THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

SOMER VALLEY HOUSE

CQC RATING GUIDE: '**GOOD**'

Privately Commissioned Inspection for

Somer Valley House

Conducted by:

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Date of Inspection:

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Contents

Executive Summary

Crystal Care's stated aim is to provide kind, compassionate care that helps people live life to the fullest. The organisation aims to prioritise well-being and strive to create welcoming environments where people can thrive. This aim is being built and delivered in a series of new purpose-built care homes across England & Wales. As part of Crystal Care'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 **Somer Valley House.** Somer Valley House is a new residential care home for older people including people living with dementia, located in Midsomer Norton in Somerset. The facilities are impressive and the environment is amongst the best in the residential care market. The home opened in November 2024, had grown well and there were 53 people in residence.

The findings of this inspection were positive and showed the home had developed very well in recent months under stable and capable leadership. There was a particularly cheerful, relaxed and contented atmosphere across both floors. Residents and their relatives were highly complimentary about the care provided and were especially full of praise for the staff group. The feedback was notably and strikingly positive, even when compared to other good care homes.

The observed care was of a high standard, with people supported to be clean and well presented. Staff at all levels spoke appreciatively of their working conditions and support they received and were proud to be a part of the home. There was a kind and caring culture in evidence. There was also much evidence of meaningful activity having taken place consistently over the past few months. There were plenty of staff on duty and they had been properly recruited in line with regulation. The lunchtime experience was well managed.

Regulatory compliance and governance systems were robust, wide-ranging and were embedded in the management routine. Medication systems were mostly well

managed. Staff supervision, appraisal and training was up to date. The home's environment was clean and well presented.

Care planning and daily care recording was presented well on the PCS system. There were some anomalies picked up around some emollient creams and the instructions for certain people's bathing and showering expectations. It will be important to drill down into this detail to ensure consistency and establish a higher level of attention to detail among the mid-ranking staff. This is a normal thing to need to focus upon at this stage of a home's development.

Care staff needed to reflect upon the safe storage of cleaning materials and dishwasher tablets, as these were left unlocked in several different areas of the home.

The team responded well to the inspection and were keen to learn and develop. The home was a pleasant and welcoming place to visit, was where it should be at this stage of its commissioning journey and was in a good position to receive its first CQC inspection.

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 solid ‘Good’ rating.

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 who were living with dementia. There were 53 people in residence on the day of my visit. The pace of growth indicated that the service had been popular in the local area since opening. The home was set out over two floors.

Staffing levels across the home were as follows:

Ground Floor

(am) 1 deputy manager, 1 senior care assistant and 3 care assistants
(pm) 1 deputy manager, 1 senior care assistant and 3 care assistants

First Floor

(am) 1 senior care assistant and 4 care assistants
(pm) 1 senior care assistant and 4 care assistants

While the staff were nominally split between the floors as above, the manager said there was some fluidity to the arrangements and staff could go up or down to assist as was necessary given the needs of the day.

At night the home was staffed with a minimum of five staff, usually comprising of a deputy manager, two senior care assistants and two care assistants. Some of the early staff came in at 7am to assist the night staff with people getting up. Some of the late staff stayed until 10pm to assist the night staff with getting people ready for bed. This arrangement, among other things, meant that the day and night teams spent some time working together which was good for overall team morale.

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

The management team undertook a regular dependency monitoring exercise as one way of ensuring the staffing was sufficient, as well as using their own observations and gathering input from care staff. From my observations during the day there were a good level of staff to care for the current resident group. There were many 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 enough staff to care for people appropriately, although some staff commented that when there was last-minute sickness absence it could be somewhat stretched.

Staff Vacancies
The home was close to completing its initial recruitment for a full home. There were sufficient staff to cover the rosters for the current resident group and there were more staff who had been recruited pending the necessary regulatory checks. These were four part-time care assistants, three bank care assistants and one housekeeper. There were vacancies for three further care staff to complete the entire staff group. This represented excellent progress.

No agency staff had ever been used at the home.

Staff Recruitment Information
I looked at the recruitment information for several staff recently recruited to the home. The files were stored securely on the Coolcare system, were well put together and contained all 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
- Information to confirm the right to work in the UK

Open Safeguarding Cases

The manager advised there was one open safeguarding case relating to a medication error where a person had gone without one of their medicines for two days. All information had been sent through to the relevant authorities, lessons had been learned with relevant staff and the manager was expecting the case to be closed in due course.

