THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

CORTON HOUSE

CQC RATING GUIDE: '**OUTSTANDING**'

Privately Commissioned Inspection for

Corton House

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Date(s) of Inspection:

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Contents

Executive Summary

Standing near the centre of the City of Norwich on the site of a former vicarage, Corton House was established over 70 years ago, following a public appeal from the Free Church Council. At that time Corton House was hailed as a pioneer in social care. Now the home has 42 available bedrooms and continues to operate as a not-for-profit enterprise, providing care and support for older people including some who live with dementia. The service is overseen by an experienced board of trustees and operational management team. Corton House is strongly rooted in the Christian ethos of kindness and of caring for one another.

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 was a full inspection visit that took place over two full days. It followed up an inspection a year ago in the summer of 2024 where a guide rating of 'Outstanding' was awarded. The findings of this inspection were similarly positive, with the high standards maintained and positive new initiatives implemented.

Corton House presented as a close, thriving community where people come to enjoy life in their twilight years. The home had a particularly kind, pleasant and caring culture. This was palpable to witness and had been retained and improved. All residents and relatives were complimentary about the care given. 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 initiatives and person-centred care and support. The lunchtime dining experience was well-managed.

The 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 and daily care recording was of a high standard. Medication systems were well managed. Staffing levels were appropriate and people were recruited in line with regulation. Staff were well trained and supervised.

The environmental refurbishment that had taken place the previous year had been transformational. Further improvements had been completed such as new lounges, bathrooms and much more.

There are a small number of recommended actions in this report, but these are relatively routine matters and not indicative of any significant concern. The home was now one of the best examples of community based person-centred care for older people and deserved the highest guide rating (rarely awarded).

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

'Outstanding' ratings are given out only on rare occasions, but this one was well-deserved.

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 44 people, although the working capacity was 42. There home was full with 42 people in residence. 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.

The home was not divided up into different areas and so the staffing levels are stated for the whole service. 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 1pm.
(pm) 1 team leader, 1 supervisor and 5 care assistants
(nights) 1 supervisor and 2 care assistants

The staffing levels were consistent with those observed in the summer of 2024, although the manager explained how he had arranged for the additional care assistant in the morning to stay for an extra hour until 1pm to assist with lunches. This indicated a flexibility and an ongoing willingness to make small improvements.

The day staff came in early at 7am to assist the night staff and some stayed later in the evening until either 9pm or 10pm, also to assist the night staff at busy times. This roster pattern enabled the busy times in the morning and the evening to be well staffed. It also contributed to better relations between the night and day staff as they worked together on a daily basis with the overlapping shifts.

The manager and the management team were happy with the overall staffing levels, believing a quality service could be delivered with the resources available. The care staff spoken with agreed that there were enough staff to meet peoples' needs, with several making favourable comparisons to previous homes they had worked in. There were many examples of staff having the time to speak with people, listen to them and engage with them in addition to completing personal care tasks.

The home used a dependency monitoring tool as one way of setting staffing levels, along with staff feedback and observations from the management team.

Ancillary Staff

In addition to the care staff there were three activity coordinators (two activity coordinators and a chaplain) and a team of kitchen staff. There were three maintenance staff who looked after all maintenance, gardening and some of the ongoing renovations. There was a housekeeping and domestic team who looked after the 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. Hairdressing and chiropody was provided by external contractors. This was a very good level of ancillary staff when compared with other similar-sized care services.

Staff Vacancies & Agency Use

The manager reported that recruitment had been successful over the course of the year and the home was fully staffed. Approximately 65-70 staff were on the books at the home. There were several bank staff, many of whom were loyal to the home, and the only ongoing recruitment was for an additional bank team member.

A new cook was due to start work at the home the following week.

No agency staff were being used.

