THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

BEESTON RISE

CQC RATING GUIDE: **'GOOD'**

Privately Commissioned Inspection for

Beeston Rise

Conducted by:

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Executive Summary

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

This is the report from a day spent at **Beeston Rise**. Beeston Rise is a new purpose-built residential care home for older people including people living with dementia, located in Beeston, Nottinghamshire. The home opened in August 2023. A new registered manager had taken up post in early January 2025 after a year where there had been three different managers.

The findings of this inspection were positive. Feedback from residents about their experiences of living at the home was complimentary, as were comments made by some of their relatives. Staff spoke highly of working at the home and of the new management team. They hoped that a lower than ideal staff retention in 2024 would now settle down. A good team spirit was apparent and all interactions between staff and residents were caring and friendly. The lunchtime experience was well-managed, with residents complimentary about the food on offer.

This inspection also revealed a strong level of regulatory compliance. The home was clean and well presented. Staff were properly recruited and trained. Management systems to ensure ongoing quality and continuous improvement had been implemented well, were robust and up to date. Care planning was of a good standard. Medication systems were well managed.

The team engaged well with the inspection process and were keen to aim high in the future. The manager was planning to grow the occupancy of the home while retaining and building upon its current standards. The home was a pleasant, happy and upbeat place to visit and was in a good position to grow and develop.

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, with no significant concerns identified.

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 people. There were 29 people in residence on the day of my visit. The home was laid out over three floors, although the top floor had yet to open to residents. The home looked after people who had residential care needs, including some living with dementia.

Staffing levels across the home were planned as follows:

Ground Floor (17 people in residence)
(am) 1 senior care assistant (or team leader) and 3 care assistants
(pm) 1 senior care assistant (or team leader) and 3 care assistants

First Floor (12 people in residence)
(am) 1 senior care assistant (or team leader) and 2 care assistants
(pm) 1 senior care assistant (or team leader) and 2 care assistants

This meant it was planned for there to be seven care staff over the two open floors throughout the day. On the day of inspection somebody had called in sick in the morning and so the team had to manage with six staff. The manager said six staff should be able to meet peoples' needs, but this would be considered as the minimum safe level.

During the night there were four staff on duty, usually comprising of one team leader, one senior care assistant and two care assistants. The manager said that it would be safe for the numbers to drop to three staff, but that did not often happen.

Ancillary Staff
As well as the care staff there was a full time front of house manager, a newly appointed lifestyle manager and a maintenance manager who was awaiting a start date pending recruitment checks. There was a head housekeeper and 2-3 domestic staff members on duty each day, to include laundry duties. A chef and a kitchen assistant worked in the kitchen. Hairdressing and chiropody services were provided by external contractors. The team was managed by the registered manager and a care manager, both of whom were supernumerary to the care staff.

Staff Vacancies
The manager explained that recruitment had been successful and the home was close to being fully staff for the second phase of growth. The only roles being recruited to were a lifestyle assistant, one part-time care assistant and a laundry assistant. Agency staff were rarely used at the home.

Several staff commented that staff retention had been difficult over the past year, with several staff leaving. This might have been partly due to three different managers in post, but there was hope that the team would now stay and consolidate.

From my observations during the day there were sufficient staff to care for the current resident group. Both the manager and the staff team agreed with this. There were plenty of 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 was staffed to grow and was in a good position to increase its occupancy numbers at a sensible rate.

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

- Recent photographs
- Medical information to ensure people are fit to work, along with risk assessments where necessary
- ID

- Full employment histories
- Contracts
- DBS information
- Satisfactory references
- Job descriptions
- Interview notes
- Evidence of relevant qualifications (see below)

Staff Member 1 had a qualification of NVQ level 3 that had been obtained prior to her appointment at the home. A copy of the certificate to evidence the qualification had not been obtained at the point of recruitment. This is required by regulation.

See Recommended Action 1.

