



**THE WOODBERRY**  
PARTNERSHIP



# **INSPECTION REPORT**

## **COPPERFIELD COURT**

**CQC RATING GUIDE: 'GOOD'**



Privately Commissioned Inspection for

# Copperfield Court

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Date of Inspection:  
29<sup>th</sup> September 2025

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## Executive Summary

Oyster Care's stated aim is to offer care and support that focuses on resident well-being and quality of life. This is being built and delivered in a series of new purpose-built care homes across the south of England. As part of Oyster's quality assurance programme, additional privately commissioned inspection visits have been commissioned from outside care professionals. This is to ensure the organisation makes use of an external eye, acting as a 'critical friend', to further improve and enhance the quality of leadership and the quality of care at their care homes. An introduction to the author is available at the end of the report.

This is the report from a day spent at **Copperfield Court**. Copperfield Court is a new purpose-built residential care home for older people including people living with dementia, located in Broadstairs, Kent. The facilities are 'state of the art' and the environment is amongst the most impressive in the residential care market. The home opened in May 2024. This was my second visit to the home, following an initial inspection a year ago in September 2024. The home had grown well and there were now 51 people in residence.

The findings of this inspection were mostly positive and encouraging. The obviously kind and caring culture that had been embedded early had been built upon. Residents were exclusively complimentary about the care they received and there was some particularly emotional and grateful feedback from visiting relatives. The staff team spoke appreciatively of their working conditions and support they received, often comparing their jobs favourably to previous places they had worked. Staff were attentive and helpful when interacting with residents. Personal care was of a high standard. There was some excellent evidence of meaningful activity and community engagement that had taken place over the past year.

There were plenty of staff on duty, with staff properly recruited in line with regulation. Staff training, supervision and appraisal was up to date. The lunchtime experience was well managed. The environment was clean and well presented.

Regulatory compliance and governance systems were robust and ably demonstrated by the care manager. The governance systems enabled the management team to stay on top of important detail that related to the complexities of all residents. Care planning was outwardly of a high standard, with care plans drafted in a person-

centred way containing important information about peoples' lives. There were some anomalies noted where care plans had not been altered when peoples' needs had changed. Ensuring the care plans remain accurate and up to date was one of the key areas to focus upon and improve. Mental capacity assessments and best interest decision making documents also required some tidying up. Medication systems were logical, although some minor issues were picked up requiring greater attention to detail. The team needed to reflect on the need for safe storage of cleaning materials.

The management team were highly engaged with the inspection process and were keen to learn and improve. The whole team deserved credit for making excellent progress over the past year.

## CQC Rating Guide

This is a ratings guide for this service on the basis of what was seen, heard, witnessed and experienced on the day of inspection. It is for guide purposes only. The methodology used for conducting the inspection and preparing the rating is discussed in more detail in a separate section at the end of the report:

	Inadequate	Requires Improvement	Good	Outstanding
Safe			X	
Effective			X	
Caring			X	
Responsive			X	
Well-Led			X	

### Overall: Good

This was a well-deserved 'Good' guide rating, although attention to each recommendation made will solidify the rating further.

## CQC Key Question - Safe

The following CQC quality statements apply to this key question:

- Learning culture
- Safe systems, pathways and transitions
- Safeguarding
- Involving people to manage risks
- Safe environments
- Safe and effective staffing
- Infection prevention and control
- Medicines optimisation

### Staffing Levels

The home is registered for a maximum of 66 older people, including some people living with dementia. There were 51 people in residence on the day of my visit. The home was laid out over two floors.

Staffing levels across the home were as follows:

#### **Ground Floor – (27 people in residence)**

(am) 1 senior care assistant and 3 care assistants

(pm) 1 senior care assistant and 3 care assistants

#### **First Floor – (24 people in residence)**

(am) 1 senior care assistant and 4 care assistants

(pm) 1 senior care assistant and 4 care assistants

There was also a deputy manager on duty throughout the day who worked across both floors. This gave a total of ten care staff. On the inspection day there were a further two members of care staff who were on their first day and were shadowing more experienced staff.

At night there were five care staff, typically one deputy manager, one senior care assistant and three care assistants. Two of the early staff came in to work at 7am and two staff who worked the late shift stayed until 10pm. These staff assisted the night staff at the beginning and end of their shifts with people who required support getting up in the morning and going to bed in the evening.

