THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

AVOCET HOUSE

CQC RATING GUIDE: '**GOOD**'

Privately Commissioned Inspection for

Avocet House

Conducted by:

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Date of Inspection:

23rd April 2025

Contents

Executive Summary

Tanglewood Care Homes operates a group of 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 **Avocet House** and was my first visit to the home since September 2023**.** Avocet House is a purpose built residential care home for older people including people living with dementia. The home opened in November 2020 and received its first full CQC inspection in October 2022, achieving a rating of 'Good' across all key questions.

The findings of this inspection visit were somewhat mixed. Firstly, there were many positive things to observe. The home was warm, clean and no unpleasant odours were noted. All interactions witnessed between staff and residents were kind, helpful and cheerful. Some good-natured banter was seen observed and staff appeared to know the residents well. Residents were generally complimentary about the care they received. Staff were mostly positive about working at the home and said they were well supported, supervised and trained by the management team. The lunchtime experience was mostly well managed. The provider's management governance systems were robust, wide-ranging and up to date.

The management team had been working consistently hard to recruit the right numbers of staff. This was almost complete, with several staff awaiting start dates pending recruitment checks. However, several staff on duty reported that numbers often fell below the desirable numbers. A couple of residents also commented on a bit of 'short-staffing.' The first floor ran below the desirable staffing level during the afternoon of the inspection. Two staff on the second floor described how the floor had run short the day before, describing the situation as 'horrendous.' On occasion, running short due to short-term issues is unavoidable, but the management team confirmed this had been occurring more regularly than they would wish.

Some of the care plans and daily care records were of a good standard, but others were less so. Several care plans were quite brief and others had key information missing and some contradictions. There was evidence of copying and pasting, leading to some odd-looking sentences. Bath and shower record-keeping needed to improve, with several people not marked as having been supported with a bath or shower in the past 28 days. Emollient cream applications were not consistently recorded on the PCS system. The management team were aware of the need to improve consistency in these important areas of practice.

One of the senior staff was observed to leave the medication trolley unlocked and unattended on one of the corridors on the second floor.

While some isolated activities did take place, such as a sing-a-long for a few people in the cinema room, the home was not a ‘hive of activity.’ In the communal areas of particularly the first and second floors there were long periods of time where people were sitting (either at dining tables or in easy chairs) without any activity occurring. Some relatives who visited in the afternoon specifically commented that they did not think the residents had enough to do in the way of moment-to-moment entertainment. It would be beneficial to review the activities provision across the home.

The management team engaged well with the inspection process and were keen to learn and continuously improve. While this report does indicate some areas for improvement, it is important to note that the general atmosphere was cheerful and positive and the home remained a pleasant place to visit.

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 borderline ‘Good’ rating. The benefit of the doubt has been given due to the positive aspects of the home on show.

However, a sensible professional case could be made for ‘Requires Improvement.’ Working through the recommendations in this report will solidify the rating at a ‘Good’ level.

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 was registered for a maximum of 66 older people. There were 65 people in residence on the day of my visit, with one person in hospital. The home was laid out over three separate floors.

The management team told me that staffing levels across the home were planned as follows, with these numbers being the correct and desirable ones to achieve a quality service:

Ground Floor (18 Rooms for people with residential care needs)
(am) 1 senior care assistant and 2 care assistants
(pm) 1 senior care assistant and 2 care assistants

First Floor (24 Rooms for older people including people living with dementia)
(am) 1 senior care assistant and 3 care assistants
(pm) 1 senior care assistant and 3 care assistants

Second Floor (24 Rooms for older people including people living with dementia)
(am) 1 senior care assistant and 3 care assistants
(pm) 1 senior care assistant and 3 care assistants

A deputy manager worked during the day as part of the above numbers, usually based on the first floor. At night the home was staffed with five staff, usually a senior care assistant and four care assistants.

The management team stated they were continuing to recruit so twelve care assistants could be on duty each day and six at night.

The management team explained that providing the above care staffing numbers (eleven care staff during the day and five at night) was the aim in order to provide a decent quality service. They expressed the view that the home was 'safe' with ten care staff rather than eleven, but when this happened (due to last-minute sickness etc) it was best to take a care assistant from the ground floor. This would preserve a minimum of four care staff on each of the two larger upper floors that cared for people living with dementia. The management team could then assist on the ground floor as necessary.

