THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

ROWNHAMS MANOR

CQC RATING GUIDE: '**GOOD**'

Privately Commissioned Inspection for

Rownhams Manor

Conducted by:

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Date of Inspection:

16th October 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 **Rownhams Manor.** Rownhams Manor is a new residential care home for older people including people living with dementia, located in Southampton. The facilities are impressive and the environment is amongst the most highly sought-after in the residential care market. This was my second visit to the home, following an initial inspection in October 2024. The home opened in May 2024 and there were 49 people in residence.

The team had continued to build on their good start and the home was developing well in all areas. Residents and relatives were complimentary about the care provided. All care interactions witnessed were of a high standard. Staff at all levels spoke appreciatively of their working conditions, the support they received and their colleagues. Nobody raised any concerns. The atmosphere was calm, positive and cheerful and there was an obviously kind and caring culture. Even though the lifestyle manager was on leave, there was good evidence of meaningful activity and proactive community engagement.

The home was performing well from a regulatory compliance perspective. Governance systems were robust, ably demonstrated and were embedded as part of the ongoing management routines. Medication systems were safely managed. Mandatory training and staff supervision were mostly up to date. There were plenty of staff on duty and they had been properly recruited in line with regulation. The lunchtime experience was well managed. The home's environment was clean and well presented. All of this was unchanged from last year's inspection.

Care planning and daily record keeping was of a good standard. However, there were some areas picked up where attention to detail could be improved. These areas

were the recording of fluids offered to people on hydration watch, the recording of the administration of emollient creams and an inconsistent standard of mental capacity assessments and best interest decision making documents. These recommendations were standard and routine matters for a home at this stage of development and not indicative of any significant concern. The management team (and the whole staff team) engaged well with the inspection process and were keen to learn and improve.

The provision was, broadly speaking, where it should be at 18 months old. The manager described the current focus as being on more staff recruitment and this was with a particular focus on the mid-ranking staff, such as senior care assistants. Once some more staff were inducted then the team would be in good shape for the final climb towards full occupancy.

The home was a pleasant and reassuring place to spend a day.

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 and comfortable ‘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 people living with dementia. There were 49 people in residence on the day of my visit. The home was laid out over two floors and both floors were fully open.

The manager confirmed that minimum staffing levels for the current occupancy levels were as follows:

Ground Floor – (25 people in residence.)
(am) 1 senior care assistant (or deputy manager) and 3 care assistants
(pm) 1 senior care assistant (or deputy manager) and 3 care assistants

First Floor – (24 people in residence.)
(am) 1 senior care assistant (or deputy manager) and 3 care assistants
(pm) 1 senior care assistant (or deputy manager) and 3 care assistants

This meant that eight care staff were the minimum acceptable level during the day, although often there were nine or ten care staff, as the home was staffed to grow its occupancy further. On the day of inspection there were nine care staff and another person who was shadowing more experienced staff as part of their induction.

At night there were five care staff, typically comprised of 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 were kitchen staff (chef or sous chef and kitchen assistant each day), maintenance manager, lifestyle manager, lifestyle assistant (to start induction shortly), front of house manager, head housekeeper, and domestic team (including dedicated laundry staff). Hairdressing 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.

Both the management team and the staff team were of the view there were comfortably enough staff to care for people appropriately and provide a quality service. From my observations during the day there were sufficient 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. The management team undertook a regular dependency monitoring exercise as one way of ensuring the staffing was sufficient. This exercise indicated that staffing was more than sufficient.

Staff Vacancies
There were enough staff on the books to cover the current staffing roster requirements, although the manager reported that additional recruitment was a priority area. Several staff had been appointed pending regulatory checks and these were two senior care assistants, three care assistants, a housekeeper, a lifestyle assistant and two bank care assistants. There was also a new head housekeeper who would replace the existing incumbent who was moving to a different home in the Oyster Care group.

Once those staff had been inducted there were another seven or so care staff who would need to be identified to complete the staff team for when the home was fully occupied.

Agency Staffing
No agency staff had ever been used at the home.

Staff Recruitment Files
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
- Supervision notes

Open Safeguarding Cases
The manager advised there were no open safeguarding cases at the home. The management team had a good understanding of safeguarding and what needed to be referred.