## **Ancillary Staff**

In addition to the care staff there was a lifestyle manager and a lifestyle assistant, kitchen staff (chef or sous chef and kitchen assistant each day), maintenance manager, front of house manager, head housekeeper and domestic team (including dedicated laundry staff). Hairdressing, optician and chiropody services were contracted externally. The team was managed by the manager (supernumerary) and a care manager (also supernumerary). This was a good level of ancillary staff for a home of this size.

The manager undertook a regular dependency monitoring exercise as one way of ensuring the staffing was sufficient, as well as her own observations and input from care staff. From my observations during the day there were enough staff to care for the current resident group. There were plenty of examples of staff having the time to speak with people, listen to them and engage with them in addition to completing personal care tasks. Both the management team and the staff team were of the view there were sufficient staff to provide a quality service.

## **Staff Vacancies**

The home was fully staffed for its current number of residents and was in a good position to accept more admissions in the final push towards full occupancy. The management team were in the final phase of recruitment. Two care assistants had been appointed and were awaiting start dates pending recruitment checks. Two full time care staff and three part time care staff needed to be identified to complete the team for when fully occupied. No agency staff had ever been used at the home.

The manager spoke of an approach to recruitment that was values-based, with any missing skills being taught later.

## **Staff Recruitment files**

I looked at the recruitment information for the staff recently recruited to the home who were on induction. The files were stored securely on the Coolcare system, were well put together and contained all of the information required by regulation and other information indicative of good and safe recruitment practice. Information seen included:

- Recent photographs

- Full employment histories
- Medical information to ensure people are fit to work
- Contracts & ID
- Suitable references
- Job descriptions
- Interview notes
- Training information
- DBS information

### **Open Safeguarding Cases**

The manager advised there were no open safeguarding cases at the home. The manager had a good understanding of safeguarding and a trusting relationship with the local safeguarding team built up over several years.

### **Medication Management**

The medication trolleys were kept in secure medical rooms on both floors. At this visit I audited the medical room on the first floor. The systems were ably demonstrated by the care manager. I found that the medication systems were safe and well-managed, although a couple of routine matters were identified. Good practice included:

- Keys were kept by the senior member of staff in charge.
- Storage temperatures were monitored daily for both the medication room and the refrigerator. Records indicated that the storage temperatures for the room was within safe a safe range. The medicine refrigerator was not operational.
- Specified room cleaning schedules were completed daily.
- The trolleys were tidy and well organised and attached to the wall when not in use.
- Medication was delivered regularly in original packaging – a non MDS approach.
- Controlled drugs were stored correctly. A random stock audit tallied.
- Do not disturb tabards were worn by staff administering medication.

The home used an electronic medication system (EMAR). The EMAR system involved scanning the medication boxes prior to administration and the system generated a MAR chart. The system prompted all prescribed medication administration and so it was not possible to ‘forget’ any medication or not sign for it.

The key to demonstrating the system is being used correctly is to ensure the stock present in the boxes and packets matches exactly the amounts recorded on the computer system. I undertook ten random stock audits. Seven were correct and three were incorrect, although the incorrect counts related to the same resident (Resident 1) and were due to the same system error.

Three bottles of liquid medication for Resident 2 had not been dated upon opening. These bottles contained liquid paracetamol, senna and lactulose.

**See Recommended Actions 1 & 2.**

### **PRN protocols**

One PRN protocol for Resident 3 stated, *“Unable to take or tolerate paracetamol due to an intolerance or allergy. Alternative pain relief options should be considered.”* This was an unusual statement, as it suggested the person was allergic to the medicine they had been prescribed. The management team confirmed this was not the case and the protocol had been incorrectly written.

Some PRN protocols were well-written, containing appropriate levels of person-centred information. Others were generic. The care manager reported that this had been identified and the team were about halfway through improving the generic protocols.

**See Recommended Actions 3 & 4.**

### **Premises Safety & Management**

The home was warm, clean and well presented. No unpleasant odours were noted anywhere. Domestic staff worked safely with their cleaning materials. Sluice rooms were locked at all times.

There were two separate situations where COSHH products, such as dishwasher tablets and other cleaning materials were not locked away securely. This occurred in the cupboards in the kitchenette areas of both of the downstairs lounges. In both cases the doors had not been locked. These items can be harmful to people living with dementia and must be kept locked away at all times.

