



THE WOODBERRY
PARTNERSHIP



INSPECTION REPORT

TRENT BRIDGE CARE HOME

CQC RATING GUIDE: 'GOOD'



Privately Commissioned Inspection for

Trent Bridge Care Home

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Date of Inspection:
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Executive Summary

Tanglewood Care Homes operates residential care homes for older people across the Midlands and the North of England. The company aims to provide high quality care in safe and comfortable surroundings, always promoting independence and choice. As part of Tanglewood's quality assurance programme, additional inspection visits have been commissioned from outside care professionals. This is to ensure the organisation makes use of an external eye, acting as a 'critical friend', to further improve and enhance the quality of leadership and the quality of care at their care homes. An introduction to the author is available at the end of the report.

This is the report from a day spent at **Trent Bridge Care Home**. Trent Bridge is a new purpose built residential care home for older people including people living with dementia, located in the city of Nottingham right next to the Trent Bridge cricket ground. The facilities are 'state of the art' and the environment is amongst the most impressive in the residential care market. The home opened in August 2024 and there were 24 people in residence.

The main finding of this inspection was that the team had made a positive, competent and successful start to life at Trent Bridge. The atmosphere at the home was welcoming, happy and cheerful and there was a palpably kind and caring culture amongst the staff group. Staff spoke appreciatively of the support they had received so far from the management and there was a good team spirit already.

Residents were complimentary about the care they received. Personal care was outwardly of a good standard and this was confirmed by daily record keeping. Staff were attentive and helpful when interacting with residents. There was a 'residents-come-first' attitude in evidence, which came from the management team and extended through all of the staff. Meaningful activities were taking place and the new lifestyle lead had many good ideas for the future. The lunchtime experience was well managed.

Regulatory compliance and governance systems were strong and already becoming embedded. Care planning was of a decent standard, although the manager wished to push the team further in this area. Staff were recruited in line with regulation and were properly inducted, trained and supervised. There were enough staff on duty. The environment was clean and well presented.

A small number of issues were picked up for consideration and improvement. The most significant of these was with medication management, as several of the stock checks undertaken were incorrect and a better system was required to record the application of emollient creams.

The team were welcoming of constructive criticism and the home was a pleasant and reassuring 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 solid 'Good' rating in all areas, notwithstanding the medication stock count inaccuracies that needed looking at.

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 72 older people, including some people living with dementia. There were 24 people in residence on the day of my visit. The home was laid out over five floors, with the ground, first and second floors being open. There were no bedrooms on the ground floor, only communal living facilities. Residents were living on the first and second floors.

Staffing levels across the home were as follows:

First Floor – (Residential care for up to 18 older people, including people living with dementia – 14 people in residence.)

(am) 1 senior care assistant and 1 care assistant

(pm) 1 senior care assistant and 1 care assistant

Second Floor – (Residential care for up to 18 older people - 10 people in residence.)

(am) 1 senior care assistant and 1 care assistant

(pm) 1 senior care assistant and 1 care assistant

In addition to the above care staff there was a care team leader who floated between the two floors. There were three students helping out who were completing work experience and one senior staff member who was shadowing as part of her induction.

At night there was 1 senior care assistant and 2 care assistants on duty across the home.

Ancillary Staff

There was a growing ancillary team. There was a lifestyle lead and a lifestyle support assistant to run the activities and wellbeing department. There was a chef and kitchen assistant each day, although the kitchen assistant role was currently being staffed by additional care staff. There was a maintenance manager, front of house manager, head housekeeper and domestic team (including dedicated laundry staff). Hairdressing and chiropody services were contracted externally.

The team was managed by a manager (supernumerary) and a care manager (also supernumerary). This was a good level of ancillary staff for a home of this size and worked well.

The staffing numbers were growing as the occupancy increased and the home was staffed to ensure the occupancy could increase at a sensible rate. The manager undertook a regular dependency monitoring exercise as one way of ensuring the staffing was sufficient, as well as input from care staff. From my observations during the day there were plenty of staff to care for the current resident group. There were examples of staff having the time to speak with people, listen to them and engage with them in addition to completing personal care tasks.

Staff Vacancies

The manager said that recruitment had been successful so far and phase 2 of the recruitment was ongoing. There was a senior care assistant on induction and one night team leader who was in the onboarding process. There were further vacancies for a senior care assistant (nights), one care assistant (days) and two kitchen assistants.

