Woodberry

Swift & Lasting Improvements in Care

INSPECTION REPORT

CORTON HOUSE

CQC RATING GUIDE: '**OUTSTANDING**'

Privately Commissioned Inspection for

Corton House

Conducted by:

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Date of Inspection:

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Contents

Executive Summary

As part of Corton Care's quality assurance programme, additional quality monitoring 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 the care home. An introduction to the author is available at the end of the report.

This is the report from a day spent at **Corton House,** a well-established residential care home for older people, including people living with dementia, located in Norwich**.** This was a full inspection visit following up a previous visit a year ago in July 2023. The home was rated 'Requires Improvement' by CQC at its last inspection and the team were working towards trying to improve that rating next time. A new manager had joined the team in April 2023 and had managed the home through a significant environmental refurbishment over the past few months.

The findings of this inspection were very positive, with excellent progress notable in all areas, leading to the home operating at a high standard. The environmental refurbishment was transformational, with the home now being bright, welcoming and beautifully presented, unrecognisable from before. The particularly kind, pleasant and caring culture amongst the staff group was retained and improved, with residents complimentary about their care. All interactions between staff and residents were cheerful and positive with plenty of encouragement and fun. Personal care was of an outwardly high standard. The home was a hive of activity and there was plenty of evidence of community involvement.

This inspection also revealed a high level of regulatory compliance. There was a full and wide-ranging governance system in place, which enabled the team to assess, monitor, correct and improve the standards of care at the home. Care planning had improved significantly. Medication systems were well managed. Staffing levels were appropriate. There are a few further recommended actions in this report, but these are routine matters and not indicative of concern. The home was now one of the best examples of person-centred care for older people and passed the 'mum' test with flying colours.

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: Outstanding

Some key factors in awarding such a high rating were the outstanding leadership during the home's complete renovation while remaining open, as well as the wide-ranging and person-centred lifestyle provision that was evident. 'Outstanding' ratings are given out only on rare occasions, but this one was well-deserved.

CQC Key Question - Safe

Staffing Levels

The home was registered for a maximum of 42 people. There were 41 people in residence on the day of my visit. The home provided care for people with residential care needs some of whom also lived with dementia. The home was run on a Christian ethos, was popular in the local area, had a good reputation and often had a waiting list.

Staffing levels at the home on the day of my visit were as follows:

(am) 1 team leader, 1 supervisor, 5 care assistants and an additional care assistant from 8am to 12 Noon.
(pm) 1 team leader, 1 supervisor and 5 care assistants
(nights) 1 supervisor and 2 care assistants

The home used a dependency monitoring tool as one way of setting staffing levels, along with staff feedback and observations from the management team. The manager explained how he had arranged for an extra staff member in the morning to help out until Noon during the busy times. Some staff came in early to assist the night staff and some stayed later in the evening, also to assist the night staff at busy times. This was different from my last visit and was indicative of a responsive and flexible attitude towards staffing numbers.

The care staff spoken with all agreed that there were enough staff to meet peoples' needs. As was the case at my previous visits 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.

Ancillary Staff

As well as the care staff there were three activity coordinators (two activity coordinators and a chaplain) and a team of kitchen staff (four on duty each day). There were three maintenance staff who looked after all maintenance and gardening. There was a housekeeping and domestic team who looked after all maintenance, cleaning and laundry. An administrator covered reception duties and much of the administration and general governance.

The team was managed by the registered manager, deputy manager and the head of care, all of whom were supernumerary to the care team. The deputy manager and the head of care would assist the care staff on the floor if the numbers were short. Care staff confirmed this to be the case. This was a very good level of ancillary staff when compared with other similar-sized care services.

Hairdressing and chiropody was provided by external contractors. There had been a recent recruitment process for these staff members, run by the residents, who interviewed the staff and made the overall recruitment decisions. This was just one among many examples of the person-centred care on display at the home.

Staff Vacancies & Agency Use

The manager reported that recruitment had been successful over the course of the year and the home was nearly fully staffed. There were only two part-time care assistants and a weekend care assistant's posts being advertised, which was a very low number in a staff team of approximately 60. There were several bank staff on the books, many of whom were loyal to the home. The manager said there had been no agency staffing use for several months, which was a significant improvement from the year before.

Staff Recruitment files

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

- Recent photographs
- Application forms with full employment histories (see below)
- Contracts & ID
- DBS information
- Job descriptions
- Interview notes
- Medical information
- Suitable references
- Evidence of qualifications
- Supervision notes

One of the personnel files (staff member A) did not contain a full employment history, in that there was an unexplained gap between 1983 and 2005. CQC has clarified that each staff member must provide a full employment history, right back to the time of first employment, together with a written explanation of any gaps in employment.