**See Recommended Action 5.**

### **Laundry Room**

This room was spacious with both an 'In' and an 'Out' door. It was clear that soiled laundry was stored correctly and washed separately on a sluice wash. Dissolvable red bags were used for safe storage and laundering.

### **Kitchen**

The home had received its first environmental health inspection, scoring 5 – 'Very Good,' which is the highest score available.

Kitchen practices were not assessed further at this visit.

## CQC Key Question - Effective

The following CQC quality statements apply to this key question:

- Assessing Needs
- Delivering evidence-based care and treatment
- How staff teams and services work together
- Supporting people to live healthier lives
- Monitoring and improving outcomes
- Consent to care and treatment

### Supervision & Appraisals

The provider used a system called Coolcare to monitor the frequency of supervision and appraisal meetings. The system showed all supervisions and appraisals were up to date, other than two where people were on maternity leave. Minutes of supervision and probation review meetings were kept on personnel files and were signed by both parties.

Staff spoken with indicated they were well supported and were happy with their working conditions. One care assistant said, *“This home is much better than the last home I worked in. The management are really approachable, they listen and sort stuff out. It’s been good to be a part of this home growing.”* A second staff member was grateful for the opportunity to go for promotion and achieve it, adding that several staff appreciated the fact there was potential for career progression. Another staff member simply said, *“I love it – love my job.”* No staff raised any concerns.

### Training

When new staff were appointed to work at the home they were expected to undertake basic training to do their jobs. There was some confusion about precisely what the mandatory training compliance percentage was. An email from the regional manager to the manager the previous week suggested **96%**. The information on the Coolcare system suggested **87%**. The manager was unsure of why there was a difference in the numbers. It may have been due to some new starters commencing work, but it would be preferable if this was clear. Either way this was a good percentage compliance and indicated that mandatory training was taken seriously by the team.

Mandatory training was wide-ranging, incorporating autism, learning disabilities, COSHH, dementia awareness, dignity in care, dysphagia, end of life care, equality and diversity, fire safety, first aid, basic food hygiene, GDPR, health and nutrition,

health and safety, infection control, MCA/DoLS, medication, mental health awareness, moving and handling, oral hygiene, pressure area care, falls awareness and safeguarding.

Two young staff referred to NVQ courses they were being supported to undertake as part of trying to work their way up through the ranks.

### **Mental Capacity - DoLS**

The management team had a good understanding of DoLS processes. A clear matrix was in place and showed that 13 DoLS applications had been made for people who fell into all 3 of the following criteria:

- a) those who lack capacity to consent to their care and treatment in the home due to dementia or severe illness;
- b) those who are not free to leave the home as and when they please (i.e. staff would stop or divert them if they tried to);
- c) those who need continuous monitoring (i.e. staff control all their medication, nutritional intake, activities etc).

Only one of the applications been determined (approved) by the local supervisory body and this was recently. A CQC notification had been submitted as required. The other applications had been chased up at regular intervals.

### **Eating and Drinking**

I witnessed the lunchtime experience in the first-floor dining rooms, which was a positive, sociable experience. Good practice included:

- Old-style music was being played during lunch and some people were heard singing along.
- Tables were nicely laid.
- Clear menus were on display.
- Staff were wearing appropriate protective equipment in the form of washable aprons.
- Napkins were available.
- There were plenty of staff around and they interacted with residents well at all times.

- Choices of different drinks were given to people. Refills were available when required.
- One-to-one attention was given appropriately by staff on an individual basis from a seated position.
- Staff were attentive and quickly helped people who required assistance.
- All of the feedback from residents about the quality of food was positive.

Choices of main courses were made the day before. As some of the people were living with dementia they may have forgotten the choices they made or may not have been able to understand the choices very well. The team might like to consider using the strategy of 'show plates.' This is when two plates of food with the different choices are presented to each resident 'in the moment.' Residents can then see, smell or even taste the food. This is the best way of offering the most meaningful choice of meals to people living with dementia.

**See Recommended Action 6.**

## **Premises Presentation**

### **Entrance and Reception Area**

The home had a bright and welcoming entrance and reception area, staffed by a friendly and helpful front of house manager. There was a fully working tea and coffee bar with fresh cakes. The manager's office was easily accessible at the side of the main reception. Information such as the home's registration certificate and the complaints policy were displayed prominently. The home did not as yet have a CQC rating, but this would be displayed after the first inspection.

### **Design and Adaptation**

The home was designed and purpose built for people who have mobility restrictions. All bedrooms had en-suite toilets and wet room showers. Full assisted bathing facilities were also available on each floor.

