, OOH providers, EPaCCS, and community teams *(see evidence 1d incl., information gathered from statement and visit)*			2
	Evidence required			**Tick if ✓ received**
	1a. Coding board/handover sheet /digital documentation showing all residents coded.			**Y**
	1b. Needs support matrix completed, or core care plans or digital documentation that clearly demonstrates actions triggered following the change of coding of a resident.			**Y**
	1c. Copy of the frailty assessment tool being used, and evidence of the severity documented in resident's notes			**Y**
	1d. Evidence of information of coding sent/discussed with GPs, OOHs, etc.			**Y**
	PORTFOLIO MARKER – Any questions to be clearly marked **Q** for visitor to address. Any comments to further support findings or where outstanding work is recognised: - Clear detailed statement includes all essential information.			

	"After our coding review or if a resident's code is changed prior to this then this is communicated with all staff using the communication book which is information passed over to all staff on each handover shift and we also discuss resident coding at staff meetings."			
	VISITOR TO COMPLETE – Any **Qs** are to be clearly responded to. Any comments to further support findings or where outstanding work is recognised: - Coding is achieved through using SBARD, NEWS2, The Edmonton Frailty Scale and the Needs Support Matrix.			
	AREAS FOR DEVELOPMENT			
2. Offered ACP Discussions Advance care planning discussions (or best Interest discussions) are offered to every resident leading to person centred care in line with preferences.	**Details for accreditation**	**Not Achieved**	**Working Towards**	**Achieved**
	2.1 There is a clearly documented process of routinely offering ACP or Best Interest discussion for every resident including preferred place of care and proxy spokesperson/LPOA for health & welfare as appropriate). Preferences are translated into care to ensure person centred care *(See evidence 2a, 2c, 2d, and 2f, incl., information gathered from statement and visit)*			2
	2.2 Mental capacity assessment undertaken as appropriate and best interest discussion with family/friends recorded where there is lack of capacity. (*See evidence 2b and 2c, incl., information gathered from statement and visit)*			2
	2.3 Resuscitation/DNACPR discussed and recorded by lead. clinician/GP/accredited nurse and staff are fully aware of decisions made for each resident. *(see evidence 2e, incl., information gathered from statement and visit)*			2
	Evidence required			**Tick if ✓ received**
	2a. ACP Tracker form 3.			Y
	2b. Completed ACP for resident in the home (anonymised)			Y
	2c. Completed best Interest discussion documentation relating to Advance Care Planning			Y

	2d. Example of ACP leaflet offered to residents/families.			Y
	2e. Completed DNACPR /ReSPECT form (anonymised).			Y
	2f. Reflection from a carer of achieving a residents' wishes at end of life were and how they were achieved.			Y
	PORTFOLIO MARKER – Any questions to be clearly marked **Q** for visitor to address. Any comments to further support findings or where outstanding work is recognised: - Statement describes a good open system of informing residents and family about the value of ACP discussions. 2a Ask about ACP completion and recording tracker. All completed on the same day – all reviewed on the same day. Relate to days when the discussions actually happened. The completed ACP does not show any wishes around care 2f 2 lines of reflection at the end of the description. No mention of ACP and impact of that.			
	VISITOR TO COMPLETE – Any **Qs** are to be clearly responded to. Any comments to further support findings or where outstanding work is recognised: - Discussed the process of offering ACP discussions. All residents and families are offered the discussion and there is plenty of supporting information available but uptake is low and existing ACPs are not detailed. The ACP tracker was discussed and the date filled in was the date of a review rather than when each discussion was offered or ACP completed..			
	AREAS FOR DEVELOPMENT Use the "Getting to know you" conversations with residents and families to establish their likes and dislikes and what is important to them in their lives, as a starting point for the "What matters to me now?" discussions. This can help gather the details of the ACP which is then more about quality of life in final days.			
3. Living Well Planned Residents are enabled to live well in the care home. This includes enabling a good quality of life	**Details for accreditation**	**Not Achieved**	**Working Towards**	**Achieved**
	3.1 Physical support is evident- promotion of proactive clinical care to reduce. dehydration, infections, falls and good symptom management. *(See evidence 3a, and 3b, incl., information gathered from statement and visit)*			2
	3.2 Social care and emotional wellbeing is enhanced. *(See evidence 3c, incl., information gathered from statement and visit)*			2
	3.3 Spiritual care is recognised as enhancing quality of life. *(See evidence 3e and 3f, incl., information gathered from statement and visit)*			2