Medication Management
The medication trolleys were kept in secure medical rooms on both floors. At this inspection I audited the medical room on the ground floor. The systems were ably demonstrated by the care manager. I found that the medication systems were safe and well-managed.

- 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.
- Fridge medicines were stored correctly.
- Specified room cleaning schedules were completed daily.
- The trolleys were tidy and well organised and attached to the wall.

- Medication was delivered regularly in original packaging – a non MDS approach.
- Controlled drugs were properly stored, regularly audited and a random spot check indicated correct stock levels.
- Bottles of liquid medicines were dated upon opening
- Do not disturb tabards were worn by staff administering medication.
- PRN protocols were in place and well written.

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 and all were correct.

Premises Safety & Management

The home was clean and well presented. No unpleasant odours were noted anywhere. The home was warm and cosy, with ambient temperatures being suitable for older and more sedentary people. There was only one exception to this where an air conditioning unit in the ceiling came on and for a short time made one person feel cold. This was sorted out quickly and the temperature reset.

Domestic staff worked safely with their cleaning materials. Sluice rooms were locked at all times. COSHH cupboards were also locked when not in use.

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 home employed 61 staff. The provider used a system called Coolcare to monitor the frequency of supervision and appraisal meetings. The system showed the vast majority of supervisions to be up to date and all appraisals. There were a variety of reasons for a few supervisions overdue, with the manager's due to take place on the day of inspection, one person on maternity leave and a couple of staff who had been on leave and were due back shortly. This meant that supervision and appraisal was closely monitored and kept up to date.

Minutes of supervision and probation review meetings were kept on personnel files and were signed by both parties.

Staff Feedback

Staff at all levels spoke appreciatively of their working conditions and support they received. It was especially notable how positive the feedback from staff was about their colleagues as well as the management. The team were keen to present that they got on well as a staff group and morale was good.

One staff member said, *"I love it here. I left for a bit but I came back because I missed it. The management are approachable and easy to work for and the rest of the staff are really nice too."* Another member of staff commented, *"This job has been really good for my confidence both inside and outside of work. So I'm very happy with it."*

Mandatory Training

When new staff were appointed to work at the home they were expected to undertake basic training to do their jobs. Mandatory training compliance figures were high, at **91%**. A good proportion of the missing 9% was due to three new staff who had only

just started work and were in the process of completing their required training during their inductions. Some face-to-face training was booked in for the next few weeks, which would push the compliance percentage higher still.

Mental Capacity - DoLS

The management team had a good understanding of DoLS requirements. A clear matrix was in place and showed that 16 DoLS applications had been correctly submitted 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 had been determined (approved) by the local supervisory body. A CQC notification had been sent as required.

Eating and Drinking

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

- Appropriate classical music was playing during lunch.
- Tables were nicely laid and clear menus were on display.
- People were given a choice of where to sit.
- Staff were wearing appropriate protective equipment in the form of washable aprons.
- Napkins were available and clothing protectors were offered to people as appropriate.
- There were plenty of staff around and they interacted with residents well, being focused on their needs and wishes.
- Some people were able to use plate guards to assist them to eat by themselves.
- Choices of different drinks were given to people.
- Refills were available on all tables, with jugs of further drink available.

- Choices of main courses were given by use of show plates, which is the best way of offering a meaningful choice to people living with dementia. Staff were discreet in how they communicated the orders back to where meals were being served.
- The chef was involved in the serving out process.
- 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, staffed by a friendly front of house manager. There was a fully working tea and coffee bar with fresh cakes that were made every day by the chef. 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 sweet shop. There was also a fully kitted out hairdressing salon. Snack and hydration stations were available in the lounges.

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. Attractive wooden name plates were attached to their bedroom doors. The bedrooms were fitted with smart televisions and refrigerators.

Garden

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

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

As was the case during my previous visit to the home, all interactions between the staff and residents at the home were compassionate and positive. The staff exhibited attentiveness, cheerfulness, and friendliness consistently. Residents were engaged with kindness and patience, with many of the staff fostering an atmosphere of playful banter and laughter where that was appropriate. Staff members allocated time beyond personal care duties to spend meaningful social time with the residents. It was notable how staff broke off conversations with me to answer call bells or attend to residents needs immediately, indicating a residents-come-first culture.