### **Communal Rooms**

The lounges and dining rooms were welcoming, clean and very nicely furnished. There were a variety of different lounges and dining rooms in the home, including a state-of-the-art cinema room, library area, garden rooms and a shop. There was also

a fully kitted out hairdressing salon and an area for nail pampering. A large snack and hydration station had been built in one of the garden rooms to encourage ongoing hydration.

### **Bedrooms**

The occupied bedrooms were nicely personalised with people's own belongings and photographs of their families. This enabled them to feel settled at the home. The bedrooms were fitted with smart televisions and refrigerators.

### **Garden**

The secure gardens around the home were well kept and presented. Some of the ground floor rooms had areas outside their patio doors for individual people to sit and enjoy nice weather.

## CQC Key Question - Caring

The following CQC quality statements apply to this key question:

- Kindness, compassion and dignity
- Treating people as individuals
- Independence, choice and control
- Responding to people's immediate needs
- Workforce wellbeing and enablement

### Residents

There was a cheerful, proactive and caring relationship between the staff and the residents that was evident all day on both floors. There was a calm and relaxed atmosphere throughout the home and a sense of general satisfaction on behalf of everyone. Feedback from residents was most positive and grateful about their experiences of living at the home. Quotes included:

*"I'm very happy with the care. I can't fault it. It's a nice community."*

*"The carers here are kind. I'm very happy."*

*"The home is very well run. The staff really respond well when you ask for things."*

*"It's too good sometimes. I look at all the facilities and wonder how I'm so lucky. The girls are superb, especially considering some of the aggravation we give them."*

*"Everyone is very nice, they are kind to me when I'm in a muddle."*

*"I'm wonderfully looked after. That's **wonderfully**, make sure you write that down."*

*"The staff work very hard. I think they need more stars."*

Everyone living at the home had a good sense of wellbeing. The standard of personal care was high throughout the home. People were supported to be clean, well-presented and wearing properly fitting clothing.

### Visitors

Visiting was able to take place unrestricted.

Some of the feedback from visiting relatives was exceptional. One relative was close to tears when talking about the care of his relative and said, *"They've encouraged a quiet man who sat in a corner for 30 years to be up and dancing and enjoying himself. I wouldn't have believed it if I hadn't seen the video clip. I now don't worry about him and know he's in safe hands. This place has changed our lives."*

The carehome.co.uk website rated the home as 9.9 out of 10 from 42 reviews, which was indicative of very high satisfaction levels from people who used that website for feedback. Reviews were written in the most complimentary terms.

### **Privacy and Dignity**

People were treated with dignity and respect throughout the day. Staff were observed to knock on doors prior to entering peoples' bedrooms. This indicated a respect for people's personal space. Call bells were left within reach of people spending time in their bedrooms and were answered quickly. Continence products were stored discreetly. Moving and handling manoeuvres were undertaken with respect and staff were communicative with people in explaining what was to happen next. Staff were alert to situations where peoples' dignity may be compromised and intervened without fuss.

In one of the communal bathrooms there were some toiletries left in a cupboard. There was a bottle of shampoo / shower gel and an opened bottle of mouthwash. Staff should return individual toiletries back to peoples' bedrooms after use, to avoid temptations of the toiletries becoming communal.

**See Recommended Action 7.**

### **Confidentiality**

Care plans were stored electronically and were password protected.

## CQC Key Question - Responsive

The following CQC quality statements apply to this key question:

- Person-centred care
- Care provision, integration and continuity
- Providing information
- Listening to and involving people
- Equity in access
- Equity in experiences and outcomes
- Planning for the future

### Care Plans

The care planning system being used was Person Centred Software (PCS), a respected and widely-used electronic care planning system. Care plans were written following detailed assessments of people and contained plenty of person-centred information, including detailed life histories. All of the care plans I read were well-drafted and informative. Specific care plans were in place for individual health conditions, such as the need for blood-thinning medicines. There was clear information recorded about who had been consulted in the drafting of each care planning section. The management team were clear about the needs of people the home was able to meet and the kind of needs that were not suitable.

Care plans had been reviewed on a monthly basis, as prompted by the computer software. Established scoring systems were used to ensure that risks to people were identified and managed effectively. The system produced a list of required risk assessments that were completed for all. These included people's risk of developing pressure ulcers, risk of becoming malnourished (MUST & Waterlow) and moving and handling risk assessments. These risk assessments had also been regularly reviewed.