Medication Management

The medication trolleys were kept in secure clinic rooms on both open floors. At this visit I audited the medical room on the first floor. The senior on duty capably demonstrated the medication systems. Good practice included:

- Keys were kept by the senior members of staff in charge.
- Storage temperatures of medication within the clinic room and the medication refrigerator were recorded daily on the EMAR system.
- The medication 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 and checked daily. A random stock check showed correct levels.
- Medication audits were conducted regularly and action plans were produced where necessary.
- PRN protocols were in place and were informative enough to enable consistent administration.

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 eight were correct and two were incorrect. The two specific inaccuracies were:

1) Resident 1 – Laxido – 60 recorded on the system, 62 in stock.
2) Resident 2 – Bisoprolol – 21 recorded on the system, 22 in stock.

See Recommended Action 2.

Open Safeguarding Cases
The manager advised there were no currently open safeguarding cases that related to the home. The manager described issues that had been appropriately referred over the past few weeks.

Premises Safety & Management
The home was warm, clean and well-presented throughout. No unpleasant odours were noted. Domestic staff were working effectively throughout the home. Sluice rooms were locked when not in use. COSHH products were kept safely locked away in all areas of the home, which was an improvement from 2024. Call bell ropes reached all the way to the floor.

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 a score of 5 – ‘Very Good’ at its last environmental health inspection, which is the highest score available.

Kitchen practices were not assessed further at this inspection.

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
Supervision and appraisals were not assessed at this inspection.

All staff spoken with indicated they were well supported by the management team and they spoke positively about their jobs, comparing their experiences positively to working at other care homes. Several staff commented that there had been a problem the previous year retaining care staff and some speculated this may have been due to changes in management. All staff said there was now a good team in place and they hoped the retention problems would settle down.

One staff member said, *"This home is better since the new manager took over. She's out on the floor, interested in what we are doing and her door is always open."* Another staff member commented that the home had great potential with the current staff team. A newly appointed staff member said they had been made to feel most welcome and their first impressions of the home were good.

Training
Training figures provided indicated that compliance with mandatory training was at **81%.** The manager said this was better than when she arrived, when it had been 72%, but the aim was to get the compliance over 95% in time.

Staff who were overdue to complete e-learning were being reminded to complete their outstanding courses, face-to-face fire marshal training had been booked for the following week and new starters were working through their training.

See Recommended Action 3.

Mental Capacity - DoLS

DoLS applications are required for people who fall into each of the following 3 categories:

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

8 DoLS applications had been submitted for people who lacked capacity to consent to their care in the home, although none of them had yet been determined by the local supervisory body. The manager said all of the other residents had capacity to consent to their care.

The team were aware of the need to submit CQC notifications when DoLS applications were determined (either approved or rejected).

Eating and Drinking

I witnessed the lunchtime experience across the first floor, which was a positive and well-managed experience. Much good practice was observed, including:

- Pleasant background music was playing.
- Plenty of staff were available to assist and were effective at encouraging the residents to eat.
- Staff were wearing appropriate protective equipment.
- Tables were nicely laid.
- Choices of drinks were offered.
- Choices of meal were given by using two different plated-up alternatives (show plates), which is the best way of offering meaningful choice to people living with dementia.
- Refills of drinks were offered.
- Desserts were appetising and proved popular.
- Nobody was rushed.
- Feedback about the quality of the food was positive.

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area, with many places to sit and watch the world go by. There were complimentary teas and coffees on offer. The manager's office was easily accessible off the main reception, as were an activity room, hair salon, medical treatment room, physiotherapy room and a 'health, wellbeing and spa' room. Information such as the home's registration certificate, employers' liability information and the complaints policy were displayed prominently. The home did not 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 bedrooms also had smart televisions, refrigerators and fitted furniture. Ample storage space was available throughout the home, including for hoists and wheelchairs.