Medication Management

The medication trolleys were kept in secure medical rooms on both floors, along with controlled drugs, refrigerated medication and stocks of medication. The systems were ably demonstrated by the senior on duty. 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 were within safe ranges.
- Specified room cleaning schedules were completed daily.
- The trolleys were tidy and well organised. They were not attached to the wall due to the fasteners malfunctioning. This had been identified and reported to the maintenance manager.
- Medication was delivered regularly in original packaging – a non MDS approach.
- Controlled drugs were stored correctly and checked regularly. A random stock check tallied correctly.
- Plastic pots, spoons and syringes used for administration were single-use.

The home used an electronic medication system (EMAR). 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 and all were correct apart from one, which related to Resident 1's Lansoprazole (5 in stock and just 4 showing on the system).

See Recommended Action 1.

PRN Protocols

PRN protocols were in place for 'as required' medicines. However, some of them were generic, meaning they did not contain sufficient information to enable consistent administration. Resident 2 was prescribed Lorazepam on a PRN basis. The PRN protocol stated, *"For agitation, restlessness and anxiety."* These are vague terms. The senior care assistant explained that when Resident 2 became agitated she called out, became highly emotional, hallucinated and tried to climb out of bed. This specific information should have been in the PRN protocol.

The following is added for additional guidance:

When medicine is prescribed a definite number of times per day, the staff member administering merely has to follow the instructions. When medicine is prescribed on a PRN or 'as required' basis, the staff member administering has to make a decision as to whether to administer or not. The factors to consider in making that decision will be different for every individual case. To ensure safety and consistency staff need clear PRN protocols to assist them in that decision-making.

The PRN protocols must refer to individual circumstances in every case:

- Does the person have capacity to consent to their medication? If not, how would staff know when to administer? How would this be established?
- If it is pain medication, where do they normally have pain, it is localised, is it general, can they tell you etc?
- If medicine is to regulate bowel functioning, details of what is normal or abnormal for the person are required.

- Where dosage directions were variable (e.g. take 1 or 2 tablets up to 4 times per day), information needs to be clear as to when the different amounts should be administered.
- Where medication is prescribed for 'agitation' there needs to be a clear protocol as to how the agitation manifests itself and in what circumstances different amounts of medicine are to be given.

A good rule of thumb is that a competent agency staff member should be able to give all PRN medicines safely and correctly to people without having to ask anyone for clarification or refer to any other documentation. This would be the case because of the clarity of the PRN protocol in place.

See Recommended Action 2.

Premises Safety & Management
The home was spotlessly clean and well presented. No unpleasant odours were noted anywhere. The home was kept at an appropriate temperature on a warm day.

Domestic staff worked safely with their cleaning materials. Sluice rooms were locked at all times. However, several cupboards were left unlocked under the sinks in the kitchenettes leaving cleaning materials and dishwasher tablets accessible. These items can be harmful to people living with dementia and must be kept locked away at all times.

See Recommended Action 3.

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 a recent 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 home employed over 60 staff. The provider used a system called Coolcare to monitor the frequency of supervision and appraisal meetings. The system showed all supervisions and appraisals to be up to date. Minutes of supervision and probation review meetings were kept on personnel files and were signed by both parties.

Staff Feedback and Morale

The staff team spoke appreciatively of their working conditions, the support they received and of each other.

One staff member said, "*A lot of us have been here since the start. I think we've worked together through teething problems quite effectively and I think we've done well."* Another staff member said, *"It's a lovely place to work. I'm happy. We have enough staff and I feel supported."* A third said, *"I think the residents are properly looked after and we really do try to put them at the front of everything we do."*

Training

When new staff were appointed to work at the home they were expected to undertake basic training to do their jobs. The manager spoke highly of the induction training that was provided and said it made sure that new recruits were able to start work with all their mandatory training complete. The percentage compliance across the staff team was **95%**

Mental Capacity - DoLS

On 2nd June it was announced that the Cheshire West ruling made in 2014 had been overturned by the supreme court. This will probably mean, in time, that far fewer

DoLS applications will be required as the criteria for submitting them will be very different. This ruling was discussed at length with the manager.

One DoLS application had been submitted and approved under the old rules (pre-2nd June) and a CQC notification had been submitted as required. Further guidance and clarification is awaited relating to the new criteria for DoLS applications, but it is likely that few, if any, of the current resident group will require one in the future.