Staff Recruitment files

I looked at the recruitment information for several staff recently recruited to the home. The files were stored securely and contained 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
- Contracts & ID
- DBS information
- Job descriptions
- Interview notes
- Medical information
- Suitable references
- Evidence of qualifications
- Supervision notes

Medication Management

The home had a newly refurbished medical room where the main stock, medication refrigerators and controlled drugs were being kept. One 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.
- Staff wore do not disturb tabards while administering medication.
- The administration practices witness over lunch were safe and hygienic.

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.

The electronic system in use was a new one and the PRN protocols had yet to be transferred to the system. This meant that staff did not have access to them while working through the medication rounds. The senior staff member gave three examples of people on PRN medication to control anxiety and said the instructions were in the medication care plans. In two of the three cases (for Resident 1 and Resident 2) there were no clear PRN instructions in the medication care plans.

See Recommended Action 1.

Premises Safety & Management

The home was very nicely presented, warm and clean. There were no unpleasant odours noted anywhere. The home was temperature controlled by 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.

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.

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

The following CQC quality statements apply to this key question:

- Assessing Needs
- Delivering evidence-based care and treatment
- How staff teams and services work together
- Supporting people to live healthier lives
- Monitoring and improving outcomes
- Consent to care and treatment

Supervision & Appraisals

The administrator demonstrated a clear matrix that indicated all supervision and appraisal was up to date. Appraisals took place at the beginning of 2025 and supervisions were bi-monthly thereafter. The spreadsheet was monitored on at least a monthly basis and heads of department were prompted if they had any supervision meetings to complete.

The supervision hierarchy was clear, with staff knowing who their supervisors were and where responsibilities lay. Supervision notes were seen in the personnel files, signed by both parties. Staff confirmed they had regular supervision.

Staff Feedback

Several staff were spoken with at length during this inspection visit. Without exception all were positive about working at the home, their job roles and the support they received from the management team. Some of the staff compared their current jobs favourably with other care establishments they had worked in. Team members were notably positive about their colleagues and about the residents. Interviewing the staff team gave a strong and clear impression of a close community feel to Corton House, with no divides between departments or between the staff and residents.

One member of staff said, *"This home is a heck of a lot nicer than other places I've worked in. The management are involved and responsive, problems get dealt with quickly and the training is really good. I have been supported both professionally and personally."* Another staff member said, *"I worked for an agency before, going in and out of lots of different homes. Having done that and seen some different ways of doing things I decided that this was where I definitely wanted to be."*

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 deputy manager had recently completed lots of in-person training, based on structured lesson plans, Formal evaluation was collected at the end of sessions. Staff described the training as collaborative and interesting. Mandatory training was at **95%**.

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 with Norfolk County Council. In an attempt to comply with the newly published guidance there had been in-person online sessions with a person with suitable experience.

New staff were expected to complete the Care Certificate and workbooks were in place in the personnel files.

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 six applications had been made as required. Three of them had been determined by the local supervisory body and the other three were awaited. CQC notifications had been submitted for each DoLS application when they were determined, as required. Two cases are discussed in more detail in the ‘Responsive’ section, where further DoLS applications may be required.

Eating and Drinking

I witnessed the lunchtime experience in the 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 pictorial menus were on display.
- 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 with their meal.
- Plenty of staff were around assisting as necessary.
- People who required on-to-one assistance to eat were given appropriately focused attention by a staff member from a seated position.

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 the reception area and watching the comings and goings. This meant that people could enjoy being at the centre of the home's activity. There was tea and coffee available from a machine in the dining room.

The home's complaints policy, CQC rating, certificates of registration, employers' liability and other useful information was on display in reception. A new television screen had streams of activity relevant to the home for people to watch. The reception area was manned by friendly staff. The administrative and senior care office was accessible on the left as one entered the home. The manager's office was also close by the main reception area.

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 had been completed in 2023/24 and was stunning and transformational. More work had been completed since that time and the team continued to make improvements to the environment. There was a new medication room, hairdressing salon, activity room, second sluice, activity/training room and upstairs quiet lounge. Some more overhead tracking had been fitted, including in one new bathroom.