The care plans looked good on the surface, but there were a couple of important examples noted where the information had not been updated when there was a change of need or when an adjustment was required. Resident 4's personal care plan described how he needed the support of one staff member to have a bath or a shower. Daily records indicated he had not been supported to have a bath or shower over the past 28 days. The management team said he had refused to be supported in the bath or shower since he moved in (March 2025) and had a strip wash each day instead. The care plan had not been updated to reflect the change, despite several reviews.

In a similar example, Resident 5's care plan stated, "[Resident 5] has said she prefers to shower every other day and will require one carer to assist her with this." Again, the team described how this was no longer the case and it was difficult to persuade her to be in the shower.

As the home has grown its occupancy the management team have increasingly relied upon on the mid-ranking staff to review and update the care plan information. It is sometimes necessary for mid-ranking staff who review care plans to be given active 'permission' to make changes and alterations. This will sometimes involve deleting whole sections of care plans (originally written by the manager or care manager) that are no longer relevant and re-writing them.

### **See Recommended Actions 8 & 9.**

#### **Consent to Care and Treatment**

Mental capacity assessments (MCAs) and best interest decision making documents had been prepared for some specific decisions where there was a doubt about the person's capacity to consent. These were well written in some cases, but others required some improvement.

Resident 5 had three specific MCAs for:

- 1) Medication administration – lacked capacity
- 2) Understanding DoLS process – lacked capacity
- 3) Use of call bell – has capacity

In assessments 1) and 2) the actual best interest decision reached had not been stated (Section 3 of the form) and the whole best interest decision making process had not been completed.

MCA 2), entitled understanding DoLS process, was about whether the person could consent to residing in the home and whether they could understand living behind a locked (coded) door. This is often known as the 'acid test' MCA. The decision is about whether the person can understand and consent to their living arrangements rather than whether they understand a DoLS process in a technical sense. The DoLS process is what follows after it has been established a person does not have

the capacity to consent to their living arrangement. It would be better to title the MCA 'residing at Copperfield Court behind a coded locked door' or something similar.

There was some discussion about a local authority expectation of involving people in a DoLS process. This expectation was unclear and could not be explored in detail due to time constraints. Aside from that, it is recommended that the 'understanding the DoLS process' MCA is changed to 'residing at Copperfield Court behind a coded (locked) door.'

Resident 6 had four MCAs completed for:

- 1) Sensor monitoring mat
- 2) Consent for CHC checklist
- 3) Medication administration
- 4) Use of bedrails

In 1) the wrong boxes had been ticked in some of the four-stage test questions, suggesting the person could retain and weigh up the decision when the text did not support that conclusion.

Assessment 2) lacked information and was not complete.

Assessment 3) contained information about the person's ability to consent to their medication, but it also contained information about the person's ability to consent to living in the home behind a locked door. These two different decisions should be addressed in separate MCAs. The best interest decision box (Section 3 of the form) had not been completed, which meant the actual decision reached had not been stated.

In assessment 4) the best interest decision box (Section 3 of the form) had not been completed, which meant the actual decision reached had not been stated.

**See Recommended Actions 10 & 11.**

The following advice is added for information and clarification:

Where there is a doubt about a person's capacity to consent to any aspect of their care that could constitute a deprivation of their liberty, there must be a mental capacity assessment (MCA) undertaken. If the MCA (through the 4-stage test) establishes the person lacks capacity to consent to the area of care being assessed, then a best interest decision process will need to follow. Key specific decisions` to consider for each person would be:

- Can the person consent to their living arrangements? Do they understand they are living at Copperfield Court and why? Do they understand there is a lock on the door?
- Can they consent to the use of sensor monitoring equipment?
- Can they consent to the use of bed rails?
- Can they consent to taking their medication?
- Can they consent to any form of restraint (such as wheelchair straps for transportation)?
- Can they consent to their personal care, especially if the personal care sometimes requires intervention to keep them safe against their momentary will?
- Can they consent to restrictive diets (e.g. soft diets recommended by SALT teams)?
- Can they consent to annual 'flu jabs?
- Can they consent to Covid19 vaccinations?

This list is not necessarily exhaustive and the management team will need to stay alert that there could be other situations where people might be deprived of their liberty through best-interest decision making.