Eating and Drinking

I witnessed the lunchtime experience across the ground floor dining rooms, which was a positive, sociable experience. Good practice included:

- There was a cheerful and cordial atmosphere throughout the whole of lunch.
- Appropriate background music was playing.
- Tables were nicely laid.
- Staff were wearing appropriate protective equipment in the form of washable aprons.
- Hand-wipes were available for people to sanitise their hands before eating.
- There were plenty of staff around from all departments and they interacted with residents well, being focused on their needs and wishes.
- Choices of different drinks were given to people.
- Choices of main courses and desserts were given to people in a way they could understand and appreciate.
- Feedback from residents about the quality of food was positive.

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area. There was a fully working tea and coffee bar with freshly baked cakes available. The manager's office was easily accessible at the side of the main reception. Information such as the home's registration certificate, the complaints policy and the employer's liability information 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 and a fully kitted out hairdressing salon. There were two garden rooms. One was used as a tiki bar and the other as an arts and crafts room. Snack and hydration stations were available throughout.

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.

Gardens
The secure gardens around the home were well kept and nicely presented. There was plenty of sturdy garden furniture with parasols for people to use. Some of the ground floor rooms had areas outside their patio doors for individual people to sit and enjoy the weather. Some people were seen sitting outside on a summer's day and it was good to see the residents able to enjoy the nice weather.

The residents and the staff team had worked hard on their entry for the Crystal Care in Bloom competition. One of the walkways had been decorated to light up at night and there were some impressive hanging baskets and plants. The managing director visited to judge the entry during the afternoon.

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 palpably warm and caring relationship between the staff and the residents throughout the home. The interactions I witnessed between staff and residents were cheerful, helpful and friendly. Staff were alert to the needs of the residents and regularly broke off conversations or other administrative tasks to attend to their needs. This indicated a residents-come-first culture. The experience of inspecting Somer Valley House was one where several people approached you proactively to tell you what a kind and caring service it was.

I spoke with several residents during the day. They were positive about the care given to them and were relaxed and comfortable in their surroundings. Nobody raised any concerns. Quotes included:

"I'm new here. It's excellent. It couldn't be better. A gorgeous place."
"The manager does a wonderful, beautiful, marvellous job, as do all the others. We are extremely lucky."
"The staff are so excellent. They are all so kind. I like to talk to people and the staff have time to talk to me."
"Everyone is polite and the food is good."
"I have no concerns and I'm happy here."
"It's spotlessly clean."
"They talk to me like I'm a person."
"The food is good on the whole."
"I have nothing to complain about."
"The girls are wonderful and they can't do enough for you."
"We have a truly lovely life now as we are getting older."
"There's a very happy atmosphere in this home, with nice staff who work hard and nice residents. We are all treated well."
"If you press the button a carer comes running."

"We do seated exercises and garden walks and quizzes. There is always something going on. All in all it's a happy place."
"The food portions were quite small, but we said something in one of the residents' meetings and it's now much better."
"It's five star."

All of the residents I met were well presented and clean, indicating good attention to personal care. Where residents became distressed due to their needs, staff responded with warmth, kindness and patience.

Visitors
Visiting was able to take place unrestricted.

Feedback from visitors was similarly positive. One visitor said, *"They are very supportive of [my relative] but they are also supportive towards me. [My relative] seems to have good relationships with the staff who care for him."* Another person said, *"The care is fantastic. I can be quite critical because I used to be a headteacher, but I can't be critical of this. Christmas was amazing, everyone dressed up as fairies and elves and the buzz was fantastic. They helped us celebrate our wedding anniversary, cooked a meal for us and hired a jazz musician."*

The latest Carehome.co.uk rating was high (9.9 out of 10 from its 36 reviews). The comments were couched in highly complimentary terms and this indicated that stakeholders were very satisfied with the care and support given to their loved ones.

Dignity & Respect
Staff routinely knocked on people's bedroom doors before entering their bedrooms, indicating respect for their personal space. People had call bells to summon attention when they were spending time alone in their rooms and these were left within their reach. Continence products were stored discreetly. Staff were alert to dignity issues and intervened without fuss when they arose.

Confidentiality
Care plans were password protected on computer systems.