The home did not use agency staff.

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, were well put together and contained all of 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
- Induction information
- DBS information
- Right to work in the UK paperwork
- Evidence of relevant qualifications

A detailed and ongoing personnel audit was seen, showing that all relevant information was in place.

Open Safeguarding Cases

The care manager advised there were two open safeguarding cases at the home. One related to a recent fall that had been fully reported and the other related to a missed insulin dose (by the district nursing team) following some confusion after a discharge from hospital. Full information had been provided to the local safeguarding team and the home was awaiting instruction.

Medication Management

The medication trolleys were kept in secure medical rooms, located on each floor. I audited the medical room on the second floor at this inspection. 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.
- The trolleys were tidy, 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. A random stock audit tallied.

- PRN protocols were in place and well written.
- Do not disturb tabards were available to be 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 six of them were correct, with four incorrect. The incorrect stocks were:

- Resident 1 – Folic Acid – 79 in stock, with 78 showing on the system.
- Resident 1 – Paracetamol – 202 tablets in stock with 204 showing on the system. (2 tablets were loose in the packet having been popped out of the packaging but not given. These should be disposed of appropriately.)
- Resident 1 – Isosorbide 5 mononitrate – 72 in stock with 65 showing on the system.
- Resident 2 – Loperamide – 171 in stock with 161 showing on the system.

There needed to be a full stock audit, a reset and then regular auditing to establish how the inaccuracies were occurring.

See Recommended Action 1.

Premises Safety & Management

The home was new, spotlessly clean and well presented. No unpleasant odours were noted anywhere. Domestic staff worked safely with their cleaning materials. COSHH products were stored safely throughout the home. Sluice rooms were locked at all times.

The heating was thermostatically controlled from electronic panels in each room. In some of the communal rooms on the ground floor the temperature was set to 18 degrees Celsius. The manager said this seemed to be the default setting and it had to be manually reset each time. These rooms were not warm enough for older people and it would be better if the default could be changed to 22 degrees Celsius or similar.

See Recommended Action 2.

Laundry Room

This room was located on the ground floor, 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 38 staff at the time of inspection. 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 with the exception of four, which would be scheduled soon. This essentially meant that supervision was essentially up to date. Most appraisals were not yet due as the home had not been open for a full year. Minutes of supervision meetings were kept on personnel files and were signed by both parties.

All staff spoken with indicated they were happy and very well supported. One staff member said, *"It's a calm place to work. I like it here. It's well run and much better than the last place I worked at."* A second staff member said, *"It's been nice to be a part of this home since it opened. I have no concerns."* A third staff member said, *"There's a nice family atmosphere. I hope I can work here until I retire."*

None of the staff raised any concerns about anything to do with the home.

Training

When new staff were appointed to work at the home they attended and completed a range of training that equipped them with the basic skills to do their jobs. Updates would then be scheduled at sensible frequencies.

Mandatory training compliance figures were high, at **91%**. Mandatory training subjects included safeguarding (adults and children), Oliver McGowan learning disability and autism course, basic life support, COSHH, fire safety, dementia awareness, GDPR, equality and diversity, dignity and respect, food safety, health and safety, infection control, moving and handling and MCA/DoLS.

Mental Capacity - DoLS

The management team had a good understanding of DoLS processes. A clear matrix was in place and showed that 7 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).

None of the applications had yet been determined (approved) by the local supervisory body. The team were aware of the need to submit CQC notifications when this happened.

Eating and Drinking

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

- Staff ensured pleasant background music was playing during lunch.
- Tables were nicely laid.
- Up to date menus were on display.
- Staff were wearing appropriate protective equipment in the form of washable aprons. Kitchen staff were involved with the serving out.
- Residents were offered napkins and other clothing protectors if they wished to wear them.
- Plenty of staff assisted with the lunchtime experience and they all interacted with residents well at all times.
- Choices of drinks were given to people.
- Choices of main courses were given to people in a suitable way they could understand.
- One-to-one support was given to people who required it from a seated position in a discreet manner.
- Nobody was rushed with their meals.

