THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

SOMER VALLEY HOUSE

CQC RATING GUIDE: '**GOOD**'

Privately Commissioned Inspection for

Somer Valley House

Conducted by:

Simon Cavadino

Date of Inspection:

21st May 2025

Contents

Executive Summary

Oyster Care's stated aim is to offer care and support that focuses on resident well-being and quality of life. This is being built and delivered in a series of new purpose-built care homes across the south of England. As part of Oyster's quality assurance programme, additional privately commissioned inspection visits have been commissioned from outside care professionals. This is to ensure the organisation makes use of an external eye, acting as a 'critical friend', to further improve and enhance the quality of leadership and the quality of care at their care homes. An introduction to the author is available at the end of the report.

This is the report from a day spent at **Somer Valley House.** Somer Valley House is a new residential care home for older people including people living with dementia, located in Midsomer Norton in Somerset. The facilities are impressive and the environment is amongst the best in the residential care market. The home opened recently in November 2024 and there were 23 people in residence. This was my first visit to the home.

The main finding of this inspection was that the home presented positively in all key areas. This was particularly notable given there had been a change of manager in the early days, which can sometimes be destabilising. Residents and relatives were complimentary about the care provided and the observed care was of an outwardly high standard. The staff team reported that they had bonded well and described a good morale. Staff at all levels spoke appreciatively of their working conditions and support they received. The atmosphere was positive and cheerful and there was a kind and caring culture in evidence. Staff were attentive and helpful when interacting with residents. There was evidence of meaningful activity, initial community participation and plenty of ideas for the future.

Regulatory compliance and governance systems were robust, ably demonstrated by the care manager and were quickly becoming embedded. Medication systems were safely managed. Staff supervision was up to date. There were plenty of staff on duty and they had been properly recruited in line with regulation. The lunchtime experience was well managed.

The home's environment was clean and well presented, with domestic staff sharing in the pride of the new service. Care planning was of a reassuring initial standard.

One issue that needed to be looked at was the slowness of functioning of the electronic care planning and medication systems. This was directly observable and was commented on by several senior staff. It was unclear what was causing the delays but it may hold the team back if not resolved. A few other routine recommendations for improvement were made.

The whole team deserved credit for a positive and reassuring start so far. The home was a pleasant and welcoming 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 comfortable ‘Good’ rating.

CQC Key Question - Safe

The following CQC quality statements apply to this key question:

- Learning culture
- Safe systems, pathways and transitions
- Safeguarding
- Involving people to manage risks
- Safe environments
- Safe and effective staffing
- Infection prevention and control
- Medicines optimisation

Staffing Levels

The home is registered for a maximum of 66 older people, including some who were living with dementia. There were 23 people in residence on the day of my visit, although one person was away in hospital. The home was set out over two floors, with only the ground floor open to residents at this stage apart from one person with full capacity who wished to live in one of the suites upstairs.

Staffing levels across the home were as follows:

(am) 1 deputy manager, 1 senior care assistant and 4 care assistants
(pm) 1 deputy manager, 1 senior care assistant and 4 care assistants
(nights) 1 senior care assistant and 2 care assistants

There were two additional staff on duty who were on induction and were shadowing more experienced staff. The home was staffed to grow its occupancy numbers. The manager stated that minimum safe numbers would be one care assistant less than the numbers above, for all day shifts. Sometimes four staff were on duty at night.

Ancillary Staff

In addition to the care staff there were kitchen staff (chef or sous chef and kitchen assistant each day), a maintenance manager, a front of house manager, a head housekeeper, lifestyle manager, lifestyle assistant and domestic team (including dedicated laundry staff). Hairdressing and chiropody services were contracted externally. The team was managed by the general manager (supernumerary) and a care manager (also supernumerary). This was a good level of ancillary staff for a home of its size.

The management team undertook a regular dependency monitoring exercise as one way of ensuring the staffing was sufficient, as well as their own observations and input from care staff. From my observations during the day there were more than enough staff to care for the current resident group. There were many examples of staff having the time to speak with people, listen to them and engage with them in addition to completing personal care tasks. Both the management team and the staff team were of the view there were comfortably enough staff to care for people appropriately at this stage.

Staff Vacancies

The home was close to being fully staffed for the second phase of recruitment (to take the home up to around 36 residents), although some newer staff were still awaiting start dates. The home was in a good position to admit more people as referrals came in.

No agency staff had ever been used at the home.

Staff Recruitment Files

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

- Recent photographs
- Full employment histories
- Medical information to ensure people are fit to work
- Contracts & ID
- Suitable references
- Job descriptions
- Interview notes
- Training information
- DBS information
- Evidence of relevant qualifications
- Supervision and probationary review notes

Open Safeguarding Cases
The manager advised there were no open safeguarding cases at the home.