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 electronic care planning system in use was Person Centred Software, which is a widely-used and respected care planning system. Care plans were written following detailed assessments of people and contained plenty of person-centred information. As well as the usual activities of daily living there were specific care plans in place for individual health conditions. 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 and as part of the resident of the day system. 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 occupancy at the home had reached a level where the delegated responsibility for ensuring care plan accuracy had reached deputy managers and senior care assistants. At this stage it is sometimes necessary to make clear to those staff the level of attention to detail and accuracy that is required when reviewing care plans, especially when peoples' needs change or develop. Sometimes more junior ranking staff are reluctant to make changes to care plans that were written initially by more senior staff and they need to be given active permission to do so.

Two issues illustrated this point. The first related to emollient creams. Resident 3 had an instruction in the planned care section of the PCS system for *"cream – apply a pea size amount to back (spine and sacrum) in the morning and at night."* The instruction did not make clear what specific cream needed to be applied. When

consulting both the 'personal care' and the 'skin integrity' care plans there was no mention of any cream being required. A similar anomaly was noted for Resident 4, who had *"cream"* that was signed for every morning by staff but there was no mention in any of her care plans about the need for emollient cream application.

A second issue related to peoples' bath and shower preferences and requirements. Resident 5's care plan stated that she, *"Preferred showers over baths and this is where she has her hair washed."* There were no baths or showers marked for the past 28 days. It was unclear from the care plan whether the person required support with showering or bathing.

Resident 6's care plan said, *"Prefers a strip wash each day,* and it also said, *"Would like to be offered a shower each day."* There was nothing recorded for the past 28 days in terms of shower support and nothing to suggest she had been offered showers. Resident 7's care plan stated, *"Prefers to have a shower in the morning and values maintaining her usual routine."* Again, it was not clear whether the person required support and there were no records of any shower support for the past 28 days.

The management team should do a focused project on reviewing each person's personal care requirements and support levels in detail, ensure the care plans accurately reflect the support required and that the daily care records evidence the support is given. Involving the mid-ranking staff in this project will be an important learning opportunity.

See Recommended Actions 4 & 5.

Food & Fluid Records

Food and fluid records were kept for people on nutrition and/or hydration watch. These were regularly kept and fluid records indicated people were sufficiently hydrated. Food records were regularly recorded, but they did not contain much detail. Most records read 'Had breakfast,' 'Had lunch' or 'Had supper.' Some detail about what people ate and roughly how much would be preferable.

See Recommended Action 6.

Care Plan Access
I was given access to read the care plans through the login and password of a staff member. It would be preferable if there were to be 'Guest Professional' login set up. This would be a read-only access account that visiting professionals could use.

See Recommended Action 7.

Consent to Care and Treatment
In the case of Residents 7 & 8 there was one Mental Capacity Assessment (MCA) in place only and this was in relation to whether the people could consent to living at the home. On further investigation it transpired that Residents 7 & 8 may also lack capacity to consent to other aspects of their care, such as medication. Through the MCA processes it is important to make clear that judgements about capacity are decision-specific. This means that a judgement of capacity can only relate to one set of circumstances, not a person generally 'lacking capacity.' Writing a full series of MCAs would help to demonstrate this more clearly.

Key areas to consider for each person might be:

- Can the person consent to their living arrangements? Do they understand they are living at Somer Valley House 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 straps for transportation)?
- Can they consent to their personal care, especially if the personal care sometimes required 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 or Covid19 jabs?

This list is not necessarily exhaustive and the management would need to stay alert that there could be other situations where people might be deprived of their liberty.

See Recommended Action 8.

Activities Arrangements

The lifestyle assistant was on duty and interacted enthusiastically with the residents all day. The residents spoke highly of her efforts. Activities witness included singing and chair exercises.

The lifestyle assistant described many activities that had taken place over the past few months. These included trips out to local farms, a place that housed birds of prey, a shopping trip to M&S, a day out at Victoria park, a trip to an American museum and regular outings to local cafes and pubs. There was a circus across the road that was performing over the next few days and the lifestyle assistant was going around the home collecting names of who may want to go.

Entertainments were brought into the home from outside. There had been singers, a magician, church services, a variety of animals (reptiles, llamas, ponies and dogs) and visits from children from local schools. The lifestyle assistant was planning to start up a choir with the residents.