Several care staff stated that the home ran shorter than the eleven staff on a regular basis. One staff member said, *"There are enough staff when everyone's here, but there have been a few challenges with sickness. There are no other problems here, it's only that."* This was typical of the feedback received.

On the inspection day in the afternoon the first floor ran with only one senior and two care assistants. The staff said this happened reasonably regularly and it was commented upon by some visiting relatives. Two staff on the second floor described how the day prior to the inspection was, *"diabolical."* They said, *"There are four staff this morning and it's still challenging. Shame you weren't here yesterday to see how we had to cope with three staff. It was impossible."* Two residents said, *"I do think they get a bit short-staffed sometimes. They are all lovely, but they could care for us better if there were more of them."*

The two examples of the first and second floor running short were problematic and went against the stated aim of always ensuring four on those floors where possible. The management team accepted that this had happened too often recently. It is important to resolve this matter quickly, lest a culture of 'we're always short-staffed' embeds itself with staff, residents and relatives and becomes the understood norm.

See Recommended Action 1.

Ancillary Staff

In addition to the care staff there were two activity coordinators, kitchen staff (one chef and one kitchen assistant each day), maintenance manager, two front of house managers (covering 7 days), head housekeeper (recruited pending recruitment checks) and domestic team (including dedicated laundry staff). Hairdressing and

chiropody services were bought in from external contractors. The home was managed by the registered manager and the care manager who were both supernumerary to the care staff.

Staff Vacancies

It had not been easy historically to recruit the numbers of staff who were of the required quality. However, progress had been made and the management team were close to being able to provide the staffing levels they ideally wanted to.

Remaining vacancies were for two senior care assistants (one day and one night) and two part time late shifts. Other key staff had been recruited and were awaiting start dates pending suitable recruitment checks. They were one head housekeeper, one housekeeper, three senior care assistants (two nights and one days) and two care assistants to work early shifts. Once these staff were inducted and working then the pressure to cover shifts should ease somewhat.

No agency staff had been used at the home for a long time.

Staff Recruitment files

I looked at the recruitment information for several staff recently recruited to the home. The files were stored securely on the computer system, were well put together and contained all of the information required by regulation and other information indicative of good and safe recruitment practice, such as:

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

Medication Management

The home had medical rooms on all 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 capably demonstrated by one of the senior staff on duty. 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 and attached to the wall when not in use.
- Controlled drugs were stored correctly.
- Medication was delivered in its original packaging rather than a monitored dosage system.
- Plastic pots and syringes were sterilised after use.
- Staff wore red 'Do Not Disturb' tabards when administering medication.

An electronic MAR system was in use. 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 bar one. Resident 1's co-codamol was showing 58 tablets on the system, but there were 57 in stock.

There were three medication issues that needed to be improved. Firstly, during the lunchtime administration of medication on the second floor the staff member in charge left the trolley unlocked and unattended. This meant that everyone's medicines were accessible for a short time.

One bottle of Lactulose (for Resident 2) had not been dated upon opening, as required. There were several PRN protocols missing from the EMAR system – for example Resident 2's Lactulose and Madopar, along with Resident 1's Diazepam.

See Recommended Actions 2-4.

Premises Safety & Management
The home was warm, clean and well-presented. No unpleasant odours were noted. Sluice rooms were locked when not in use and COSHH products were stored safely throughout the home in locked cupboards. Domestic staff kept their cleaning trolleys close to them, which was an improvement on my last visit.

On the first floor there was a tub of thickening powder that was unlocked in one of the kitchenette cupboards in the lounge / dining room area. This item can be harmful to people living with dementia if ingested.

See Recommended Action 5.

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

Kitchen
At its last environmental health inspection the kitchen received a score of 5 – 'Very Good,' which was 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

Compliance with supervision and appraisal was monitored on the provider's Coolcare system. This was an effective way of operating and it was clear that almost all supervisions and appraisals were up to date for the whole team. Minutes of meetings were kept in the office and were signed by both parties.