The home's corridors were bright and cheerful, with facilities to dim the lights at night. Different corridors were decorated in different colours and there were places to sit in small corners.

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.

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. There was a display 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.

Gardens
There was a pleasant secure garden and people enjoyed sitting outside during warm weather. The summerhouse had been painted and filled with new furniture. There was a plan for a new patio to be built in the middle of the lawn with a wooden gazebo and some raised planters. This would be ready for next summer.

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 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 visits. People were encouraged to engage in meaningful activity and were interacted with in a kindly and patient manner. Staff had time to spend with residents other than providing personal care. Staff broke off conversations with me to attend to residents' presenting needs, indicating a residents-come-first culture.

All feedback from residents was complimentary about the care they received and there was an obvious and palpable warmth between everyone. Quotes included:

"The staff are absolutely marvellous. I don't think we need an inspection – you don't need to be here."
"I'm new, but I'm settling nicely. First impressions are really good."
"When I was in hospital I couldn't wait to get back here. No praise is high enough for this establishment."
"They look after us very well. They keep the place clean. When I was out the cleaners did a deep clean, which I appreciated."
"Some of the staff are very skilled at predicting when people need help."
"I've not been here that long, so I'm still getting used to it, but the staff are kind and friendly. This is especially at night. If I'm struggling they make me a hot chocolate."
"I love it here. It's friendly and there are people to look after me. I've made some new friends."
"The food is very good – excellent variety."
"The staff are friendly, it's not regimented. You get your freedom. They have nice personalities."
"I like the activities. I join in with anything I can. I was living on my own and I didn't like it. It's much better here with other people."
"I really like sitting here looking at the garden."

"We've grown our own vegetables in the garden this year – cabbages, peas, potatoes, lettuces and tomatoes. They've gone to the kitchen and been used in food. Some of us get a real kick out of this."
"I appreciated being able to choose whether to make my respite stay permanent and not feel pressured by the decision."
"People here are kind here and they look after me."

The standard of personal care was good across the home, with people supported to be well-groomed. Everyone was wearing appropriately fitting clothing.

Visitors
Visiting was allowed unrestricted across the home. Feedback from visiting relatives was similarly complimentary. One relative said, *"I've been coming here for years. The staff are very kind. There's a group of them who have worked here for a long time and they're all great. I've been impressed with the investment in the building over the last couple of years. I've no concerns and I've never really had any either."* Another relative said, *"I used to work in and around social care, so I've seen many different care facilities. This one is really good. I've no concerns and they seem to have nothing to learn. They know what they are doing and it is reassuring."*

A visiting professional commented, *"This is the best home I work with. The staff are knowledgeable and welcoming. They know the residents really well and they have common sense about when to call us. I have no concerns about any of the care. There seems to be a lower level of hospital admissions from here and I further note that lots of the residents are either close to or over a hundred years old, which says something. The residents say the activities keep them going."*

The latest Carehome.co.uk rating was displayed in reception at 9.9 out of 10 from 32 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. Moving and handling manoeuvres were undertaken with dignity and respect, with staff being appropriately communicative about what they were going to do next. Continence products were stored discreetly.

Confidentiality

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

CQC Key Question - Responsive

The following CQC quality statements apply to this key question:

- Person-centred care
- Care provision, integration and continuity
- Providing information
- Listening to and involving people
- Equity in access
- Equity in experiences and outcomes
- Planning for the future

Care Plans

The 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. Care plans were well-written (in the first person), were person-centred and contained a good amount of information in each section.

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.

Consent to Care and Treatment

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. These were mostly decision-specific. For example, in one case there were MCAs for consent to care and treatment, leaving the building unattended, medication, personal care and nutrition.

Resident 3 had one MCA in place for the decision 'capacity to consent.' This was not correct, as it did not relate to one specific decision. The person had been found to lack capacity to consent and there was a comment about the person being *"largely non-verbal now."* This did indicate that the person may lack capacity to consent to some or all of the key aspects of their care. A series of MCAs needed to be undertaken. If the person was found to lack capacity in key areas that deprived or restricted their liberty, then a DoLS application would also need to be considered.