See Required Action 1.

Medication Management

The home had a temporary medical room where the main stock, medication refrigerators and controlled drugs were being kept until the usual medication room had been refurbished. Two of the senior staff capably demonstrated the systems. Good practice included:

- Keys were kept by the senior nursing staff.
- Temperatures of the medication room and medication refrigerator were monitored on a daily basis. The records indicated safe storage temperatures.
- The medical room was clean and well organised.
- The medication trolleys were organised logically and attached to the wall when not in use.
- Bottles of liquid medication had been dated upon opening.
- Controlled drugs were stored properly and were counted weekly and on each administration.
- Plastic pots and spoons were sterilised in between uses or disposed of.

The home used an electronic MAR chart system. The 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 on the system. I undertook 10 separate random stock checks and all of them were correct.

Premises Safety & Management

The home was clean and appropriately presented, especially when compared with before. The refurbishment is described in more detail in the next section. No unpleasant odours were noted.

The home was properly ventilated on a warm day. The team were trialling an automatic ambient temperature monitoring system. This involved gadgets that set off a warning alert with the staff team if the temperature went above or below pre-set minimum levels. A new radiator had been installed in the Church Way corridor, which was good to see as this corridor had occasionally got cold during winter weather.

Sluice rooms were kept locked when not in use. COSHH cupboards were also kept locked. Domestic staff had been given lockable trolleys to ensure they kept their cleaning products safe at all times, which was an improvement from my last visit.

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 had been rated with a score of 5 – 'Very Good', which was the highest score available.

CQC Key Question – Effective

Supervision & Appraisals

The administrator demonstrated a clear matrix that indicated all supervision and appraisal was up to date. Appraisals took place at the end of 2023 and supervisions were done quarterly. The spreadsheet was monitored on at least a monthly basis and heads of department were prompted if they had any supervision outstanding. Supervision notes were seen in the personnel files, signed by both parties.

Staff spoken with during the visit said they were very well supported and that morale had increased significantly over the past year. Several staff said that working during the refurbishment had been a challenge, but overall it was definitely worth it as the investment in the home had cheered everyone significantly. One member of staff said, *"It's a lovely place to work. The works have made a real difference. We're happier and it's more homely."* Two longer serving staff commented, *"We're well supported now. This is the best manager we've had here."*

Training

An in depth training matrix was demonstrated by the administrator. For each course area it was shown how often the training would need to be refreshed and the date the staff member last completed the training was shown. The administrator commented that the deputy manager had recently completed lots of in-person training, especially since the refurbishment had been completed. Mandatory training was at **93%**, which was a good level and a significant improvement from last year.

Mandatory training included first aid (practical and theory), nutrition and hydration, food safety, allergen awareness, health and safety, infection control, medication (for seniors), DoLS/MCA, moving and handling (theory and practical), GDPR, safeguarding (children and adults), skin integrity and pressure ulcers, diabetes, oral health, dementia awareness, person centred care, recording and reporting, privacy and dignity, duty of candour and epilepsy. The Oliver McGowan learning disability and autism training had been completed but was registered under the 'additional' training. As it is mandatory by regulation it should be transferred over to the mandatory spreadsheet and monitored in that space.

See Required Action 2.

Mental Capacity - DoLS
DoLS applications are required for people who meet all 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).

A clear matrix was in place, indicating that five applications had been made as required. Three of them had been determined by the local supervisory body and two were awaited. CQC notifications had been submitted for each DoLS application when they were determined, as required.

All other people living at the home had capacity to consent to their care, although the management team were aware of a small number of people who were being reviewed regularly as their dementia journey progressed.

Eating and Drinking
I witnessed the lunchtime experience in the tastefully refurbished main dining room, which was a positive and well-managed experience and this was unchanged since my last visit. Much good practice was observed, including:

- The service was based on a Christian ethos. Grace was said before the meal after the ringing of a bell and this was traditional and appreciated by all.
- Hand-cleansing wipes were offered before lunch was served.
- People were offered napkins and aprons to protect their clothes if they wished.
- Staff were wearing appropriate protective equipment in the form of aprons.
- Clear menus were on display and tables were nicely laid.
- People were given choices of main course and dessert.
- Choices of several drinks were offered.
- Gravy, sauces and vegetables were served separately.
- All interactions between staff and residents were kind, encouraging, polite and cheerful.
- Nobody was rushed.
- Plenty of staff were around assisting as necessary.