Staff spoken with were happy and positive, notwithstanding the remarks about the staffing fluctuations detailed in the previous section. They indicated they were well supported by the management team and enjoyed working at the home. One staff member said, *"I think we're a happy team. The managers are easy to approach and are very nice."* Another staff member commented, *"I feel lucky to have been taken on to work here to be honest. It's a lovely place to work."* A third staff member said, *"I love my job and I love my managers. I'm so grateful to them. They help me so much."*

Mandatory Training

The provider's training system indicated that compliance with 'mandatory' training was **91%.** The care manager said that the few areas of non-compliance were mostly face-to-face training. One of the senior care assistants had recently completed a basic life support 'train the trainer' course and would be setting up courses with groups of staff in the near future. The same applied to moving and handling training that had expired for some staff who required a refresher course.

Mental Capacity - DoLS

The management team had a good understanding of when DoLS applications were required. DoLS applications are required for people who fall into each of the following 3 categories:

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).

A DoLS matrix was in place containing relevant information about when the applications had been made, when they were approved and when they expired. This was reviewed formally each month as part of the home's governance system.

33 DoLS applications had been submitted, with 22 authorised and 11 awaiting authorisation. CQC notifications had been submitted as required when the applications were determined. The care manager was working on one additional DoLS application for a person very recently admitted to the home.

Eating and Drinking

I witnessed the lunchtime experience in the dining room on the second floor. The dining experience was positive and well-managed, with plenty of good practice observed. Good practice included:

- Staff were wearing appropriate protective equipment.
- People were offered napkins and aprons to protect their clothes if they wished.
- Choices of drinks were offered.
- Meals were offered to people in a manner suitable to their needs.
- There were different meal choices served for different people, as per their requests. People were reminded what they had chosen when the food arrived.
- Alternatives were provided when people decided they did not want their original choice.
- Sauces, such as gravy, were served separately.
- All interactions between staff and residents were kind, cheerful and patient.
- Plenty of staff were available and people were assisted appropriately.
- Staff noticed when people needed assistance and provided it quickly, calmly and without fuss.
- Where people were supported to eat their lunches this was done individually from a seated position.

There was music playing in the background, although it was a contemporary radio station with advertisements and music that was of no interest to the resident group. It would have been preferable if music from the residents' era and of their choice was played instead.

See Recommended Action 6.

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area, staffed by friendly and helpful reception staff, with many places to sit and watch the world go by. The manager's office was easily accessible off the main reception. Information such as the home's registration certificate, CQC rating and the complaints policy were displayed prominently.

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. The bedrooms also had smart televisions, refrigerators and the facility for a telephone line. Ample storage space was available throughout the home, including for hoists and wheelchairs.

Communal Rooms

The lounges and dining rooms were welcoming, clean and pleasantly furnished. There were a variety of different lounges and dining rooms in the home, including a state-of-the-art cinema room, library, tea room and sky bar area. There was a balcony on the first floor for people to enjoy the views from the home during warm weather. There was also a fully kitted out hairdressing salon. Hydration stations were in place on all occupied floors.

There was one bathroom where the signage had come off. On both the first and second floors there were doors missing on the kitchenette cupboards in the lounge/dining room areas. These looked unsightly and required repair.

See Recommended Action 7.

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. One person commented specifically on how she was pleased to have her own chairs, embroidery displays and photographs from her previous home.

Gardens
There were well presented and tended gardens surrounding the home, which were secure and ready for use as the weather got warmer.

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

All staff were attentive and friendly at all times in their interactions with residents. People were interacted with in a kindly and patient manner. There was plenty of laughter and playful, natural banter. This was very positive.

Some of the people were unable to speak meaningfully with me due to their needs, but most people had a good sense of wellbeing. The standard of personal care appeared high throughout the home, with people clean, well-presented and wearing properly fitting clothing. Residents with whom I spoke were generally complimentary about the care they received. Positive quotes included:

"Oh, the staff are very caring."
"I certainly have no complaints about the way I am helped here."
"I'd say everything is fine. Some of the others might grumble, but I don't."
"The carers are great. I press this bell and they come and help me."

However, one comment made by several residents separately on the ground and first floor was a variant of the following:

"The staff are nice, but some are better than others."
"The carers are lovely, well, most of them are."
"I'm well looked after, although there's one or two carers who like everything done 'their way' and don't really listen to what I want."

It was notable that this general idea of 'most' of the care staff being lovely was repeated a few times. In the vast majority of good homes residents say 'all' of the care staff are lovely. It would be worth drilling into this with as many residents as possible with a view to establishing if there may be one or two of the staff who are perhaps not working as well as others.

See Recommended Action 8.

