THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

SANDPIPER CARE HOME

CQC RATING GUIDE: '**GOOD**'

Privately Commissioned Inspection for

Sandpiper Care Home

Conducted by:

Simon Cavadino

Date of Inspection:

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Executive Summary

Tanglewood Care Homes operates residential care homes for older people across the Midlands and the North of England. The company aims to provide high quality care in safe and comfortable surroundings, always promoting independence and choice. As part of Tanglewood's quality assurance programme, additional 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 **Sandpiper** residential home in Alford, Lincolnshire**.** Sandpiper provides residential care for older people, including some living with dementia. This was an inspection visit, along with giving some management support and was my first visit to the home since November 2023. A new manager (Steven Clements) had taken over in September 2024, promoted from within the team into his first registered manager position.

The new manager had made a good start to his new role. Sandpiper was a smaller family-style care home and the intimate, friendly feel had been retained and enhanced. Interactions between staff and residents were cheerful, relaxed and caring and this was unchanged from previous visits. Feedback from residents and their relatives was complimentary about the care provided. Personal care was of a good standard across the home, with people well-presented and wearing properly fitted clothing.

The mealtime experience was well managed. Some fun activities took place during the day, although the team were awaiting the start of a full-time lifestyle lead, who was currently on induction in another Tanglewood home. Staff were recruited in line with regulation and were well trained and supervised. Staff spoken with were complimentary about the new manager, describing him as approachable and supportive. The staff team from all departments were friendly and welcoming.

Quality assurance and governance systems were in place, which were robust and up to date. Medication systems were properly managed, with a new electronic system recently implemented. Care planning was of a decent standard 'on the surface,' but there was one case in particular where the care plan did not reflect the

person's presenting needs or the care provided. There were some people who required regular repositioning to avoid (and to treat) pressure injuries. Records were well kept during the day but did not always reflect necessary repositioning at night. Some improvements were necessary in the recording of emollient creams. Recommended actions for these matters are made as necessary in the report.

The manager and his team responded well to the inspection process and were keen to learn and develop. The home was a pleasant 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 'Good' rating in most areas. However, some important improvements in some aspects of care planning and daily record keeping were required, meaning the benefit of the doubt was given with the score for the 'Responsive' key question.

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

Care Staffing Levels

The home was registered for a maximum of 30 people and there were 28 people in residence on the day of my visit. The home was popular in the local area with a good reputation. The home cared for people with residential care needs, some of whom lived with dementia. Care staffing levels were as follows:

(am) 2 senior care assistants and 4 care assistants.
(pm) 1 senior care assistant and 4 care assistants.
(nights) 1 senior care assistant and 2 care assistants

The manager was happy with the care staffing levels, as were the care staff who expressed an opinion. The manager was confident that if residents' needs changed significantly the provider would respond favourably to conversations about additional staffing. Regular dependency monitoring work took place, using a formal staffing dependency tool that was updated monthly. The dependency tool indicated staffing levels were comfortable and above the minimum necessary.

From my observations during the day there were plenty of staff to care for the current resident group, with staff having time not only to attend to peoples' personal care but also to engage them in pleasant conversation and relaxed activity, which they did throughout the day. This contributed to a calm and cheerful atmosphere.

Ancillary Staff

In addition to the care staff there were several domestic staff (including laundry cover), a chef and a kitchen assistant on duty each day. There was a maintenance manager, head housekeeper and an administrator. A lifestyle assistant was

employed and working in the home, with a new lifestyle lead just appointed and on induction. Hairdressing and chiropody was provided by local contractors.

The registered manager was supernumerary to the care team and there was a residential care manager who had some allocated supernumerary time.

Staff Vacancies
The home was staffed by a committed group of local staff and was almost fully staffed. Some staff had worked at the home for a long period of time. There was one care vacancy, to cover a period of maternity leave for one night staff member. The manager had recently appointed a bank housekeeper to cover any shortages.

It was no longer necessary to use agency staff at the home.

Open Safeguarding Cases
The manager described one open safeguarding case. This related to an unsafe discharge from hospital where a person had been returned to the home with an injury. This had been raised by the home against the hospital. There were no safeguarding cases open where the home was under any scrutiny.