- People who required 1:1 assistance to eat were given appropriate focused attention by a staff member.

Premises Presentation
Entrance and Reception Area
The home had a bright and welcoming entrance and reception area, with places to sit and wait to be seen. Some residents enjoyed sitting in reception and watching the comings and goings. The reception area had been extended as part of the refurbishment, with part of a former lounge opened out into a 'snug.' This meant more people could enjoy being at the centre of the home's activity.

The home's complaints policy, CQC rating, certificates of registration, employers' liability and other useful information was on display in reception. The reception area was manned by friendly staff and the administrative and senior care office was accessible on the left as one entered the home.

Design and Adaptation
The home was adapted for people who have mobility restrictions, including overhead tracking in some rooms. All bedrooms had ensuite toilets and wash hand basins. Full assisted bathing facilities were also available on each floor.

Communal Rooms
The home's refurbishment was stunning and transformational. To have achieved such a difference with décor, design, lighting and facilities, while also running a home during the process, was some achievement. It is the best refurbishment of an operational home I have ever seen.

The home's corridors were quite dark before, but the lighting was now bright and cheerful. There was also the facility to dim the lighting significantly at night. This was done every night, in response to comments from residents about their doors opening to flashes of bright light. Corridors also had new flooring (chosen by the residents), new ceilings and new electrics. Different corridors were decorated in different colours and there were places to sit in small corners. The home had a new call bell system, which some staff commented had made the home quieter and there was a feeling of it being more relaxed.

There were a variety of lounges in the home that had been refurbished, with others planned. The Edith Cavell leisure room had been spruced up and there was an air conditioning facility to keep it cool. The main lounge and dining room had been re-designed and there was a 'Colman's café' at one end of the dining room. There were attractive secure gardens and it was good to see lots of people outside enjoying the hot weather on a nice summer's day. There were hydration and snack stations available throughout the home, which were well used. Sky television had been installed in the main lounge, so people had more choices of watch, including the sports. Staff had some new facilities in the staff room to make their breaks more comfortable. Outside the dining room there were new, well-presented and informative noticeboards, including 'You Said, We Did' information.

More refurbishment was underway and was planned for the future. The medication room was being changed at the time of my visit and there were plans to fully refit the hairdressing salon next and the quiet lounge.

Bedrooms

Many of the bedrooms were nicely personalised with people's own belongings and photographs of their families. This enabled them to feel settled at the home.

The team had implemented an initiative displayed outside each consenting person's room entitled, "What I would like you to know about me." This was a person-centred introduction to each person. A couple of people had not wanted one and this was also respected.

CQC Key Question – Caring

Residents
All interactions between staff and residents were cheerful, helpful and friendly. There was a long-established good culture of care, which was a similar to previous and was confirmed by the staff, several of whom commented they felt it was even better than before. People were encouraged to engage in meaningful activity and generally interacted with in a kindly and patient manner. Staff had time to spend with residents other than providing personal care.

All feedback from residents was complimentary about the care they received (with the exception of one remark dealt with later in the report) and there was an obvious and palpable warmth between everyone. Quotes included:

"The staff are wonderful. I say so and that's all you need to know."
"We are all very well looked after."
"They arrange for us to go in a taxi to our old church in Thorpe St Andrew. It was lovely to see old friends. I'm now hoping to go to the cathedral."
"We had the Welsh society in. That was fun."
"Ooh, everyone's lovely. What can I say."
"I've made friends here. I did not expect that, so it's exceeded my expectations."
"They bring us tea all the time. They are very nice."
"The food is good. We always get a choice."

A few people were not able to speak meaningfully with me due to their needs. However, from observations of care I noted that there was an excellent relationship between the staff and the residents. Staff appeared to know the residents well. The standard of personal care was good across the home, with people supported to be well-groomed and wearing appropriately fitting clothing.

Visitors
Visiting was allowed unrestricted after the pandemic. Several visitors approached me to tell me how they held the team and the home in high regard. One visitor said, *"I visit a lot of places, but this is a cut above. Totally different and better than most. Staff are fabulous. The place also is built on a Christian ethos, which is important to me."*

The latest Carehome.co.uk rating was displayed in reception at 9.7 out of 10 from 21 reviews. This showed a high level of satisfaction among stakeholders who used this website for feedback. The score had increased since last year. Recent reviews were written in particularly warm terms.

Dignity & 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 private bedrooms and many of the residents wore pendants. Staff were particularly responsive to peoples' needs when there was a possibility that dignity might be compromised.