Resident 4 had MCAs and best interest decision making documents in place that indicated she lacked the capacity to consent to her care and treatment, her medication, her personal care and her nutritional intake. The care plan stated that she was able to understand most of the above questions but was not able to discuss why tasks were carried out and what would happen if they were not completed. There was no MCA in place for whether Resident 4 was able to consent to live at Corton House behind a locked door. This MCA needed to be completed and a DoLS application considered.

See Recommended Action 2.

Daily Care Charts – Fluid Balance Charts

These were generally well kept and indicated that people were offered mostly well in excess of their minimum fluid targets. Regular fluid promotion was seen occurring throughout the day. There was the occasional day where the amount offered was below the daily target, but overall the charts showed a good level of fluid promotion.

Daily Care Charts – Food Records

Staff kept food records on the PCS system and in most cases the records were better kept than they year before. There were two cases where people were marked as on 'nutrition watch,' but there were some entries missing for main meals in the past week. In the case of Resident 5 there were missing records for 20th September (tea-time), 21st September (lunch and tea-time) and 22nd September (breakfast and lunch). Resident 6 was missing 18th September (tea-time) and 23rd September (breakfast and lunch).

See Recommended Action 3.

Daily Care Charts - Repositioning

Resident 3's care plan stated that she needed to be repositioned every two hours. The charts were reasonably good, showing regular turns on all days, but there were several occasions over the past week where gaps of 3.5 to 4.5 hours were seen. If the requirement is 2-hourly then it is important to ensure this is achieved consistently.

See Recommended Action 5.

Daily Care Charts - Topical MAR charts (TMAR)
Topical MAR charts (TMAR) had been transferred to the PCS system. This had been done well and TMAR charts were diligently completed and well managed.

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 one-to-one counselling and life history work. 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 one-to-one work was vital in this regard from a pastoral, spiritual and prayerful perspective.

There were a whole range of general activities for people to enjoy. A visit from a therapy dog brought much cheer during the inspection. There was flower arranging and a sunflower growing competition, with the winner being enormous (over ten feet high). There were lots of musical sessions and birthday parties for residents. There were reminiscence sessions, arts and crafts, quizzes (including some written and hosted by residents), smoothie and milkshake making, use of an 'Omi-board' projector, poetry group, knitting group, seated exercises and much more. Some people were able to help with clearing up after lunch, which they wanted to do.

There had been a series of larger events and trips out from the home. The summer fete was success and the team were pleased that 29 of the residents had attended. Families were involved and the event had raised over £4,000 that would be used to improve the garden. A trip to the seaside in Yarmouth had been a highlight. Some people had been out to watch a local string quartet, attend a show at another care home locally and also to attend local churches. Not everyone could go on each trip, but the activity team had recorded who had been out and were able to report that all bar five residents had been on at least one trip in the last year.

Male residents had the opportunity to attend the 'Men's club' that was run by the maintenance team, at which more typically male activities took place. Two residents who did not get out much had particularly enjoyed an outing to a 'cat lounge,' where they could sit and enjoy time around lots of cats. Some residents had appreciated being involved with a pen pal scheme. One resident used to live around the corner from the home and so staff took him back to where he used to live, which was very much appreciated.

Some residents had been involved in interviewing for staff.

The team wanted to promote positive inter-ethnic integration and belonging. Staff from southern India had been encouraged to give a talk about their culture. There was also a talk from a local Polish heritage group, which prompted discussion and connections. There had been sessions for staff and residents on using inclusive language and specific staff members had been appointed as EDI champions. The home had been shortlisted for 'EDI champions' award at the forthcoming Norfolk Care Awards.