Medication Management
The medication trolleys were kept in a secure medical room on the ground floor. There was another medical room on the first floor for when it opened. The systems were ably demonstrated by the deputy manager on duty.

Good practice included:

- Keys were kept by the senior member of staff in charge.
- Storage temperatures were monitored daily for both the medication room and the refrigerator. Records indicated that the storage temperatures were within safe ranges.
- Specified room cleaning schedules were completed daily.
- The trolleys were tidy and well organised and attached to the wall when not in use.
- Medication was delivered regularly in original packaging – a non MDS approach.
- Controlled drugs were stored correctly and checked regularly. A random stock check tallied correctly.
- Do not disturb tabards were worn by staff administering medication.

The home used an electronic medication system (EMAR). The EMAR system involved scanning the medication boxes prior to administration and the system generated a MAR chart. The system prompted all prescribed medication administration and so it was not possible to 'forget' any medication or not sign for it. The key to demonstrating the system is being used correctly is to ensure the stock present in the boxes and packets matches exactly the amounts recorded on the computer system. I undertook ten random stock audits and all were correct apart from one, which related to Resident 1's Ramipril (11 in stock and 12 showing on the system).

Plastic pots and syringes (for administering medication) were being washed in the sink and left to air dry before re-use. These items should be sterilised in between uses or disposed of after use.

Latanoprost eye drops were being stored in the refrigerator after opening. This medicine can be stored at room temperature after opening and then disposed of after 28 days. The item had not been dated upon opening.

See Recommended Actions 1-3.

Slow Computer Systems

The deputy manager said that the EMAR system could be very slow sometimes and this was an impediment to getting the medication round completed efficiently. Other senior staff confirmed this and commented that the PCS care planning system could be similarly slow. When reading the care plans I noted this to be the case, with frustratingly long waits to load a single page. With both software systems being slow it would suggest a WiFi speed issue (or something similar) at site level.

This will need to be resolved or it may affect the quality of care planning and the accuracy of medication administration in the future.

See Recommended Action 4.

Premises Safety & Management

The home was new and was spotlessly clean and well presented. No unpleasant odours were noted anywhere. The home was kept at an appropriate temperature on a warm day.

Domestic staff worked safely with their cleaning materials. Sluice rooms were locked at all times. COSHH cupboards were also locked when not in use, apart from on one occasion later in the day when a cupboard under the sink in one of the kitchenettes was left unlocked leaving cleaning materials and a dishwasher tablet accessible. These items can be harmful to people living with dementia and must be kept locked away at all times.

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
The home had received its first environmental health inspection, scoring 5 – ‘Very Good,’ which is the highest score available.

Kitchen practices were not assessed further at this visit.

CQC Key Question - Effective

The following CQC quality statements apply to this key question:

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

Supervision & Appraisals

The home employed 47 staff. The provider used a system called Coolcare to monitor the frequency of supervision and appraisal meetings. The system showed all supervisions to be up to date, other than four. These related to one bank staff member who was proving difficult to contact, one person who was off sick and two other meetings that were planned and due to take place shortly. This meant that supervisions were actively managed and kept up to date. The home had not been open long enough for appraisals to be due, but these would be conducted annually. Minutes of supervision and probation review meetings were kept on personnel files and were signed by both parties.

The staff team were a new group who spoke appreciatively of their working conditions and support they received. One staff member said, *"It's really nice here, better than the last home I worked at."* Another staff member who had achieved a promotion said, *"I've been given more responsibility and the managers have been really helpful to me. I couldn't ask for more."*

Training

When new staff were appointed to work at the home they were expected to undertake basic training to do their jobs. Mandatory training compliance figures looked a little low, at **69%**. However, the majority of the 'non-compliance' related to new staff who had just begun their employment and were in the process of completing their required training during their inductions. This meant the mandatory training statistics were as high as they could be and would increase quickly/.

Mandatory training was wide-ranging, incorporating autism, learning disabilities, COSHH, dementia awareness, dignity in care, dysphagia, end of life care, equality and diversity, fire safety, first aid, basic food hygiene, GDPR, health and nutrition,

health and safety, infection control, MCA/DoLS, medication, mental health awareness, moving and handling, oral hygiene, pressure area care, falls awareness and safeguarding.