### **Daily Care Records**

Most of the daily records were kept diligently by staff. Daily care records were available for monitoring peoples' fluid intake and food intake. There were hygiene charts to record personal care given and repositioning charts for people who required regular turning. These were well completed.

The application of each emollient cream was reliably recorded on the PCS system, which was an improvement from the last inspection. The one improvement still required was to ensure clear application directions were transcribed. For example, Resident 8's cream instructions stated, *"500mg of cream – use on sacrum and groin."*

This instruction did not make clear which cream should be applied. In various other cases the application instructions merely stated, “*Cream.*”

## **See Recommended Action 12.**

### **Activities Arrangements**

It was unfortunate not to meet either of the lifestyle team, as they were both not on duty on the inspection day. Nevertheless, there was much evidence available of meaningful activity having taken place over past months. There was a focus on providing certain activities that were special to individual people and some of these were presented on a ‘You Said, We Did’ board.

One person wanted to go to a zoo and so a day trip to Wingham Wildlife Park was organised. Several other residents joined in too. Afterwards the person said, “*This was a fantastic day out. People are always quick to moan if something is wrong, but everything was perfect. I’d like to thank the staff. It meant a lot to me.*”

Another person wanted to get some fresh air and look at boats like he used to. So the staff took him to Broadstairs Harbour. They had a promenade walk and watched some live music at the bandstand. He said, “*I really enjoyed that. The boats and the sea were lovely.*”

Another person wanted to do something for other people like she used to when she was younger. She helped with putting together the Harvest Festival Hamper, so food and provisions could be given to people in need. She said, “*It made me feel wonderful knowing I was giving back to the community. I slept well that night knowing I had helped someone else. It reminded me of the things I used to do and gave me that warm feeling again.*”

There was a ‘community tree’ on display, indicating a variety of community links that had been forged and resultant activities. These included some primary school children singing carols, meeting with dementia action alliance, a link with Margate’s fire and rescue team, volunteers from a local college coming in to play games with the residents, Kent Wildlife Trust helping with the gardens and another group of people who came in to share holistic wellness, head massage and nail painting.

Day-to-day activities included film afternoons, arts and crafts, seated exercises, church services, various games, quizzes, musical activities and reminiscence sessions. There was a 'busy-board' on the wall containing word games, word-searches and brain teasers. People could help themselves to any of these at any time. The manager said this had been requested by the residents.

## CQC Key Question – Well Led

The following CQC quality statements apply to this key question:

- Shared direction and culture
- Capable, compassionate and inclusive leaders
- Freedom to speak up
- Workforce equality, diversity and inclusion
- Governance, management and sustainability
- Partnerships and communities
- Learning, improvement and innovation
- Environmental sustainability – sustainable development

### Registered Manager

The manager, Eve Balcombe, had been registered as manager since the home opened.

The home had yet to be inspected by CQC and was unrated.

### Management Audits & Governance

A robust internal auditing and governance system was in place, as designated by the provider. A wide range of key areas were covered each month. The sheer amount and depth of the auditing gave confidence the home was well run. The management team believed in the governance system and felt it helped to keep everyone safe. Actions identified through the audits were placed on a home action plan. The systems were capably demonstrated by the care manager. Audits included:

- Pressure ulcer audit
- Moisture lesions
- Bed rails
- Wounds and actions taken
- Weights and weight loss management
- Infections audit
- CQC notifications review
- DoLS review
- Duty of candour communication
- Safeguarding review (none)
- Complaints (none)
- Equipment log

- Hoists and slings
- Health and safety – fire drill
- Maintenance certificates
- Call bell analysis (very good response times)
- Accident and incident review with graphical and trend analysis
- Falls summary
- Distressed behaviour tracker
- Dependency tracker
- Call bell response time monitoring analysis (very good results)
- Medication audits
- Care plan audits (10% minimum)
- Dining experience audit
- First impressions audit
- Finance audit
- Infection control audit
- First aid box audit
- Mattress audit
- Unannounced night visit
- Pressure cushion audit
- Lifestyle audit

Other auditing took place weekly and bi-monthly. Every day there were formal walk-around audits and a resident of the day process. These were monitored both by the management team and by senior management staff of Oyster Care.

### **Management and Leadership Observations.**

The management team presented the home very well, took their responsibilities seriously and aimed high in terms of quality of care and regulatory compliance. Staff all confirmed that the management were approachable, would listen to issues and were good to work for. Commissioning a new home is a full-on job and the progress over the first year and a half had been very positive and encouraging. The team were in a good position to complete the commissioning over the next year.