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

The following CQC quality statements apply to this key question:

- Shared direction and culture
- Capable, compassionate and inclusive leaders
- Freedom to speak up
- Workforce equality, diversity and inclusion
- Governance, management and sustainability
- Partnerships and communities
- Learning, improvement and innovation
- Environmental sustainability – sustainable development

Registered Manager

The manager, 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, albeit the home had been re-registered under a different registered name since that time. The new registered entity of 'Corton House and Brewster Court' replaced the old 'Corton House Limited' in April 2025.

Corton House was literally unrecognisable from the time of that previous CQC inspection rating under the old registration. The team were hoping for the opportunity to update the rating as soon as possible. There had been a PAMMS inspection at the end of 2024. This had gone well, with the home achieving a 'Good' score in most areas and a couple of scores of 'Excellent.'

CQC Notifications & Duty of Candour

CQC notifications were submitted as required.

Open Safeguarding Cases

The manager explained there were two safeguarding cases that were technically open. One related to an unwitnessed fall and fracture. The other related to an allegation from one staff member about another. Both matters had been dealt with, all information shared appropriately and the manager was expecting closure shortly.

Management Auditing and Governance

There was a clear and wide-ranging governance system implemented across the home, with a series of regularly repeating audits that led to action plans, lessons learned meetings and continuous progress. The system was demonstrated by the administrator who collated and chased everything each month to ensure completion. Audits included, but were not limited to:

- Care plan audits (see below)
- Dependency monitoring (staffing level) check
- A variety of medication audits and checks
- Health and safety audit
- Detailed health and safety checks by the maintenance team
- Mattress audit
- Infection control audit
- Hand hygiene audit
- Walk around audit
- Mealtime audit
- Catering audit
- Activities review
- DoLS review
- Training matrix review
- Supervision and appraisal review
- Personal file audit
- Complaints audit
- Safeguarding audit
- Satisfaction surveys
- Call bell response time audit (see below)
- A good governance meeting, where everything clinical was reviewed among the senior team, including weight loss & gain, fluid intake, infections review, accidents and incidents review and infections review.

Three full care plan audits had been completed in August by the management team. Sometimes trustees and others helped out with an extra one or two, but this had not occurred in August. Regulators tend to look for 10% as a minimum, so I would recommend a minimum of four care plans to be reviewed each month.

See Recommended Action 5.

The call bell average response time was showing at over twelve minutes for over 4000 calls in the month of August. This was not likely to be correct. Over the two days of inspection call bells were answered promptly and nobody raised any concerns about long waits. The longest call (as stated in the data) was over 65 hours, indicating a glitch in the system. This reading alone would substantially affect the 'average' time to make unrepresentative of the norm. Some call bell systems give data about what percentage of calls are answered in under 5 minutes, 5-10 minutes and then over 10 minutes. Such data would be more meaningful to look at than the current set up.

See Recommended Action 6.

Management and Leadership Observations.

The home was well managed and the team felt they were as together as they had been as a management team. The home was a close community, with few divides between staff or between staff and residents and this was palpable in the atmosphere. There were many proactive initiatives that had contributed to this as well as general day-to-day good attitude.

The combination of the resident satisfaction levels, personal care, environmental improvements, good staff morale, quality care planning, meaningful activity and strong governance meant the home continued to be high-performing in comparison to most other similar establishments.

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 and community-based care for older people and deserved the highest guide rating.

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 PRN protocols are uploaded to the electronic medication system for all cases of 'as required' medication.
2	Please review the MCAs and best interest decisions for Residents 3 and 4, considering whether DoLS applications are required in either or both cases.
3	Please remind staff to record all food intake (and refusals) for breakfast, lunch and supper when people are on nutrition watch.
4	Please ensure Resident 4 is repositioned on a 2-hourly basis as stated in her care plan.
5	Please ensure a minimum of 10% of care plans are audited by management each month.
6	Please review and consider enhancing the information analysed in the monthly call bell response time audit.

Inspection Methodology

The inspection took place over two full days 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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