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area, staffed by friendly and helpful reception staff, with many places to sit and wait to be seen. The manager's office was easily accessible behind the reception area. Information such as the home's registration certificate, employer's liability information 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.

The whole home had been designed with a view to being able to see various views of Nottingham, including a spectacular view of the Trent Bridge cricket ground that was just across the road. Various balconies gave excellent views of the cricket, including a large and secure roof terrace on the top of the home.

There was plenty of sporting memorabilia, relating both to the overall cricketing theme and Notts County and Nottingham Forest football clubs. Both football grounds could be seen from the upper floor balconies.

Communal Rooms

The lounges and dining rooms were welcoming, clean and very nicely furnished. There were a variety of different lounges (such as quiet lounges) on each floor of the home, including an activity room, family room, cinema, physio and exercise room and a treatment room. There was also a fully kitted out hairdressing salon.

Snack and hydration stations were available on the open floors.

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.

Many of the bedrooms had similarly spectacular views to those described in the previous section.

Garden

The secure gardens around the home were well kept and presented.

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 kind, caring and respectful relationship between the staff and the residents, with staff breaking off conversations in order to attend to residents needs first. This was a clear sign of a good culture of care. Feedback from residents was positive and grateful about their experiences of living at the home. This was most encouraging given how new the home was.

Quotes included:

"All the staff are really nice to me."

"The food is nice and you get a cup of tea whenever you want one."

"When I came here I thought I was in a palace."

"I was in a care home before and it wasn't good like this one. I'm grateful for everything they do."

"I've made friends and we trust each other. We all get on. It's all good."

"The staff are cheerful and friendly and we have a laugh and a joke."

"It's lovely here, ten thousand times better than where I was before."

The standard of personal care was high throughout the home and this was properly evidenced by daily record keeping. People were supported to be clean, well-presented and were wearing properly fitting clothing.

Visitors

Visiting was able to take place unrestricted.

The carehome.co.uk website rated the home as 9.8 out of 10 from the first 18 reviews, which was indicative of very high satisfaction levels from people who used that website for feedback.

Privacy and Dignity

People were treated with dignity and respect throughout the day. Staff were observed to knock on doors prior to entering peoples' bedrooms. This indicated a respect for people's personal space. Continence products were stored discreetly. Staff were alert to situations where peoples' dignity may be compromised and intervened without fuss.

Call bells were left within reach of people who were spending time in their private bedrooms. Moving and handling manoeuvres were undertaken with care and dignity. Staff were alive to situations where peoples' dignity may be compromised and intervened without fuss.

There was one situation (likely an oversight) where a staff member was assisting a person with personal care in their ensuite bathroom. The door to the ensuite was open, as was the door to the person's room. This meant all of the private conversations about the person's personal care could be heard from the corridor, which was not dignified.

See Recommended Action 3.

Confidentiality

Care plans were stored electronically and were password protected.

CQC Key Question - Responsive

The following CQC quality statements apply to this key question:

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

Care Plans

The care planning system being used 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, including some life history information. The care plans I read were informative. Specific care plans were in place for individual health conditions, such as being on antiplatelet medication and having an indwelling catheter.

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.

While the care plans were compliant with key regulations, the management team expressed the desire to increase their quality over forthcoming weeks and months.

Daily Care Records

Staff had taken well to the PCS system, with all of the records kept well. Daily care records were available for monitoring peoples' fluid intake and food intake and the charts showed good food and fluid promotion. There were hygiene charts to record personal care given, showing regular personal care and support with showers and baths. There was regular repositioning information where this was necessary for a small number of people.

The one missing daily care record of importance was the recording of the application of emollient creams on topical MAR charts (TMAR). This had been identified by the care manager who was proposing to use the PCS system to correct this. The application directions for each emollient cream prescribed can be transferred to the system and, where the prescription is regular, these can be set up as 'must do' tasks in the planned care section. In the application directions it is important to include the exact cream, where (on the person's body) the cream application should be made and how often the cream should be applied. Care assistants then can record having completed these tasks on the system, prompted each day on their handsets. Once all the emollient creams have been set up in this way, three clicks of a mouse can produce full topical MAR charts (TMAR) for the last 28 days.

See Recommended Action 4.

Consent to Care and Treatment

Mental capacity assessments (MCAs) were in place where there was a doubt about individual people's capacity to consent to various specific aspects of their care. The MCAs were well written in most cases and best interest decision making documents had been prepared when people lacked the capacity to consent to a specific decision.