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, bar and pool room, games room and a library. Upper floors also had balconies on both sides of the home to catch the sun during warmer weather. 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. There was a clear difference between the vacant rooms, which were 'show rooms' and the rooms that were occupied, which felt homely and specific to each person.

Gardens

Attractive secure gardens surrounded the home. It was good to see people wrapped up warm and outside enjoying the early spring sunshine.

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 of the interactions witnessed between the staff and residents at the home were compassionate and friendly. This included domestic and ancillary staff, not just care staff. The staff exhibited attentiveness and cheerfulness consistently. Residents were also engaged with kindness and patience and there were examples where staff responded well to peoples' emotional distress. Staff members tried to spend meaningful social time with residents.

The feedback received from residents praised and complimented the quality of care, without exception. Quotes included:

"The home is kept very clean. I like that."
"The manager pops in every day to check I'm alright. The staff are carefully selected and they always come into my room with a smile."
"It is absolute perfection here."
"The food is good. There is a variety and a decent selection."
"The staff are all very helpful. They are good at anticipating what I need."
"We have entertainments. I like the quizzes, they get everyone going."
"I have no complaints at all."
"You can have a good laugh and a joke with the staff. They are all lovely."
"The personal care given is always gentle and they tell you what they are going to do before they do it."
"They took us out to the local shops. It was the first time we'd been out for ages. We had a drink out and did a lot of laughing. The staff were brilliant."
"If you press your bell the staff come and help you."

Everyone living at the home had a good sense of wellbeing. The standard of personal care was outwardly high. People were supported to be clean, well-presented and were wearing properly fitting clothing.

Visitors
Visiting was allowed unrestricted. Feedback from visitors was similarly positive. One person said, *"I think the home is amazing. The manager is easy to communicate with and I've never had any concerns."*

The latest Carehome.co.uk rating was 9.8/10 from its first 22 reviews, which demonstrated a very high level of satisfaction about the quality of care from the people who used that website for feedback.

Dignity
I saw that the staff routinely knocked on people's bedroom doors and waited for a response before entering their bedrooms, indicating respect for their personal space.

Call bells were left within reach of people when they were spending time in their bedrooms and were answered quickly. Continence products were stored discreetly. Moving and handling manoeuvres were undertaken with dignity, patience and care. Staff were alive to situations where peoples' dignity may be compromised and they intervened quickly and without fuss.

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, a well-established care planning software package. All people had detailed care plans in standard areas of care written up on the system. All of the care plans I looked at were presented in a user-friendly and readable format. They were well written in narrative style and were person-centred. There was evidence that people had been consulted and involved in the preparation of their care plans.

Key sections were completed properly and there were additional care plans written for specific conditions, such as being prescribed blood-thinning medication and for fibromyalgia. This was the case even for people who had only been admitted over the past couple of days. Summary sections provided a good introduction to people's care on the front page. Life history information was available in the care plans I looked at, which made the care plans come alive in a person-centred way. Care plans had been reviewed regularly.

Risk assessments were completed, with standard scoring systems to ensure that risks to people were identified and managed effectively. This included people's risk of developing pressure ulcers, risk of falling and risk of becoming malnourished. The risk assessments had also been reviewed regularly.

Consent to Care and Treatment

Mental capacity assessments (MCAs) and best interest decision records had been completed where necessary, in cases where people may lack capacity to consent to important areas of their care. Good information was available in the MCAs to indicate why the judgements had been reached. Each MCA in place was decision specific.

In the case of Resident 3 there were MCAs for 'day-to-day decisions,' 'medication management' and 'personal care.' The problem was that the 'day-to-day decisions' MCA included medication management and personal care and indicated that Resident 3 had the capacity to consent to his medication and personal care. However, the individual MCAs for personal care and medication indicated that he did not have the capacity to consent to these decisions, so the assessments were contradictory.