Visitors
Visiting was allowed unrestricted. I spoke with a group of relatives during the afternoon who, while being complimentary about the attitude and effort of many of the individual care staff, expressed some concern that there was not enough in the way of activity and entertainment going on at the home. This point is explored in more detail in the next section.

The latest Carehome.co.uk rating was 9.6/10 from 73 reviews, which demonstrated a high level of general satisfaction over time about the quality of care.

Dignity
People were treated with dignity and respect. I saw that the staff routinely knocked on people's bedroom doors before entering their bedrooms, indicating respect for their personal space. Call bells were left within reach of people spending time in their bedrooms. Continence products were stored discreetly. Staff intervened quietly to preserve dignity when necessary.

There were toiletries in the cupboard in the downstairs bathroom that had not been returned to the person's bedroom after use. There was also a bottle of bath gel, labelled 'BATH' that appeared to be communal. Communal toiletries are seen as institutionalised and should not be kept.

See Recommended Action 9.

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 & Daily Care Records

The care planning system in use was Person Centred Software (PCS), a well-designed and popular care planning system that is respected across the sector. I looked at several care plans and several sets of daily care records stored on the PCS system as part of this inspection.

Some of the care plans were of a good standard, but others were not as good and required some corrections. Many of the care plans required more detail. The management team had identified that work was necessary on some of the care plans. Food charts and fluid balance charts were in place and had been completed well by the staff team.

Resident 3 – Care Plan

Resident 3 was struggling behaviourally. During the morning I witnessed Resident 3 shouting and swearing in her bedroom. Staff on duty said they had tried to assist her with personal care but she had refused. The management team told me that Resident 3 had been smashing property, both in her bedroom and in the sky bar area, so much so that a keypad lock had been installed on the door to the sky bar to protect it. None of this information was in Resident 3's care plan and there were no strategies written about how best to manage the person's behaviours.

In the summary section it was stated that Resident 3 would prefer a female carer. In the personal care plan it stated that Resident 3 was happy to be supported by a female or male carer and had no preference. This was contradictory information that could lead to confusion with the person's personal care.

The care plan summary stated that Resident 3 *"Wanders with purpose."* The phrase 'walks with purpose' replaced the use of the term *'wandering'* and is seen as more respectful terminology. There were several examples of the word 'wandering' being used, both in Resident 3's care plan and in several other care plans.

In the nutrition/hydration care plan it was stated, *"[Resident 3] likes to eat snakes with one cup of tea."* On further investigation it transpired this meant 'snacks.' While arguably only a typographical error, this kind of mistake should ideally be picked up and corrected on review.

Resident 4 - Care Plan

Resident 4's care plan also lacked detail. MCAs and best interest decision making documents were in place for the decisions of residing at Avocet House, receiving personal care and administration of medication. The MCAs were properly put together, but were not referenced in the mental capacity care plan. The mental capacity care plan was brief and, therefore, vague about the specific decisions he lacked capacity to make and how staff were to act in his best interests.

Resident 4 had a 'risk of unintended bruising' care plan. This appeared to have been copied and pasted from someone else's care plan. Resident 4 was male, but the following sentences were seen:

- *[Resident 4] has a diagnosis of dementia which has an impact on **her** cognitive development.*
- *[Resident 4] will refuse care and thrash **her** arms and legs which can lead to unintentional bruising to his body.*

The issues described for Residents 3 and 4 were illustrative of apparent patterns across many of the care plans that I had a more cursory look at.

See Recommended Actions 10-12.

Recording of Emollient Cream Applications

The application of medicinal creams was recorded on the EMAR system. However, there were gaps in the recording of the application of emollient and hydrating creams (such as Cavillon, E45 etc).

The management team accepted they should review each emollient cream in use at the home and ensure the application directions for each emollient cream prescribed are accurately transcribed to the PCS system. 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. Where the prescription is regular, these actions can be set up as 'must do' tasks. This should mean there will always be a signature and should avoid any unexplained gaps. Care assistants then can record having completed these tasks on the system, prompted by 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 13.

Baths / Showers

While people appeared well-presented and outwardly well cared for, there were some gaps in recording relating to assistance with baths and showers. The manager said this had been identified and she was working on a plan to correct the situation.

