THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

MEADOWS PARK

CQC RATING GUIDE: **'GOOD'**

Privately Commissioned Inspection for

Meadows Park

Conducted by:

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Date of Inspection:

4th February 2025

Contents

Executive Summary

Tanglewood Care Homes operates 17 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 **Meadows Park,** Louth**.** Meadows Park is a purpose-built residential care home for older people including people living with dementia. This was a privately commissioned inspection and was my first visit to the home for about a year.

The key finding of this inspection was that the home had grown and developed in a safe and consistent way over the past year and was nearly fully occupied. Feedback from residents about their care was complimentary, as was feedback from relatives. Staff members spoke positively about the support they received from the management team. The team presented as kind, caring, cheerful and they interacted well with the residents. There were meaningful activities taking place at different times on both floors. The lunchtime experience was well managed, with some excellent practice noted.

Regulatory compliance was of a good and reassuring standard. Quality auditing systems to monitor and improve the quality of care had been implemented and were wide-ranging. Staff recruitment was conducted in line with regulation and mandatory training and supervision was up to date. Care planning was mostly of a high standard. Medication management had improved, despite ongoing challenges with getting the correct medication delivered on time from the local pharmacy.

There were a few matters identified for improvement and/or correction. These are detailed throughout the report and in the recommended actions. None of these issues were indicative of any serious concern. The manager and the team remained open to constructive criticism and were keen to keep learning and improving.

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 60 people in residence on the day of my visit. Staffing levels across the home were described as follows:

Ground Floor (For older people with residential care needs)
(am) 1 deputy manager, 1 senior care assistant and 3 care assistants
(pm) 1 deputy manager, 1 senior care assistant and 3 care assistants

First Floor – (For people living with dementia & one corridor of active recovery)
(am) 2 senior care assistants and 3 care assistants
(pm) 2 senior care assistants and 3 care assistants

At night the whole home was staffed by a minimum of 2 senior care assistants and 4 care assistants. As the occupancy increased the manager was in the process of working towards a further care assistant to work on the first floor each day.

Nine of the beds on the first floor were contracted with North East Lincolnshire council for 'Active Recovery.' This manager said this had been a successful enterprise, although the contract was up for review in March 2025.

Ancillary Staff

Each day, in addition to the care staff there was a lifestyle manager, several domestic staff (including laundry), a kitchen assistant and a front of house manager. The team were further supported by a maintenance manager, head housekeeper (post vacant) and a gardener (pending recruitment checks).

The manager and the care manager were both supernumerary to the care staffing numbers.

Staff Vacancies
The home was well staffed. There was a vacancy for a head housekeeper and for a care assistant to work nights. There would likely be a couple more care assistant vacancies when staffing levels rose as the last few residents were admitted.

No agency staffing had been used for several months.

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

- Full employment histories
- Medical information to ensure people are fit to work
- Photographs & ID
- Contracts
- DBS information
- Satisfactory references
- Job descriptions
- Interview notes
- Training information

Open Safeguarding Cases
The manager described two open safeguarding cases that would likely be closed soon. In the next section (medication management) there is a section that describes how the management team were struggling, despite their best efforts, to obtain all of the required medication for people. There were some medicines that were not supplied on time, which meant people were put at risk. The manager was in the process of raising a safeguarding situation about this, putting some scrutiny on local GP surgeries and pharmacies with a view to getting a good future outcome.

Medication Management
The medication trolleys were kept in secure medical rooms on each floor. One of the home's deputy managers capably demonstrated the systems on the ground floor. Good practice included:

- Keys were kept by the senior member of staff in charge.
- 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 safely and a stock check matched.
- Medication was appropriately received into the home.
- Medication audits were conducted regularly and action plans were produced where necessary.
- Fridge and room temperatures were taken each day and recorded on the system.
- Plastic pots and spoons were sterilised after each use.

The home used an electronic medication system. This involved scanning the medication boxes prior to administration and the system generated a MAR chart. The system prompted all prescribed medication administration and so it was not possible to 'forget' any medication or not sign for it. The key to demonstrating the system is being used correctly is to ensure the stock present in the boxes and packets matches exactly the amounts on the system. I undertook ten separate random stock checks and the amounts were correct all cases, which represented a significant improvement from the previous year.

PRN protocols
PRN protocols were in place on the computer system for 'as required' medicines, but they did not contain sufficient instructions to ensure consistent administration. There was some good information in people's care plans, but this information was not available to staff on the electronic medication system in the PRN protocols.