Mental Capacity - DoLS

The management team had a good understanding of DoLS requirements. A clear matrix was in place and showed that 4 DoLS applications had been correctly made for people who fell into all 3 of the following criteria:

a) those who lack capacity to consent to their care and treatment in the home due to dementia or severe illness;
b) those who are not free to leave the home as and when they please (i.e. staff would stop or divert them if they tried to);
c) those who need continuous monitoring (i.e. staff control all their medication, nutritional intake, activities etc).

One of the applications been determined (approved) by the local supervisory body and a CQC notification had been submitted as required. The other applications were still awaiting determination.

Eating and Drinking

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

- Appropriate background music was playing during lunch.
- Tables were nicely laid.
- Staff were wearing appropriate protective equipment in the form of washable aprons.
- Hand-wipes were available for people to sanitise their hands before eating.
- Napkins and clothing protectors were available.
- There were plenty of staff around and they interacted with residents well, being focused on their needs and wishes. Staff were alive to situations where they needed to intervene, such as picking up and replacing cutlery that had been dropped on the floor.
- Choices of different drinks were given to people.

- Choices of main courses and desserts were given to people using show plates with different alternatives. This is the best way of offering meaningful choice to people living with dementia.
- The chef was involved in the serving out process.
- Feedback from residents about the quality of food was positive.

Premises Presentation
Entrance and Reception Area
The home had a bright and welcoming entrance and reception area, staffed by a friendly and enthusiastic front of house manager. There was a fully working tea and coffee bar. The manager's office was easily accessible at the side of the main reception. Information such as the home's registration certificate and the complaints policy were displayed prominently.

The home did not as yet have a CQC rating, but this would be displayed after the first inspection.

Design and Adaptation
The home was designed and purpose built for people who have mobility restrictions. All bedrooms had en-suite toilets and wet room showers. Full assisted bathing facilities were also available on each floor.

Communal Rooms
The lounges and dining rooms were welcoming, clean and very nicely furnished. There were a variety of different lounges and dining rooms in the home, including a state-of-the-art cinema room, library area, garden rooms and a fully kitted out hairdressing salon.

Impressive and well stocked snack and hydration stations were available on the ground floor.

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. The

bedrooms were fitted with smart televisions, refrigerators and the facility for a telephone line.

Garden

The secure gardens around the home were well kept and nicely presented. Some of the ground floor rooms had areas outside their patio doors for individual people to sit and enjoy the weather. Some people were seen enjoying doing this. It was good to see the residents able to enjoy the nice weather.

CQC Key Question - Caring

The following CQC quality statements apply to this key question:

- Kindness, compassion and dignity
- Treating people as individuals
- Independence, choice and control
- Responding to people's immediate needs
- Workforce wellbeing and enablement

Residents

There was a positive relationship between the staff and the residents. The interactions I witnessed between staff and residents were cheerful, helpful and friendly. All indications were of a good culture of care. I spoke with several residents during the day. They were positive about the care given to them at the home and some were able to joke in a relaxed manner, indicating that they were comfortable in their surroundings. Nobody raised any concerns.

Quotes included:

"They make a lovely cup of tea here."
"The staff can't do enough for you. Everyone is so friendly."
"There's nothing at all wrong. I feel like I'm settling in well."
"They're brilliant. We're all dotty in different ways and the staff are very tolerant."
"There are activities going on – probably more than I want to do really. But you're not forced to participate."
"The food is well prepared and presented. I can't recall a complaint."
"I'm leaving today as I came for respite. I couldn't have asked for more and I may well come back at some point."

All of the residents I met were well presented and clean, indicating good attention to personal care. Where residents became distressed due to their needs, staff responded with warmth, kindness and patience.

Visitors

Visiting was able to take place unrestricted.

Feedback from relatives was similarly positive. Two visitors said, *"[Our relative] has only been here for a few days, but everything has been good so far. The first impression has been excellent.* Another visitor expressed much gratitude for how the team had cared for her relative during a respite stay.

The latest Carehome.co.uk rating was high (9.5 out of 10 from its first 9 reviews). The comments were couched in highly complimentary terms and this indicated that stakeholders were satisfied with the care and support offered to their loved ones.

Dignity
Staff routinely knocked on people's bedroom doors before entering their bedrooms, indicating respect for their personal space. People had call bells to summon attention when they were spending time alone in their rooms and these were left within their reach. Continence products were stored discreetly. Staff were alert to dignity issues and intervened without fuss when they arose.

There were some shampoo and conditioner bottles stored in a cupboard in one of the communal bathrooms. These items should always be returned to peoples' bedrooms after use to avoid the temptation of the toiletries being used for other people and becoming 'communal.'

See Recommended Action 6.