In one bedroom there were three large packs of continence pads placed prominently on top of the wardrobe, the first thing you saw as you entered the room. This unnecessarily advertised the person's continence issues and was undignified.

See Required Action 3.

Confidentiality

Care plans and care information was stored on password protected computer systems.

CQC Key Question – Responsive

Care Plans

The care planning system in use at the home was Person Centred Software, which is a well-designed computerised care planning system. All of the care plans I looked at were presented in a user-friendly and readable format. The senior team had worked hard on improving the care planning and it was notable they were all of a much higher standard than the year before. Care plans were well-written, person-centred and contained a good amount of information in each section. End of life plans were detailed and mature.

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.

There was one person (Resident 1) who had not been shaved that morning. Through discussion it became clear that he did not always wish to comply with the request to assist him shaving. However, the care plan did not make this clear. In a similar vein, Resident 2's care plan stated she, *"Needs assistance to bath/shower"* but the care records did not show any baths or showers in the last 28 days. On further investigation it became clear that Resident 2 would never consent to baths or showers and the care plan needed to be updated.

See Required Action 4:

Consent to Care and Treatment

The mental capacity assessments (MCAs) and best interest decision making documents had significantly improved since my last visit. Mental capacity assessments (MCAs) had been undertaken for people when there was a doubt about their capacity to consent and the care given might deprive them of their liberty.

For example, in one case (Resident 3) there were four MCAs for consent to care and treatment, medication, receipt of personal care and nutrition. Given Resident 3's care

needs it would be beneficial for there to be two more MCAs, one for accommodation at the care home and another for use of sensor monitoring equipment.

See Required Action 5.

Daily Care Charts – Fluid Balance Charts
These were well kept and significantly improved from last year. The charts indicated people were offered mostly well in excess of their minimum fluid targets. Regular fluid promotion was seen occurring throughout the day.

Daily Care Charts - Topical MAR charts (TMAR)
Topical MAR charts (TMAR) had been transferred to the PCS system. This had been done well, except for two small omissions. Resident 4's instructions said, *"125g of cream"* but did not say which cream. Resident 5's instructions said similar, *"90g of cream"* but did not say what cream.

See Required Action 6.

Daily Care Charts – Food Records
Staff kept some food records on the PCS system, although there was room for improvement in the record keeping. Most of the records were written under 'Other,' meaning it was unclear when each food entry had been consumed. Sometimes what the person had eaten was recorded, but often the entry said 'nutrition intake noted,' which was unclear. This looked like a 'default' note from the computer system that had not been changed.

The manager undertook to do a full review of food intake recording.

See Required Action 7.

Activities Arrangements
There were three activity staff who undertook different roles. The activity lead coordinated everything, the group activity coordinator organised and took a lot of the group sessions and the chaplain led on religious services and 1:1 counselling and

life history work. There was a student on work experience who was also helping out. The roles as described were a lot wider besides. I got the distinct impression that there was so much going on that I could have usefully spent the entire day with the team and produced a very long report about all of the activities.

The activity lead had a chart to monitor how every single person at the home had been in receipt of some fulsome and meaningful interaction over the past week. Some people were sociable and wanted to join in everything, but others were harder to reach and it was important they were not forgotten. The chaplain's 1:1 work was vital in this regard from a pastoral, spiritual and prayerful perspective. Hand massage was successful, with people relaxing and then opening up about what was on their minds.

There were a whole range of general activities for people to enjoy. These included a mother and baby group who came to the home sometimes to play. The residents got a lot out of this with the young children. Recently there had been a visit from some little donkeys and a PAT dog. Singers and general entertainers were booked to perform at least once a month. There had been a choir, an orchestra and a ukulele band. There were regular coffee mornings, seated Zumba sessions, knit and natter groups, poetry groups, bowling, art workshops, balloon tennis, healing and meditation sessions, flower arranging groups and an annual summer fete.

These group entertainments were all very well, but the home particularly stood out for the person-centred activities. One resident was in the habit of writing and hosting quizzes for the other. She led the quizzes and this was encouraged. Two people wanted to go back to their local church in Thorpe St Andrew, where they were involved years ago. This was made to happen and the two people were able to see lots of old friends.

Some ex-teachers were taken back to a local primary school to visit and speak with the young children. Residents had said they wanted fairly short trips out, such as to local garden centres and these happened regularly. One person had to give up their home due to infirmity and missed doing gardening, such as growing sweet peas. This had been arranged and the person was supported to grow vegetables in the garden.