including physical, emotional, social, spiritual, and practical areas and measures to reduce avoidable hospitalisation.	3.4 There is person centred care and a practical Dementia-friendly environment to meet the needs of people with cognitive impairment. *incl., information gathered from statement and visit)*			2
	3.5 **Reduction and review of inappropriate/crisis hospital admission and length of stay, particularly in the final days, and fewer hospital deaths**. *(See evidence 3d, 3e and 3f incl., information gathered from statement and visit)*			2
	Evidence required.			**Tick if ✓ received**
	3a. Evidence of completed pain assessment tool including the actions taken and the outcomes.			Y
	3b. Evidence of a completed referral form to any member of the MDT e.g., SLT or Dietician or TVN to include ouitcomes.			Y
	3c. Evidence of documentation of the emotional and spiritual needs of residents being recognised and support offered to meet these needs.			Y
	3d. Evidence of care plan with GP collaboration to reduce hospital admissions of a resident (e.g., treatment escalation plan).			Y
	3e. Hospital admission Audit is completed and reflected upon (Tracker 4)			Y
	3f. A reflection from a senior carer/ nurse following an unplanned hospital admission which identifies lessons learnt.			Y
	PORTFOLIO MARKER – Any questions to be clearly marked **Q** for visitor to address. Any comments to further support findings or where outstanding work is recognised: - Discuss 3.5 how staff are trained /supported re preventing hospital admission. 3c good About me and wellness document/record 3f Good reflection could be used as an example**.**			
	VISITOR TO COMPLETE – Any **Qs** are to be clearly responded to. Any comments to further support findings or where outstanding work is recognised: - "Within our care plans the wishes of the resident and their families are always taken into account. This includes whether they are for hospital admission and the escalation of treatment, this is also undertaken by our GP surgery and a personalised GP care plan is in place for each resident to make sure that we are following the wishes of the resident and their families" Discussed avoiding unnecessary hospital admissions with staff.			

	"we have a hospital audit that we have started using as part of the GSF framework and we find that this has been very helpful."			
	AREAS FOR DEVELOPMENT			
4. Dying Well Planned Care in the final days is of high quality, supporting residents to die well in their care home, if that is their wish including anticipatory prescribing and good after-death care for the resident (and others)	**Details for accreditation**	**Not Achieved**	**Working Towards**	**Achieved**
	4.1 Demonstrable evidence of supporting residents to die well at home following a personalised care plan for the final days in line with NICE guidance and the 5 Priorities of Care. *(See evidence 4a, 4b, and 4e, incl., information gathered from statement and visit)*			2
	4.2 Anticipatory medication is put in place *(See evidence 4c and 4d, incl., information gathered from statement and visit)*			2
	4.3 There is good after-death care and communication to others *(See evidence 4a and 4e, incl., information gathered from statement and visit)*			2
	Evidence required.			**Tick if ✓ received**
	4a. Evidence of written information for families – What to expect when someone is dying?			Y
	4b. Evidence of a personalised care plan in final days with the 5 priorities of care being addressed.			Y
	4c. Evidence of symptoms at end of life being assessed.			Y
	4d. Evidence of MARS sheet with anticipatory medication prescribed.			Y
	4e. Reflection from a carer of care given to a dying resident.			Y
	PORTFOLIO MARKER – Any questions to be clearly marked **Q** for visitor to address. Any comments to further support findings or where outstanding work is recognised: - "All of our staff know our residents extremely well and they are excellent at spotting signs of agitation and reposting it to senior staff so that they can make an assessment and escalate the treatment needed to the district nurses so that anticipatory medication can be started if needed" Good communication with GP 4a is specific to the home. 4e good reflection.			

	VISITOR TO COMPLETE – Any **Qs** are to be clearly responded to. Any comments to further support findings or where outstanding work is recognised: -			
	AREAS FOR DEVELOPMENT			
5.Carers and Families Supported There is awareness of the needs of relatives, friends and carers and proactive support offered at transition into the care home, during the final days and in bereavement.	**Details for accreditation**	**Not Achieved**	**Working Towards**	**Achieved**
	5.1 Staff understand the impact for families of having a loved one in a care home. and supporting them through a range of emotions during this transition. *(See evidence 5b, incl., information gathered from statement and visit)*			**2**
	5.2 There is effective support for relatives/friends during the final days. *(See Evidence 5a, and 5b, incl., information gathered from statement and visit)*			**2**
	5.3 Bereavement support and signposting for relatives is evident. *(See evidence 5b and 5c, incl., information gathered from statement and visit)*			**2**
	5.4 Bereavement support for other residents and staff affected by the death is ensured. *(See evidence 5d, and 5e, incl., information gathered from statement and visit)*			**2**
	Evidence required.			**Tick if ✓ received**
	5a. Example of written information that is available for relatives concerning practical support, information about legalities and the emotional impact following the death of a loved one.			Y
	5b. Evidence of the carer's (family member) needs/concerns have been identified and documented.			Y
	5c. Evidence of memorial book/garden/etc.			Y
	5d. Evidence of notification of a death of a resident is displayed for all to view (this can be photos).			Y
	5e. A reflection from a carer supporting another resident following the death of a resident/friend.			Y
	PORTFOLIO MARKER – Any questions to be clearly marked **Q** for visitor to address. Any comments to further support findings or where outstanding work is recognised: - Strong detailed evidence for 5.1-5.4 in statement 5b detailed record of how relatives needs identified and addressed.. 5 insightful – well written reflection.			