Feedback from residents was most positive and grateful about their experiences of living at the home. Quotes included:

"This is so much better than my last home. It's the culture. It's like a friendly family."
"The staff work really hard."
"The lunches are normally very nice."
"Manners maketh man as they say – and this lot succeed."
"The staff are polite when they address you. I appreciate that and this applies to all of the staff."
"I've been dancing this morning. I'm exhausted now. It's been great."
"Everyone is so kind and caring and lovely."
"I've been here a couple of months and I'd say the food is excellent."
"We're all friends here. It's a friendly place."
"I can make my own cups of tea."
"They take us out sometimes. We went to a place with aeroplanes. It was fun to go out on the coach."
"They look after me here and they're lovely. I have no complaints about anything."

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. The feedback received from visitors was similarly positive to the resident quotes in the previous section. One visitor said, *"They've been absolutely wonderful. This is streets ahead of the last place he was in."*

The carehome.co.uk website rated the home as 9.9 out of 10 from the first 21 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 Staff were alert to situations where peoples' dignity may be compromised and intervened without fuss.

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 electronic care planning system was Person Centred Software, which is a respected and widely-used care planning system. Care plans were written following detailed assessments of people and contained plenty of person-centred information. The care plans I read were well-drafted and informative, including plenty of life history information. Specific care plans were in place for individual health conditions, for example being on antibiotics for infections.

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. People were only accepted to live at the home if their needs could be met and were compatible with the needs of other people already living at the home.

Care plans had been reviewed on a monthly basis, as part of the provider's resident of the day scheme. 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.

Consent to Care and Treatment

Mental capacity assessments (MCAs) were in place where there was a doubt about individual people's capacity to consent to various specific aspects of their care. Best interest decision making documents had been prepared when people lacked the capacity to consent to a specific decision. For example, in Resident 2's case there were separate MCAs and best interest processes for use of a sensor monitoring mat,

flu vaccinations, living at Rownhams Manor behind a key coded door and medication administration. This person's MCAs were well drafted.

In Resident 1's case the MCAs were less well drafted. There were two MCAs in place, one for living at Rownhams Manor and the other for use of a sensor monitoring mat. In the first one there was no best interest decision recorded and the best interest checklist had been left blank. Also, the person may have required additional MCAs to be considered for other specific decisions, such as medication management, and these were missing.

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 Rownhams Manor 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.

See Recommended Actions 1 & 2.

Mental capacity care plans should be updated to include a write up of each specific MCA and then best interest decision taken. Each MCA and best interest decision reached should be addressed individually in the care plan. Then the care plan should move on to discuss what aspects of life the person is able to consent to and so these things can be encouraged and promoted.

See Recommended Action 3.

Daily Care Records

Use of the PCS system meant that paper charts were not required and records could be kept quickly and contemporaneously by use of electronic handsets. Hygiene charts were in place for everyone and these indicated personal care had been given regularly and as required. This matched with the outward presentation of personal care within the home.

Food records were recorded diligently by staff for people on nutrition watch. There was one person (Resident 3) who had been placed on hydration watch after being prescribed antibiotics. A daily fluid target of 1,500mls had been set. The amounts offered for each day were recorded a much less than this – specifically 1440, 400, 680, 0, 1210, 200, 0. Fluids were being offered regularly during the day throughout the home by staff as a matter of course, so this was likely a recording issue. Nevertheless, it could not be demonstrated that Resident 3 had been offered at least her daily target of fluids each day over the past week.

See Recommended Action 4.

The team had made a recent change to record the application of emollient creams on the PCS system. There were several signature gaps noted, but these issues were all due to the cream applications not being prompted in the 'planned care' facility.

Resident 4 – *"500mg of Epimax original cream. To be used twice daily to all areas of skin."* There was only the occasional signature and this was not being recorded as done twice daily.

Resident 5 - *"500mg of Epimax original cream. To be used twice daily to all areas of skin."* This was only being signed for once a day.

Resident 6 – *"500mg of Zeroveen cream. To be applied to body twice daily."* No signatures had been made since 5th October.

Resident 7 – *"500mg of Zeroveen cream. To be applied to body twice daily."* Only one signature in the last few days.

These are examples and all emollient creams should be checked for similar issues.

See Recommended Action 5.

Activities Arrangements

The lifestyle manager was not working on the day of inspection, but care staff ensured some activities took place. One of these was pumpkin decorating for Halloween. Some of the residents described how they found the activity sessions engaging.