Staff Recruitment files
I looked at the recruitment information for staff recently recruited to the home, demonstrated by the administrator. The personnel files were stored securely on the computer system and contained all of the required information, including:

- Recent photographs
- Full employment histories
- DBS information
- ID
- Job descriptions
- Contracts and terms and conditions
- Medical questionnaires
- Suitable references
- Supervision and appraisal documents
- Various key policy documents – signed as seen

Medication Management

The home had medical rooms on both floors, where the main stock, medication refrigerators and controlled drugs were kept. At this visit I audited the medical room on the ground floor. The medication systems were ably demonstrated by one of the senior care assistants. Good practice included:

- Temperatures of the medication room and medication refrigerator were monitored on a daily basis. The records indicated safe storage temperatures.
- Keys were kept safely by senior staff.
- The medical room was clean and well organised.
- The medication trolley was organised logically.
- Controlled drugs were stored correctly.
- Medication was delivered in its original packaging rather than a monitored dosage system.
- Bottles of liquid medication had been dated upon opening.
- Regular stock checks were conducted on the medication.

The home used an electronic MAR system. This 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 on the system. I undertook ten separate random stock checks and the amounts were correct in all cases.

The medication trolley had not been attached to the wall in the medical room.

See Recommended Action 1.

PRN protocols

PRN protocols were in place for 'as required' medicines. Some of them were well written, but others were generic and missing key information. For example, Resident 1 was prescribed Lorazepam on an 'as required' basis and there were no instructions to guide staff about the circumstances when the medicine should and should not be given. There was little information about the circumstances when Resident 2's paracetamol should be given. Both PRN protocols required much more detail to

explain the exact circumstances when the PRN medicines should be given. The following information is added for further 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 should refer to the following 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?
- If medicine is to regulate bowel functioning, details of what is normal or abnormal for the person are required.
- Where dosage directions are 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 warm and clean throughout. No unpleasant odours were noted. Domestic staff worked hard throughout the day.

All COSHH products were stored securely and all sluice rooms were locked. Domestic staff looked after their trolleys and cleaning materials well.

Laundry Room
The laundry room was located on the ground floor. A red bag system was used to wash soiled laundry separately on sluice washes. The laundry equipment was all functioning well.

Kitchen
At the most recent Environmental Health (EHO) inspection the kitchen had received a score of 3. This was disappointing for the home, with the issues being mainly the need for a new dishwasher and some new sink units. The remedial work had been done and the provider had requested a reinspection from EHO.

The kitchen was clean, with detailed daily cleaning schedules in place. Dining room cleaning schedules were also kept. Food was stored correctly in fridges and freezers, with temperatures monitored daily. Hot food temperatures were taken daily and recorded, indicating safe hot food was served. The kitchen was in a good position to receive a re-inspection, although the only thing that could not be located was the last time the food probe was calibrated. The chef undertook to ensure that was resolved.

See Recommended Action 3.

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 & Appraisal

There were 43 staff employed at the home. The manager demonstrated through use of the Coolcare system that supervision and appraisal was up to date for all staff. Supervision was scheduled to take place every three months and appraisals were conducted annually. Supervision notes, signed by both parties were scanned into the staff personnel files.

Staff spoke positively about the new manager, indicating a healthy culture at the home. One staff member said, *"Steven is a nice manager to work for. You can go to him with a problem and he listens."* Several staff referred to the 'family' atmosphere of the home, which the team deliberately cultivated and appreciated.

Training

The training system (E-Learning for You) presented clearly when all of the staff had last completed their mandatory training courses. The manager said that there had been efforts made recently to improve the compliance levels. This had been successful, as mandatory training levels were showing at over **97%**.

Courses covered by the mandatory training included basic life support, fire marshal training, fire safety, safeguarding (adults and children), Oliver McGowan (learning disability and autism) training, COSHH, GDPR, dementia training, dignity and respect, equality and diversity, food safety, health and safety, infection prevention and control, moving and handling (practical) and MCA/DoLS.

Once these courses had been completed staff were then required to attain the following courses as 'additional' training: Diabetes, positive behavioural support, customer service, dysphasia and texture, oral health, pressure ulcer care, sharps awareness, topical medication, urinary incontinence, wound care management, duty

of candour, end of life care, fluids and nutrition, person centred care and sepsis awareness. Records showed that **86%** of these additional courses were complete.

Mental Capacity - DoLS

The manager evidenced a good understanding of when DoLS applications were required for people through discussion. DoLS applications are required when people meet all three 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.