Within the home there were many day-to-day activities, such as bingo, yoga, various games, musical activities, quizzes, crosswords, paddling outside in a paddling pool, baking, pizza making, one-to-one sessions with people and much more. The garden project had been completed for the home's entry into the Crystal Care in Bloom competition.

Some special activities had also taken place for individuals. One lady had begun knitting again after a discussion with the activity team. Another person was taken out into town to a place where she used to work. She said, *"She had the loveliest day out and felt like crying."*

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

Rhona Sievewright had been promoted to manager a few months prior to the inspection. Rhona had applied to CQC for registration as manager and was awaiting interview.

The home had yet to be inspected by CQC and was unrated. CQC has indicated that new services over one year old without an inspection are on their priority list. So it was likely the home's first full inspection would take place soon.

Management Governance and Audits

A robust internal auditing system was in place, as was the case throughout Crystal Care's homes. The auditing system was robust and covered a wide range of key areas. The sheer amount and depth of the auditing gave confidence the home was well run. The manager believed in the governance system and felt it certainly helped to keep them safe. Actions identified through the audits were placed on a home action plan.

Audits were demonstrated by the manager and included:

- Daily walk around checks
- Daily clinical oversight
- Staffing KPIs
- Pressure ulcer review (none)
- Moisture lesions review
- Bed rails and grab rails audit
- Wounds review

- Weights and weight loss management
- Infections review with trend analysis
- Distressed behaviours list
- Antipsychotic medicine review
- CQC notifications review
- DoLS audit
- Duty of candour audit (none)
- Safeguarding review (none)
- Complaints audit
- Equipment log
- Hoists and slings audit
- Fire drills (day and night)
- Maintenance certificate review
- Call bell response time monitoring (see below)
- Dependency staffing calculations
- Catering audit
- Lifestyle audit
- First impressions audit
- Night visit
- Finance audit
- Dining experience audit
- Mattress audit
- Pressure cushions audit

The call bell response time data was surprisingly low. The feedback from residents and the general patterns of care through the day did not suggest that call bells were ringing for a long time before being answered. However, the data said otherwise, with statistics for recent weeks indicating that only 75% or so of call bells were answered in under 5 minutes. This had been identified by the manager and the regional director. Analysis was taking place to try to ascertain precisely why this was the case and an action plan was being formulated.

See Recommended Action 9.

Provider Visits

The regional director was present during the inspection. The provider had an in-depth MGV (monthly governance visit) that the regional director would complete every

month for each home, which formed part of the KPI document. This was in addition to the other support that the regional director would give to the team.

Management and Leadership Observations.

The general manager had done an excellent job since her appointment, providing stable and capable leadership. The manager presented the home enthusiastically, demonstrating a great affection for the residents of the home and their different characters. Both residents and relatives were full of praise for the job the manager and her staff did. Staff were also positive about the management team. This was the case without exception.

The team responded well to the inspection and were keen to learn and develop. Recommended actions were received in a constructive manner. The home was a pleasant and welcoming place to visit, was where it should be at this stage of its commissioning journey and was in a good position to receive its first CQC inspection.

Crystal Care is a new provider, with an ambitious growth plan for several newly constructed residential homes across the country. The directors and senior staff are experienced operators with much experience of building, growing, owning and operating high quality care services. The management systems in place for governance, regulatory compliance and culture are strong and are a hybrid of the best bits of management systems taken from several different successful organisations both past and present. The company's growth plan will only succeed if management teams adhere closely to the tried and tested methods in place.

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 investigate the stock discrepancy for Resident 1's Lansoprazole.
2	Please improve the information available in the PRN protocols, as explained in the main body of the report.
3	Please ensure staff keep potentially hazardous cleaning materials and dishwasher tablets locked away at all times when not in use.
4	Please update Resident 3 and Resident 4's care plans in relation to their emollient cream requirements.
5	Please review each person's personal care requirements (especially relating to baths and showers) in detail. This is with a view to ensuring that care plans accurately reflect their personal care requirements and that daily care records reflect the support that is given.
6	Please enhance the food records with more detail about what people have eaten and roughly how much.
7	Please consider having a read-only 'guest professional' login available. This would give access to the PCS system that is not under an individual staff member's personal account.

8	Please undertake a series of Mental Capacity Assessments (MCAs) for the specific decisions that Residents 7 & 8 may lack the capacity to consent to.
9	Please look carefully at the call bell response time data to try to improve the response times to at least 90% answered in under 5 minutes.

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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