Resident 3's care plan was also contradictory about this. The care plan stated that a DoLS application had been made, but other sections stated that he still had capacity to consent to his care despite a dementia diagnosis. The manager said this issue had been identified, but not yet changed.

See Recommended Action 4.

Daily Care Charts

The PCS system meant that there was no need for daily care charts in paper form, as cream charts, fluid charts and similar were recorded on the computer system. Fluids offered to, and consumed by people had been diligently recorded, as had food eaten. Hygiene charts indicated good attention to personal care. Emollient creams were recorded on the system and clear topical MAR charts (TMARs) could be produced. Repositioning activity was also diligently recorded.

Activities Arrangements

The new lifestyle manager had only been in post for one week so was just getting started. He was able to describe some activities that had taken place during his first week, such as quizzes, arts and crafts and a much-enjoyed trip out to the pub with a few residents. The home had a series of ongoing activities provided by external providers, such as chair-based yoga and a regular church service from a local reverend.

The conversation was about the lifestyle manager's ideas for the future and included planning for an Easter Fayre, 2 birthday parties and attendance at a garage market. The lifestyle lead was intending to try to organise more trips out, such as to local garden centres, markets and resource centres, as well as trying to forge a relationship with a local nursery to get some small children into the home.

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 were made appropriately and kept on file. There were two incidents earlier in the year that needed duty of candour letters to be produced. The manager was awaiting guidance from the provider as to the format these should take.

See Recommended Action 5.

Registered Manager

Michelle King was registered as manager. This had been sorted out quickly upon her starting work at the home.

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

Management Audits & Governance

A robust internal governance system was in place, as designated by the provider. Tanglewood's monthly audits are robust and cover a wide range of key areas. The sheer amount and depth of the auditing gave confidence the home was well run. The manager demonstrated the governance systems enthusiastically, believed in them felt the systems helped keep the home safe.

Governance work for January 2025 had been completed, with February's almost completed. Actions identified through the audits were added to the home improvement plan, which was an ongoing document of actions for management staff to work from. Audits included:

- Night visit (95% score)
- 10 at 10 meetings daily, conducted in a consistent structured way
- Residents meeting
- Nutrition and catering meeting
- Relatives meeting
- Seniors care assistants meeting
- Health and safety meeting
- Care plan audits (10% minimum)
- Health and safety audit
- HR and recruitment audit
- Medication audits
- Finance audit
- Infection control audit
- Daily clinical audit (& resident of the day)
- Pressure ulcer audit
- Wounds review
- Bed rails audit (none)
- Bed log
- Weights and weight loss management audit
- Infections review with trend analysis
- CQC notifications review
- Safeguarding review
- Whistleblowing review (none)
- Complaints (none)
- Accidents and incidents review, with graphical trend analysis
- Dependency monitoring
- Call bell analysis (good response times)

Provider Visits

The manager indicated she had been well supported by the provider organisation since taking up post. The regional manager completed a detailed governance visit report each month, setting action plans where it was deemed necessary.

Management and Leadership Observations.

The new manager commented that she was happy to take on a good home from a regulatory compliance perspective and had made a positive start in tackling staff

morale. Staff and relatives had only complimentary things to say about the recent management changes. The manager understood that one of her main challenges was to manage the growth the occupancy numbers while retaining and building upon the home's good atmosphere and high regulatory standards.

The team engaged well with the inspection process and the home was a pleasant, happy and upbeat place to visit and was in a good position to grow and develop. The home was ready to receive its first CQC inspection.

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 gather documentary evidence of relevant qualifications (such as NVQ 2 and 3) for each new staff member who is recruited. Please gather this information specifically for Staff Member 1 as discussed.
2	Please investigate the circumstances of the two medication stock discrepancies identified.
3	Please keep working towards the mandatory training compliance being in excess of 95%.
4	Please review Resident 3's care plans and MCAs to ensure they do not contradict.
5	Please write the two necessary duty of candour letters following the relevant incidents earlier in 2025.

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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