Several residents had no records of being supported with a bath or shower in the past 28 days. Residents 5, 6 and 7 had no information about their bath and shower preferences recorded in their care plans. For Resident 8 it stated in her care plan, *Care staff to offer [Resident 8] a shower regularly – should she decline this it should be logged."* This had not been done. For Resident 9 it stated in her care plan, *"[Resident 9] likes to shower twice a week."*

See Recommended Action 14.

Activities Arrangements

The manager advised that the activity coordinator on duty was on her first day back after an extended period of illness.

While some isolated activities did take place, such as a sing-a-long for a few people in the cinema room, the home was not a 'hive of activity.' In homes where the activity function is working well there are general activities, both big and small happening throughout the day, hence the 'hive of activity' phrase. During this inspection it was

notable that in the communal areas of particularly the first and second floors there were long periods of time where people were sitting (either at dining tables or in easy chairs) without any activity or entertainment occurring.

Some relatives who visited in the afternoon specifically commented that they did not think the residents had enough in the way of moment-to-moment activity and entertainment. They compared this situation less favourably with other local care homes they had visited.

It would be beneficial to review the activities provision across the home.

See Recommended Action 15.

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 had been made appropriately and were kept on file.

Registered Manager

Tracey Klue was registered as manager with CQC.

Management Audits 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's central improvement plan and implemented. I looked in detail at the governance work for March 2025, which had been completed in good order.

Auditing and governance work completed included:

- Accidents and incidents review, with trend and graphical analysis (30 falls in March, but one person a very frequent faller)
- Dependency monitoring
- Call bell analysis (showing good response times)
- Care plan audits (10%)
- Catering audit
- HR and recruitment audit
- Medication audits (for each floor)
- Health and safety audit
- Night visit from management, with report

- DoLS review
- Pressure ulcer review
- Wound care review
- Bed rail audit
- Bed log
- Weights and weight loss management
- Medications review, including covert medications, antipsychotics and benzodiazepines
- CQC notifications review
- Infections review
- Safeguarding review
- Complaints and compliments

Management and Leadership Observations.

The management team were highly skilled in creating a warm, pleasant and cordial atmosphere to live in and to work in. All interactions witnessed between staff and residents were kind, helpful and cheerful. Some good-natured banter was seen observed and staff appeared to know the residents well. Residents were generally complimentary about the care they received. This is all vital to the provision of a high-quality care service.

This inspection visit did highlight the need for a refocusing in certain areas, such as ensuring consistent staffing provision, care planning, daily record keeping and creating a ‘hive of activity’ throughout the home. A focus on the recommendations in this report should stand the team in good stead for the future.

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 provide a consistent minimum staffing number of 11 care staff (including seniors and deputies) across the home, especially ensuring 4 care staff on the first and second floors during the day shifts.
2	Please ensure staff do not leave medication trolleys unlocked and unattended in corridors.
3	Please ensure all bottles of liquid medication are dated upon opening.
4	Please ensure all ‘as required’ medicines have a PRN protocol accessible on the EMAR system.
5	Please ensure thickening powder is kept locked away at all times.
6	Please consider playing music during the lunchtime experience that is more from the era of the residents.
7	Please repair the missing bathroom sign and the missing cupboard doors on the first and second floor kitchenettes.

8	Please investigate in detail the comments about ‘most’ care staff being lovely, with a view to picking up any situations where the attitude of some staff could be falling short of ideal.
9	Please remove the communal bath gel (labelled BATH) from the ground floor bathroom and ensure there are no other communal toiletries.
10	Please add more detail to Resident 3’s care plan about her behaviours and struggles, along with instructions to staff about how to manage her behaviours. Please also correct the contradiction about the person’s gender preferences for carers.
11	Please remove the term ‘wandering’ from all care plans where it appears.
12	Please ensure Resident 4’s mental capacity care plan references all the MCAs and best interest decision making documents on file, specifying what staff must do for each decision in the person’s best interests. This action will likely be relevant to several other care plans.
13	Please review all emollient creams in use for each resident, ensure the application instructions are accurately transcribed to the PCS system and set up ‘must do’ actions for the regular ones. This will ensure complete TMAR charts can be generated.
14	Please ensure that each person has their bath/shower preferences written clearly in their personal care plans. Please then ensure that staff support them as per the instructions and make suitable record when they do so.
15	Please review the activity provision with a view to making the communal areas much more of a day-to-day ‘hive of activity.’

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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