The home had designated resident representatives to feed back to staff what people were thinking and feeling. This was augmented by a 'what makes us feel safe' group, where all ideas and comments were written on a big piece of paper and considered

by the management team. There was a ‘You Said, We Did’ noticeboard with plenty of examples of things that had been made to happen at the behest of residents. A group of residents interviewed the potential hairdressers and chiropodists for the home, decided who they wanted and chose the appointments. The amount of meaningful activity available and the quality of it was well in excess of most registered care homes.

CQC Key Question – Well Led

CQC Notifications & Duty of Candour

CQC notifications were submitted as required.

Registered Manager

The manager, Jason Parker, was registered as manager with CQC.

CQC Rating

The home was rated 'Requires Improvement' by CQC at its last inspection in the spring of 2022. It is notable that this has been a very long time between inspections and the home is literally unrecognisable from that time. The team were hoping for the opportunity to correct and update the rating as soon as possible.

Management Audits

There was a clear and wide-ranging governance system implemented across the home, with a series of regularly repeating audits. The system was demonstrated by the manager. Audits included, but were not limited to:

- Falls monitoring
- Infections review
- Weights and weight loss management information
- Fluid intake review
- DoLS/MCA review
- RCAs for each fall
- Complaints (none)
- Wounds & pressure ulcer review
- Medication errors
- Safeguarding review
- Health and safety check
- Care plan audits x4
- Medication audits
- Walk-around audits
- Dining experience audit

- Catering audit
- Activities summary report
- Training review
- Personnel file audit
- Call bell monitoring (see below)
- A good governance meeting, where everything was reviewed among the senior team.

The call bell system was new and the team were still getting used to how the statistics worked. The last set of statistics stated that the average call bell response time was over nine minutes. This seemed unlikely and on further investigation it transpired there were some problems with the accuracy of the statistics, for example when people pressed their pendants it was sometimes the case that the staff turned off the call bell point near to them but not the pendant itself. This meant that there were some very long response times (such as 21 hours) which spoiled the statistics. The only negative remark received from anyone living at the home was one person who said, *"We have a call bell problem. The staff don't always come quickly."* It was important to resolve the statistical anomalies so that accurate call bell information was available and the above grumble could be looked at properly.

See Required Action 8.

Management and Leadership Observations.
The registered manager had joined the team in April 2023 and had played a key role in changing the home for the better. Along with the transformational refurbishment the home was almost unrecognisable from one year previously. The combination of the satisfaction levels, personal care, environmental changes, better staff morale, improved care planning, meaningful activity and stronger governance meant the home was now high-performing in comparison to most other similar establishments.

A staff satisfaction survey was undertaken in September 2023 and then repeated in March 2024. The results showed a significant improvement in staff morale and perception of management over that time period. Two particular examples illustrated this very well. Firstly, the question of whether morale was good was answered yes by 45% of the staff in September 2023 and then 92% in March 2024. Secondly, the question of whether the staff perceived they were paid fairly for their roles was

answered yes by 72% in September 2023 and then 92% in March 2024. There had been no pay increase in that period of time.

While the team were still keen to improve continuously and had many more plans for the future, the home was now one of the best examples of person-centred care for older people and passed the ‘mum’ test with flying colours.

Required and Recommended Actions

'Required' actions are matters picked up during the inspection process that would be either in breach of regulation, arguably in breach of regulation or issues that CQC inspectors commonly criticise if not seen as correctly implemented. 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.

Recommended actions are either minor points to consider or good practice suggestions picked up elsewhere that may enhance the service in a variety of ways. There is no imperative to implement any recommendations if the provider did not consider it necessary to do so.

Required Actions

1	Please ensure all staff members have provided a full employment history, right back to the time of their first employment, together with a written explanation of any gaps.
2	Please monitor the Oliver McGowan training as part of the 'mandatory' courses.
3	Please ensure that continence products are stored discreetly in peoples' private bedrooms.
4	Please update Resident 1 and Resident 2's personal care plan sections to reflect the true nature of their personal care.
5	Please write MCAs and best interest decision making documents for Resident 3 for accommodation at the home and use of sensor monitoring equipment.

6	Please amend the application instructions for Resident 4 and Resident 5 on the TMAR charts on PCS.
7	Please look into the methods of food recording on PCS and make appropriate changes as necessary.
8	Please work on ensuring that the call bell statistics are accurate.

Recommended Actions

	None.

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. In my view, this is what a meaningful rating is and always has been. I have long argued that an awarded rating is a 'description,' not a 'score.' It is a 'narrative judgement,' not a 'numerical calculation.' Therefore, this inspection does not set about the business of mimicking CQC's new highly 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.

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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