The whole team were welcoming of constructive criticism and took the inspection process seriously. A lot of ground was covered during the day. If the team keep going on their current trajectory, as well as attending to the recommendations in this report then there should be a highly successful future for the home.

## Required and Recommended Actions

The following list consists of matters picked up during the inspection process that would be either in breach of regulation, arguably in breach of regulation, issues that CQC inspectors commonly criticise if not seen as correctly implemented and general good practice suggestions.

The regulations in question are the HSCA 2008 (Regulated Activities) Regulations 2014, The Care Quality Commission Registration Regulations 2009 and The Mental Capacity Act 2005. There are other regulations that can be relevant, but these ones cover the vast majority of issues to consider.

1	Please review the medication stock discrepancies for Resident 1 to ensure the relevant staff understand the system error that was made.
2	Please ensure that bottles of liquid medication are dated upon opening.
3	Please correct the PRN protocol for Resident 3 that incorrectly stated she was allergic to paracetamol.
4	Please complete the review of PRN protocols to ensure they are all sufficiently person-centred and contain clear instructions to staff to ensure consistent administration.
5	Please ensure that COSHH products, including dishwasher tablets, are locked away at all times when not in use.
6	Please consider the use of 'show plates' to give people living with dementia the most meaningful choice of meals.
7	Please remind staff to return all toiletries to peoples' private bedrooms after use in communal bathrooms.
8	Please update the personal care plans for Residents 4 & 5 in relation to their bath and shower preferences.

9	Please speak formally to senior staff to ensure they are aware of their responsibilities to make active alterations to care plans when they become inaccurate due to changes in need.
10	Please ensure the actual best interest decisions reached are stated clearly in Section 3 of the MCA/best interest forms on the PCS system (e.g. for Residents 5 & 6).
11	Please split Resident 6's 'medication' MCA into two different MCAs, one for medication and one for residing at the home behind a coded (locked) door.
12	Please ensure application instructions for all emollient creams are clear, describing the name of the cream, required frequency of application and where the cream should be applied.

## Inspection Methodology

The inspection took place over one full day on site at the home. Evidence was obtained in the following forms:

- Observations of care and staff interactions with residents.
- Observations of general living and activities.
- Discussions with people who lived at the home.
- Discussions with staff who worked at the home, including management staff.
- Inspection of the internal and external environment.
- Inspection of live contemporaneous care records.
- Inspection of live contemporaneous management records.
- Inspection of medication management systems.

The main inspection focus was against compliance with the following regulations:

- HSCA 2008 (Regulated Activities) Regulations 2014.
- The Care Quality Commission Registration Regulations 2009.
- The Mental Capacity Act 2005.

Full account is also taken of the following key guidance, although this list is not designed to be exhaustive:

- CQC's recently published Single Assessment Framework (SAF) and its associated Quality Statements.
- The recently retired Key Lines of Enquiry (KLOEs), as these were always a good technical guide for what appropriate quality care looks like.
- NICE guidelines on decision making and mental capacity.
- NICE guidelines on medication management.
- A whole variety of CQC's clarification documents from over the years.
- RIDDOR guidance on reporting injuries and dangerous occurrences.

The ratings awarded for each key question are professional judgements based on over 25 years' experience of inspecting and rating care services. I believe the most meaningful rating is a 'description,' not a 'score.' It is a 'narrative judgement,' not a 'numerical calculation.' This inspection does not attempt to mimic CQC's current complex scoring system.

## Introduction to Author

### **Simon Cavadino**

Simon has worked in the provision, management and regulation of social care and healthcare services for over 25 years. He currently works with a range of different care provider organisations, offering advice on the Health and Social Care Act (2008) and its accompanying regulations. He is able to undertake detailed compliance advice work and/or senior-level management advice and coaching. Simon trades under the banner of The Woodberry Partnership.

During his career Simon has worked as an inspector for the Commission for Social Care Inspection (CSCI) and for the Care Quality Commission (CQC). He has undertaken detailed inspection, registration and enforcement work during his two spells working for the national regulator.

Simon has also worked for care provider organisations in both the private and voluntary sectors, achieving high quality services wherever he has worked. His most notable career achievement was as Director of Operations for a private sector provider, where he commissioned, built, opened and ran 25 sought-after care services for adults with a learning disability over a period of 8 years.

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