Confidentiality
Care plans were password protected on 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 electronic care planning system in use was Person Centred Software, which I have seen implemented successfully in different care environments. Care plans were written following detailed assessments of people and contained plenty of person-centred information. The care plans I read were drafted in the first person and were informative. As well as the usual activities of daily living there were specific care plans in place for individual health conditions and to describe strategies to care for individuals who were distressed or agitated.

The management team were clear about the needs of people the home was able to meet and the kind of needs that were not suitable.

Care plans had been reviewed on a monthly basis, as prompted by the computer software. Established scoring systems were used to ensure that risks to people were identified and managed effectively. The system produced a list of required risk assessments that were completed for all. These included people's risk of developing pressure ulcers, risk of becoming malnourished (MUST & Waterlow) and moving and handling risk assessments. These risk assessments had also been regularly reviewed.

I was given access to read the care plans through the login and password of a staff member. It would be preferable if there were to be ‘Guest Professional’ login set up. This would be a read-only access account that visiting professionals could use.

See Recommended Action 7.

Consent to Care and Treatment
In the case of Resident 2 there was one Mental Capacity Assessment (MCA) in place and this was entitled 'Capacity to receive care at Somer Valley House.' On further investigation it transpired that Resident 2 would lack capacity to consent to other aspects of his care, such as medication. Through MCA processes it is important to make clear that judgements about capacity are decision-specific. This means that a judgement of capacity can only relate to one set of circumstances, not a person generally 'lacking capacity.' Writing a full series of MCAs would demonstrate this.

Key areas to consider for each person might be:

- Can the person consent to their living arrangements? Do they understand they are living at Somer Valley House and why? Do they understand there is a lock on the door?
- Can they consent to the use of sensor monitoring equipment?
- Can they consent to the use of bed rails?
- Can they consent to taking their medication?
- Can they consent to any form of restraint (such as straps for transportation)?
- Can they consent to their personal care, especially if the personal care sometimes required intervention to keep them safe against their momentary will?
- Can they consent to restrictive diets (e.g. soft diets recommended by SALT teams)?
- Can they consent to annual 'flu jabs or Covid19 jabs?

This list is not necessarily exhaustive and the management would need to stay alert that there could be other situations where people might be deprived of their liberty.

See Recommended Action 8.

Daily Care Records
Hygiene charts were in place for everyone and these indicated personal care had been given regularly and as required. The quality manager described a recent decision to record the application of emollient creams on the PCS system. This was work in progress and will be followed up in more detail at future inspections.

Fluid intake recording was being recorded by the staff on the PCS handsets for Resident 3. The person had a minimum fluid target of 1,500mls per day and the amounts offered over the past week were showing as regularly less than the fluid target amount (**1080, 1080, 200, 960,** 1520, 1640 and **900**). If the resident is not offered their minimum target amount they will be unable to reach it.

See Recommended Action 9.

Activities Arrangements

The lifestyle manager was only in her first week of employment but already had plenty of good ideas for the future. She had already made efforts to talk to residents individually and get to know them and had started work towards individual reminiscence packages.

Activities that took place during the day included games of Scrabble, reading and arts and crafts. There was a memory clinic that took place upstairs where people from the community were invited to the home. There were reports of residents being assisted to attend church and to go shopping in the local town. Other minibus trips were planned.

The lifestyle and activity function will be looked at in more detail at future inspections.

CQC Key Question – Well Led

The following CQC quality statements apply to this key question:

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

CQC Notifications

CQC notifications had been submitted as required.

Registered Manager

Carol Britton was registered as manager. Carol had been registered (when working in the role of regional manager) as part of the home's original CQC application. A full-time registered manager had been employed but then unfortunately failed her probationary period. The CQC registration did not get transferred to the new manager during that time. Carol had agreed to step back in and was set to be working as general manager until August.

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

Management Governance and Audits

A robust internal auditing system was in place, as was the case throughout Oyster Care's homes. The auditing system was robust and covered a wide range of key areas. The sheer amount and depth of the auditing gave confidence the home was well run. The management team believed in the governance system and felt it would certainly help to keep them safe as both the home and the organisation grew. Actions identified through the audits were placed on a home action plan.

Audits were demonstrated by the care manager and included:

- Daily walk around checks
- Daily clinical oversight

- First aid box audit
- Medication audits
- Catering audit
- Fire drill audit
- Dining experience audit
- First impressions audit
- Lifestyle audit
- Pressure ulcer audit
- Moisture lesions audit
- Bed rails audit
- Wounds audit
- Weights and weight loss management audit
- Infections audit and trend analysis
- CQC notifications review
- DoLS review
- Duty of candour cases (none)
- Safeguarding review
- Equipment log
- Care plan audits (at least 10% and others audited from head office care plan manager)
- Maintenance review
- Staffing KPIs
- Dependency audit
- Accident, incident and near miss audit, with graphical presentations and trend analysis.
- Hoists and slings audit

Every day there was a resident of the day process. The governance work was monitored both by the management team and by senior management staff of Oyster Care. The governance systems were early in their implementation, but were built to cope with significant growth.