	VISITOR TO COMPLETE – Any **Qs** are to be clearly responded to. Any comments to further support findings or where outstanding work is recognised: - This is an area of strength. Staff have been trained in EOLC and how to support relatives including how to look out for them and offer support. Comfort baskets "Thinking of you baskets " are available for relatives who may be staying over. Other residents are also sensitively supported and given the opportunity to say goodbye.			
	AREAS FOR DEVELOPMENT			
6. With Compassionate Care Compassionate dignity-enhancing care is given by all staff, who are themselves supported and enabled through reflective practice and self-care, within a compassionate system or culture.	**Details for accreditation**	**Not Achieved**	**Working Towards**	**Achieved**
	6.1 Compassionate dignity-enhancing care is given by all to all residents and relatives. *(See evidence 6a, incl., information gathered from statement and visit)*			**2**
	6.2 Staff are supported and enabled through reflective practice and self-care. *(See evidence 6b and 6c, incl., information gathered from statement and visit)*			**2**
	Evidence required.			**Tick if ✓ received**
	6a. Reflections from a staff member that demonstrates dignity and respect of an individual resident whilst giving personal care			Y
	6b. Reflection from a carer following the death of resident which demonstrates the support received from colleagues			Y
	6c. Evidence of support system for staff through supervision which encompasses EOLC			Y
	PORTFOLIO MARKER – Any questions to be clearly marked **Q** for visitor to address. Any comments to further support findings or where outstanding work is recognised: - Informative detailed statement In the case study it mentions that staff were allowed a tour around the two local funeral directors so that they are aware of what happens to a resident when they leave their care "Each time we lose a resident, it is like losing a member of our extended family so it is very reassuring to know that they were in safe hands"			

	"The staff have always been sympathetic to the residents needs and one of the reasons that we can do this is for us to reflect on our practices through staff supervision and then change what we do" Discuss 6.1.and 6.2			
	VISITOR TO COMPLETE – Any **Qs** are to be clearly responded to. Any comments to further support findings or where outstanding work is recognised: - 6.1 Compassionate, dignity enhancing care is a consistent quality of the home 6.2 Discussed on the visit The wellbeing of staff is also a strength "If a staff member is struggling after the death of a resident, then we have support services for them that we can point them towards and we also have in house wellbeing and mental health champions in place. " Staff are valued and each persons role is respected.			
	AREAS FOR DEVELOPMENT			
7. Systematic Care Demonstrating that high quality care is consistent and systematic for all residents, that this includes the whole team with all staff involved, with effective leadership and teamworking.	**Details for accreditation**	**Not Achieved**	**Working Towards**	**Achieved**
	7.1 High quality care is consistent, systematic, and fully embedded. ***(See evidence 7a, 7e and 7f, incl., information gathered from statement and visit)***			**2**
	7.2 All staff are involved with appropriate levels of awareness and training. *(See evidence 7b, 7c, 7d, and 7f, incl., information gathered from statement and visit)*			**2**
	7.3 Effective leadership & teamwork that promotes continuity of care. *(See evidence 7f, 7g, incl., information gathered from statement and visit)*			**2**
	Evidence required.			**Tick if ✓ received**
	7a. Evidence of KORs and ADAs.			Y
	7b. Evidence that GSF training is part of the induction programme for all staff.			Y
	7c. Completed Tracker 2 staff training (Accreditation only).			Y
	7d. Evidence from a family member/or friend of the resident, that highlights and recognises the quality care that they/or their loved one received (e.g., a thank you letter/card).			Y

	7e. Evidence of minutes/staff meetings where GSF or EoLC has been discussed.	Y
	7f. Evidence of where the home meets with other professionals and organisations within the locality (e.g., Minutes of a meeting).	_
	7g. Action plan for the next 3 years to continue GSF and with quality improvements and for **re-accreditation** the action plan from previous portfolio submission (reaccreditation only)	Y
	PORTFOLIO MARKER – Any questions to be clearly marked **Q** for visitor to address. Any comments to further support findings or where outstanding work is recognised: - Statement shows GSF systematic and embedded. Ask staff about GSF training and staff meetings 7f notes from a ward round not a meeting with other external organisation	
	VISITOR TO COMPLETE – Any **Qs** are to be clearly responded to. Any comments to further support findings or where outstanding work is recognised: - 7f Through the discussions on the visit it was evident that the home is well integrated into the local community Staff training is a priority and starts with the GSF training at induction. Further end of life care training is available and appraisals are used to highlight other areas where staff may need/want training.	
	AREAS FOR DEVELOPMENT	

Note to All Assessors:

Now add up the total number of scores, including scores awarded for case study, portfolio and KOR and input at the top of the page for the panel.

Any **Areas for Development** identified should be included at the top of the report– stating to which key task this applies to.

There is also space for you to identify **Areas of Strength** within your report.

If the home is being recognised as outstanding practice, please can you write a statement of why you think this home should receive a nomination for care home of the year (Reaccreditation only) – Within the statement please state clearly what has 'wowed' you – to achieve Care Home of the Year they need to have achieved above and beyond GSF expectations.