Specific activities were advertised for each day during the month. These included chair exercises, arts and crafts, birthday parties, games, nails and pampering, meditation sessions, baking, ladies club, movie afternoons, reminiscence sessions, quizzes, flower arranging and much more. There had even been a silent disco. There were regular sessions of chair yoga and an Emmerdale club, for a group of residents who gathered regularly to watch Emmerdale Farm on the television.

There had been various community-based activities. The team had participated in many charity events and had raised money for several different charities. In one case a resident wished for money raised by the summer fayre to be sent to a local hospice that had looked after her husband. This was agreed and the gesture made the resident very happy.

Various people had come to the home to visit. This included a local church, a local Scouts troop, a 'Men's Shed' group, a local band (who played some music) and a local library came for a reading visit.

The team had recently started to present individual stories on an Impact Tree. This was where the team had enabled events that were particularly special to individuals. One of the residents was a hundred years old and used to work at sea on board large ships, including twenty years as a captain for P&O Ferries. The team arranged for him to have a VIP tour of a modern ship, including individual sessions with the crew. He was able to exchange stories with them. He was enlivened by the whole process saying, *“I’m so touched by this. The technology is remarkable. Back in my day it was all smaller and much more manual.”*

Another person used to be a teacher and so the team took her to a local community school to reminisce about the teaching profession. She said, *“It’s changed so much from when I did it. I think I’ve done my time.”*

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, Sam Squibb, was registered as manager with CQC.

CQC Rating

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

CQC Notifications

CQC notifications had been submitted as required.

Management Governance and Audits

A robust internal auditing system was in place, as was the case throughout Oyster 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 governance system was presented in detail by the care manager. The management team believed in the governance system and it was embedded as a daily part of the home's running. Actions identified through the auditing and governance processes were placed on a home action plan. Audits for September 2025 included:

- Daily walk around checks
- Pressure ulcer audit
- Moisture lesions audit

- Wounds review
- Bed rails (none)
- Weights and weight loss management
- Infections review
- CQC notifications
- DoLS review
- Duty of candour
- Safeguarding review
- Complaints log
- Equipment log
- Hoists and slings audit
- Fire drill audit
- Maintenance certificates (all in date)
- Accidents and incidents review, with graphical and trend analysis
- Falls summary
- Distressed behaviour lists
- Dependency tracker
- Call bell response times monitoring (good results)
- Night visit audit
- Lifestyle audit
- Catering audit
- Medication audits
- Finance audits
- Care plan audits (by management – minimum 10%)
- Health and safety audits
- Pressure cushion audits
- Mattress checks

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

Provider Visits

The home's management team were full of praise for the support they received. The provider had an in-depth MGV (monthly governance visit) that the regional director completed every month for each home, in addition to other support available. The regional director was present throughout the inspection day.

Management and Leadership Observations.
The management team presented as capable, knowledgeable, sensible and hard-working. The home had continued to progress in line with the provider's plan over the past year. The home presented competently in almost every aspect of the service. This report contains very few recommended actions for a report written after 18 months of continuous growth.

Residents and relatives were complimentary about the care provided. All care interactions witnessed were of a high standard. Staff at all levels spoke appreciatively of their working conditions, the support they received and their colleagues. Nobody raised any concerns. The atmosphere was calm, positive and cheerful and there was an obviously kind and caring culture. The home was performing well from a regulatory compliance perspective. The home's environment was clean and well presented.

Even though the lifestyle manager was on leave, there was good evidence of meaningful activity and proactive community engagement. The impact tree and community tree were good initiatives and helped the team to showcase their work in an appropriately positive way.

The home was a pleasant and reassuring place to spend a day.

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 complete Resident 1's mental capacity assessment for living at Rownhams Manor, explain what the best interest decision is and complete the best interest checklist.
2	Please review all mental capacity assessments and best interest decisions for people who lack capacity to consent to key aspects of their care, ensuring they are completed to the same standard as those of Resident 2. Please draft additional MCAs for other specific decisions as required (as explained in the main body of the report).
3	Please ensure mental capacity care plans make reference to each specific aspect of the person's care where a best interest decision has been taken and explain how the care is to be given in detail.
4	Please ensure that Resident 3 is offered at least her daily recommended target of fluids.
5	Please ensure that staff sign on PCS when they have applied emollient creams.

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.

www.woodberrypartnership.co.uk

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