24 DoLS applications had been made and copies were kept on file. 18 of the applications had been determined by the local authority with 6 still awaited. CQC notifications had been submitted as required. This information was presented clearly on an up-to-date spreadsheet that was monitored monthly as part of the home's governance systems.

Eating and Drinking

I witnessed the lunchtime experience in the dining room on the first floor. The dining experience was positive, calm and well-managed, with much good practice observed:

- Old-style background music was playing, which lightened the atmosphere.
- Plenty of staff were assisting, including from the ancillary departments.
- Staff were wearing appropriate protective equipment.
- People were offered napkins and aprons to protect their clothes if they wished.
- Choices of drinks were offered.
- Meal choices were offered to people by offering them plated-up alternatives. This is the best way of ensuring a meaningful choice is given to people living with dementia and was an improvement from my last visit to the home.
- All interactions between staff and residents were kind, cheerful and patient.
- Where people were supported to eat their lunches this was done individually and from a seated position.

- Nobody was rushed with their meals.
- Families were welcome to visit during lunchtime and assist where required.

Premises Presentation
Entrance and Reception Area
The home had a bright entrance and reception area, staffed by a helpful administrator. The manager's office was accessible off the main reception. Comfortable chairs were available, enjoyed by quite a few people who lived at the home and liked to watch the comings and goings from the home.

Certificates of registration, employers' liability information, CQC rating and other key information was displayed on the walls. This included the home's statement of purpose. This document was out of date and needed updating to include the details of the new manager.

See Recommended Action 4.

Design and Adaptation
The home was adapted for people who have mobility restrictions. None of the bedrooms had ensuite toilet facilities, but all had wash hand basins. Full communal assisted toilet and bathing facilities were available on each floor.

Communal Rooms
The lounges and dining rooms were welcoming, clean and appropriately furnished. Some redecoration was taking place to the communal area upstairs. There were lounges on both floors, one which doubled as a dining room. In the lounges there was music playing and televisions to watch.

Orientation boards with the dates and times were all up to date and correct. Snack and hydration stations were available throughout the home, with lots of cakes and attractively looking food. Objects of reference suitable for people living with dementia (such as dolls and games) were available and were well used by some of the residents.

The old green carpets were gradually being replaced with more appropriate flooring. However, some still remained and these let down the presentation of the home in the reception area and the upstairs corridors. The manager said that replacement of these carpets was on the list of forthcoming upgrades.

Bedrooms

Many of the bedrooms were nicely personalised with people's own belongings and photographs of their families. In some cases people had their own furniture in their rooms, which was actively encouraged. This enabled them to feel settled at the home.

Garden

There was a pleasant and well-presented secure garden area.

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 positive and cheerful relationship between the staff and the residents. There was plenty of gentle banter, happy chatter and laughter throughout the day. The staff showed unconditional positive regard and patience for people living with dementia, despite it being a very busy morning at the home. This creditable attitude remained unchanged from previous visits. Staff had time to spend interacting with people and did so in a friendly, cheerful and positive way.

Feedback from residents was complimentary about the staff and their care. Nobody raised any concerns. Quotes included:

"I feel at home here. If I ever didn't I'd soon tell them."
"All of the staff are lovely. I can't fault them."
"It's a happy place. We have some fun. There's a lovely family atmosphere."
"We can have visitors when we want. I love it when my granddaughter comes."
"We get well fed."
"I've been here a long time and it's like home."

Some people were not able to speak meaningfully with me due to their dementia care needs, although most people had a good sense of wellbeing. Staff responded proactively and with compassion to people who were distressed. Personal care was of a good standard across both floors with people clean, well presented and wearing properly fitting clothing.

Visitors

Visiting was allowed unrestricted, with relatives coming in and out in a way that suggested they were always welcome at all times. Feedback from relatives was similarly positive to that received from residents.

The latest Carehome.co.uk rating was 9.9 out of 10 from the last 29 reviews, indicating a consistently high level of satisfaction from relatives. Recent reviews were written in warm and positive terms.

The manager had put up a ‘compliments’ board in reception where cards and compliments were recorded for all to see. There were lots of heartfelt thanks and praise for the work of the team over the past year.