For example, in one case there were separately considered MCAs for:

- Living at Trent Bridge behind a key coded door
- Medication administration
- Nutrition and hydration
- Personal care

In the case of Resident 3 there were also plenty of specific decisions considered, including the four areas mentioned above. These were all written up on the same MCA and best interest template. To be fair, each specific decision was reported in the document and so it did strictly comply with regulation. However, it is preferable for a different template to be used for each specific decision to demonstrate there is a separate process for each decision.

See Recommended Action 5.

Activities Arrangements

Activities seen at the home included a religious service with a local chaplain, a film afternoon, word games and the offer of a few residents being taken out shopping. Activities advertised for the week included external musical entertainment, pampering sessions, fitness groups, a sing-a-long, rooftop picnic, poetry club and a flower arranging session.

The new lifestyle lead gave an enthusiastic account of the activities on offer at the home. She had only been in post a matter of weeks, but said she had been welcomed by the whole team and had many ideas for the future. The lifestyle lead spoke positively about arranging community links, for example a local nursery had recently started to bring some small children to play in the home about once a fortnight. Some new entertainers had been booked, as had a therapy dog session.

The VE Day celebrations had been taking place over the last couple of days and the lifestyle lead had been impressed by the number of visitors the events attracted. A buffet was laid on amid the celebrations.

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 & Duty of Candour

CQC notifications had been made appropriately and were kept on file. The management team were aware of the circumstances where duty of candour letters needed to be written.

Registered Manager

The manager, Sally Tebbett, was an experienced registered manager and had been registered as part of the home's originating application.

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

Management Governance

A robust internal auditing system was in place, as was the case in all of the provider's care homes. The system 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 helped keep them safe.

Daily clinical oversight and resident of the day processes kept an ongoing look at important clinical detail. Actions identified through the audits were placed on a home action plan. Governance work for April 2025 was demonstrated and included:

- Accident and incident review, with graphical and trend analysis (5 falls)
- Dependency tracker
- Call bell analysis
- Pressure ulcer audit (x1)

- Wounds audit
- Bed rail audit
- Bed log
- Weights and weight loss management audit
- Regular medication review information, along with antipsychotics and covert medication list (none currently)
- Infections review
- CQC notifications (none necessary in April)
- Safeguarding cases
- Whistleblowing issues (none)
- Complaints review (none)
- Finance audit
- Human resources audit
- Mattress audit
- Medication audit
- Health and safety audit
- Pressure cushion audit
- Care plan audits (10% minimum)
- Team meeting minutes (various)
- DoLS review
- Daily work, such as clinical meetings with heads of department and manager walkarounds

Provider Visits

The management team advised there was a newly appointed regional manager to provide support to the home's management. A full monthly governance report would be completed going forward.

Management and Leadership Observations.

The home was being well led by an experienced manager.

The whole team had made a positive, competent and successful start to life at Trent Bridge. The atmosphere at the home was welcoming, happy and cheerful and there was a palpably kind and caring culture amongst the staff group. Staff spoke appreciatively of the support they had received so far from the management and there was a good team spirit already.

Residents were complimentary about the care they received. Personal care was outwardly of a good standard and this was confirmed by daily record keeping. Staff were attentive and helpful when interacting with residents. The lunchtime experience was well managed.

Regulatory compliance and governance systems were strong and already becoming embedded. Care planning was of a decent standard, although the manager wished to push the team further in this area. Staff were recruited in line with regulation and were properly inducted, trained and supervised. There were enough staff on duty. The environment was clean and well presented.

The team were welcoming of constructive criticism and the home was a pleasant and reassuring place to visit. I was confident that the recommended actions would be addressed swiftly.

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 conduct a full medication stock audit, reset where necessary and then implement additional auditing to ensure the stock issues do not reoccur.
2	Please try to reset the heating defaults for all communal rooms to 22 degrees Celsius or similar.
3	Please remind care staff to always shut peoples' bedroom doors when providing personal care.
4	Please set up all emollient creams in use at the home to be recorded on the PCS system.
5	Please consider producing separate MCAs and best interest decision making documents for each specific decision considered, rather than recording them all in the same document.

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.

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