Provider Visits

A new regional manager was present during the inspection. The provider had an in-depth MGV (monthly governance visit) that the regional director would complete every month for each home, in addition to the other support that would be provided to the team.

Management and Leadership Observations.
The general manager described needing to tackle a few issues after the previous manager failed her probationary period. However, through observation and talking to staff and residents there was no mention of anything related to this and everyone was nothing but positive about the home.

The provider was beginning the process of recruiting a new registered manager, as fresh leadership will be required from August 2025 to take the home to its next phase of growth.

Required and Recommended Actions

The following list consists of matters picked up during the inspection process that would be either in breach of regulation, arguably in breach of regulation, issues that CQC inspectors commonly criticise if not seen as correctly implemented and general good practice suggestions. The regulations in question are the HSCA 2008 (Regulated Activities) Regulations 2014, The Care Quality Commission Registration Regulations 2009 and The Mental Capacity Act 2005. There are other regulations that can be relevant, but these ones cover the vast majority of issues to consider.

1	Please ensure that plastic pots and spoons used to administer medication are either sterilised in between uses or disposed of.
2	Please investigate the reason for the medication stock discrepancy.
3	Please store Latanoprost eye drops at room temperature after opening and ensure that staff date this item upon opening.
4	Please resolve the hardware issues that are causing the PCS care planning computer system and the EMAR computer systems to be running slowly.
5	Please ensure staff keep potentially hazardous cleaning materials and dishwasher tablets locked away at all times when not in use.
6	Please ensure that staff return all toiletries to peoples' bedrooms after use to avoid the temptation of them becoming communal.
7	Please consider having a read-only 'guest professional' login available. This would give appropriate access to the PCS system that is not under an individual staff member's personal account.

8	Please undertake a series of Mental Capacity Assessments (MCAs) for the specific decisions that Resident 2 may lack the capacity to consent to.
9	Please ensure Resident 3 is offered at least her minimum fluid target each day and that staff record this reliably.

Inspection Methodology

The inspection took place over one full day on site at the home. Evidence was obtained in the following forms:

- Observations of care and staff interactions with residents.
- Observations of general living and activities.
- Discussions with people who lived at the home.
- Discussions with staff who worked at the home, including management staff.
- Inspection of the internal and external environment.
- Inspection of live contemporaneous care records.
- Inspection of live contemporaneous management records.
- Inspection of medication management systems.

The main inspection focus was against compliance with the following regulations:

- HSCA 2008 (Regulated Activities) Regulations 2014.
- The Care Quality Commission Registration Regulations 2009.
- The Mental Capacity Act 2005.

Full account is also taken of the following key guidance, although this list is not designed to be exhaustive:

- CQC's recently published Single Assessment Framework (SAF) and its associated Quality Statements.
- The recently retired Key Lines of Enquiry (KLOEs), as these were always a good technical guide for what appropriate quality care looks like.
- NICE guidelines on decision making and mental capacity.
- NICE guidelines on medication management.
- A whole variety of CQC's clarification documents from over the years.
- RIDDOR guidance on reporting injuries and dangerous occurrences.

The ratings awarded for each key question are professional judgements based on over 25 years' experience of inspecting and rating care services. I believe the most meaningful rating is a 'description,' not a 'score.' It is a 'narrative judgement,' not a 'numerical calculation.' This inspection does not attempt to mimic CQC's current complex scoring system.

Introduction to Author

Simon Cavadino
Simon has worked in the provision, management and regulation of social care and healthcare services for over 25 years. He currently works with a range of different care provider organisations, offering advice on the Health and Social Care Act (2008) and its accompanying regulations. He is able to undertake detailed compliance advice work and/or senior-level management advice and coaching. Simon trades under the banner of The Woodberry Partnership.

During his career Simon has worked as an inspector for the Commission for Social Care Inspection (CSCI) and for the Care Quality Commission (CQC). He has undertaken detailed inspection, registration and enforcement work during his two spells working for the national regulator.

Simon has also worked for care provider organisations in both the private and voluntary sectors, achieving high quality services wherever he has worked. His most notable career achievement was as Director of Operations for a private sector provider, where he commissioned, built, opened and ran 25 sought-after care services for adults with a learning disability over a period of 8 years.

www.woodberrypartnership.co.uk

[End]