Privacy and Dignity
The staff team were responsive to people when they required personal care and assistance. Staff knocked on doors and waited for a response before entering, indicating a respect for people’s personal space. Call bells were left within people’s reach when spending time in their bedrooms. Continence products were stored discreetly. Moving and handling manoeuvres were undertaken with dignity.

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

A new care planning system, Person Centred Software (PCS) - a well-established care planning software package, had been fully implemented.

Residents had detailed care plans in standard areas of care written up on the system. The care plans I looked at were presented in a user-friendly and readable format. All of the key sections were completed properly and there were additional care plans written for specific conditions. Summary sections provided a good introduction to people's care on the front page. This was the case for a care plan for a newly admitted resident, showing that the team were keeping up with what was required. Care plans had been reviewed regularly.

Risk assessments were completed, with standard scoring systems to ensure that risks to people were identified and managed effectively. This included people's risk of developing pressure ulcers, risk of falling and risk of becoming malnourished. The risk assessments had also been reviewed regularly.

I looked at Resident 3's care plan in detail, partly due to observing her walking around upstairs on linoleum with only socks on her feet. The falls prevention care plan stated, *"The team are to ensure that [Resident 3] is wearing correctly fitting footwear at all times. These must fit well, be fully fitting and fasten correctly. [Resident 3] will need support from the team to put on their footwear."* Resident 3's mobility care plan also confirmed the need for the properly fitting footwear. The falls prevention care plan referred to Resident 3 having a walking frame that staff should prompt her to use.

There were no attempts from staff either to prompt Resident 3 to use a walking frame or to try to assist her to put on properly fitting footwear. The care plan did not reflect the reality of the care on the ground. On further investigation it transpired that there

would be little chance of the resident accepting support to wear full footwear and the staff were unaware of any walking frame.

In the falls prevention care plan there were some poor sentences, with odd pronouns, that suggested the care plan had been copied and pasted (at least initially) from elsewhere. For example, one sentence read, *"[Resident 3] requires the use of a walking frame when walking. **They** will often forget to use this and will need the team to regularly observe **him** [Resident 3 is female] and prompt **them** to use the walking frame." [My emphasis].*

The falls prevention care plan stated Resident 3 had a high risk of falls. The mobility care plan said the risk of falls was medium. This was contradictory information.

In Resident 3's care plan for behaviour support there was the use of the word 'wander' to describe a resident's walking. This is a term that some can find disrespectful and so use of 'walking with (or without) purpose' would be a better term to get into the habit of using.

See Recommended Actions 5 & 6.

Consent to Care and Treatment

Mental capacity assessments (MCAs) and best interest decision making documents had been completed where people lacked capacity to consent to some or all of their care. The documents were decision-specific and related to important areas of care where people may be deprived of their liberties. In the case of Resident 3 the topics covered by the different MCAs were residing at Sandpiper and receiving 24-hour care, nutrition and hydration, medication management, covert medication, medical information and continence and toileting.

The mental capacity care plans (both for Resident 3 and in other examples) did not make reference to the MCAs and best interest decisions taken. All MCAs and best interest decisions taken should be referenced individually in the mental capacity care plan, along with details of what the person does have capacity to do.

See Recommended Action 7.

Daily Care Records
Food records were kept diligently by staff, as were records of personal care and hygiene interventions.

Fluid intake recording was being recorded by the staff on the PCS handsets for people who required this. In most cases records were well made. However, for Resident 4 the records of amounts offered were less than the fluid target amount.

Resident 4 – (1500mls per day target). The last few days were 1280, 1350, 1400, 960, 1500, 1150, 1150.

See Recommended Action 8.

It was unclear where the application of emollient creams was being recorded. The manager believed that the PCS system was being used, but live examples were discussed where the information could not be seen. The application directions for each emollient cream prescribed should be transferred to the system and, where the prescription is regular, these can be set up as 'must do' tasks in the daily planned care. In the application directions it is important to include the exact cream, where (on the person's body) the cream application should be made and how often the cream should be applied. Care assistants then can record having completed these tasks on the system, prompted each day on their handsets. Once all the emollient creams have been set up in this way, three clicks of a mouse can produce full topical MAR charts (TMAR) for the last 28 days.

See Recommended Action 9.

Resident 2 required repositioning by staff every 4 hours, including during the night. Records showed good repositioning activity during the day, but there were several examples where gaps of much longer than 4 hours were left during the night:

- 22.36 on 2 June to 06.31 on 3 June
- 23.34 on 31 May to 07.01 on 1 June
- 23.15 on 30 May to 07.12 on 31 May
- 21.27 on 29 May to 05.02 on 30 May

- 23.36 on 28 May to 07.01 on 29 May

Resident 4 had a similar issue noted. Needing 4-hourly repositioning during the night (having been admitted recently to the home with a pre-existing pressure ulcer) there were regularly much longer gaps than 4 hours in the records:

- 00.02 to 08.03 on 3 June
- 20.47 on 1 June to 08.12 on 2 June
- 20.01 on 29 May to 12.05 on 30 May
- 20.09 on 28 May to 07.26 on 29 May

See Recommended Action 10.

Activities Arrangements

The manager had been working towards recruiting a full-time lifestyle manager to enhance the activity function, which had been identified as one aspect of the home to improve. A new lifestyle manager had just started induction and was undertaking training at another Tanglewood home locally.

The existing lifestyle assistant was on duty and interacted well with the residents during the day, for example running an exercise session on the first floor before lunch. This was enjoyed by those that participated and there was plenty of fun and laughter. There had been a recent trip to Woodthorpe Garden Centre and there was a forthcoming day at Skegness Aquarium.

Activities will be looked at in more detail at future inspections.

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

CQC Notifications

CQC notifications were made appropriately and were kept on file. These included death notifications, notification of serious injury and DoLS approvals.

Registered Manager

The manager, Steven Clements, was recently registered as manager with CQC.

Management Auditing and Governance

The provider's management and governance systems were historically strong. Auditing was wide-ranging, regularly repeating and robust. When auditing and governance work identified actions to complete they were added to the home improvement plan and implemented. The manager demonstrated governance work relating to May 2025, which included:

- Daily clinical and operational oversight
- 10 at 10 meetings
- Pressure ulcer audit
- Wound care audit
- Bed log
- Bed rails audit
- Monthly weight review and action plan for losses
- Medication monitoring
- Covert medicines list, antipsychotic medicines and benzodiazepines review
- Infection monitoring
- CQC notifications review

- Safeguarding cases review
- Whistleblowing cases (none)
- Complaints (none)
- Accident and incident reporting with detailed graphical representation and trend analysis
- Dependency monitoring
- Call bell response time analysis (very good response times)
- DoLS review
- Care plans (10%)
- Catering audit
- Dining experience audit
- First impressions audit
- HR and recruitment audit
- Infection control audit
- Medication audit
- Mattress audit
- Health and safety audit
- Sling audit
- Various minutes of meetings (full staff meeting, team leaders, nutrition and residents' meetings)

Management and Leadership Observations

The new manager had made a good start to his first registered manager role, describing the issues faced so far with good sense and maturity. He described cultivating a good working relationship with the local authority, visiting professionals and with the local GP surgery.

Sandpiper was a smaller family-style care home and the intimate, friendly feel had been retained and enhanced. Interactions between staff and residents were cheerful, relaxed, caring and this was unchanged from previous visits. Feedback from residents and relatives was complimentary about the care provided.

Quality assurance and governance systems were robust and up to date. Medication systems were properly managed. The matters identified for improvement, particularly relating to care plans and daily care records were received appropriately and with diligence. The home was a friendly, reassuring and welcoming place to visit.

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 ensure that medication trolleys are attached to the wall when not in use.
2	Please improve the PRN protocols to include information about each person's specific circumstances, as explained in the main body of the report.
3	Please confirm that the food probe has been recently calibrated and suitable record made.
4	Please update the home's statement of purpose with the new manager's details.
5	Please review and update Resident 3's falls prevention and mobility care plans to reflect the current realities of her care.
6	Please avoid using the terms 'wander' or 'wandering' in the care plans. Instead use the phrases 'walking with purpose' or 'walking without purpose.'
7	Please ensure all mental capacity care plans make reference to all MCAs and best interest decision making processes that have been undertaken.

8	Please ensure Resident 4 gets offered at least her minimum target amount of fluid each day and that this is accurately recorded by staff.
9	Please work towards staff accurately and clearly recording all emollient cream applications on PCS.
10	Please ensure that Resident 2 and Resident 4 are repositioned as required during the night and that staff make suitable record when they have undertaken this task.

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

[End]