One issue was that there was insufficient space on the PRN protocol template on the electronic medication system to write a detailed PRN protocol. The management team were liaising with the medication system provider to request the appropriate design changes.

See Recommended Action 1.

Stock Issues
The management team updated me in some detail about problems they were experiencing in obtaining all required medication on time. The issues were complex and involved the liaison with and the liaison between the GP surgeries and the pharmacy. I was presented with a list of several medications that had not been provided at the beginning of the medication cycle that some residents would have do without until the medicines could be obtained. These medicines included amitriptyline, metformin, colecalciferol, loperamide, mirtazapine and macrogol. The manager was in the process of raising a safeguarding enquiry with the local authority, having tried everything else in an attempt to resolve the matter.

Premises Safety & Management
The home was clean throughout and well presented. No unpleasant odours were detected. Sluice rooms and COSHH cupboards were kept locked when not in use. Domestic staff worked safely with their cleaning materials.

On the first floor the staff had opened some windows. The day was a cold one and there were two residents sat underneath open windows in one of the lounges. I asked them if they were warm enough and both replied, *"Well we would be warmer if it wasn't for the cold draught coming down through our necks."* One added, *"I don't mind for a bit, but not all morning."*

The staff needed to be careful about this. Care and domestic staff work physically hard and are often too warm and so they open windows, forgetting that older people are sedentary and require a much warmer ambient temperature.

See Recommended Action 2.

Laundry Room
This room was spacious with both an 'In' and an 'Out' door. It was clear that soiled laundry was stored correctly and washed separately on a sluice wash. Dissolvable red bags were used for safe storage and laundering.

Kitchen

At the home's recent environmental inspection the kitchen had received a score of 5 – 'Very Good,' which was 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 60+ staff and used a system called Coolcare to monitor compliance with formal supervision. Each member of staff would have a formal meeting quarterly as a minimum. All supervision and appraisals were shown as up to date, apart from two. One person was due to have their meeting today and another person would be spoken with the day after when they returned from annual leave. This meant supervision and appraisal was up to date. Minutes of meetings were signed by both parties and scanned onto the personnel files.

Staff spoke positively about working at the home and were complimentary about the management team. One person described the managers as, *"helpful and lovely."* Another person described having worked for the manager at another home and commented, *"Managers in care can vary – when you find one you like it makes sense to follow them."*

Training

Compliance with mandatory training across the staff team was presented on the computer system as being at **88%**. This was a significant improvement from the previous year. The manager advised that the actual compliance figure was a little higher, as there were some recent courses still to be put on the system and there was a face-to-face first aid training course taking place on the day of inspection.

Mental Capacity - DoLS

DoLS applications had been made for 18 people living at the home. 12 of them had been determined by the local authority and the results of the other applications were awaited. The manager was clear on her understanding of 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).

A DoLS matrix was in place containing relevant information the applications. CQC notifications had been made when DoLS applications had been determined.

Eating and Drinking

I witnessed a very positive lunchtime experience in the upstairs dining rooms. Good practice included:

- Old-style background music was playing.
- Plenty of staff were available and they were helpful and attentive to peoples' needs.
- Staff were wearing appropriate protective equipment.
- People were offered napkins and aprons to protect their clothing.
- Tables were nicely laid and correct menus were on display.
- Show plates were used to give people living with dementia a meaningful choice 'in the moment.' This is the best way of offering meaningful choice to people living with dementia and it worked well in several cases. This was for both main course and dessert.
- Choices of drinks were given effectively.
- 1:1 assistance was given appropriately and from a seated position. There were some particularly good interactions from staff assisting people. In one case the person was served soft, liquidised food that was well presented. The person was non-verbal, but the staff member was highly attentive to the different facial expressions the person was displaying to interpret which different foods they were enjoying most.
- The chef was involved with plating up the meals and interacting with residents.

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area, staffed by friendly and helpful front of house staff, with many places to sit and watch the world go by. The manager's office was easily accessible off the main reception.

Information such as the home's registration certificate and the complaints policy were displayed prominently. The home's 'Good' CQC rating had been 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 the facility for a telephone line. 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, garden rooms and hair salon. One of the garden rooms was known as the 'potting shed' and contained a pool table.

The home had been open for a few years and there were just beginning to be signs of wear and tear on some of the communal carpets. The manager was considering requesting a professional clean and was aware that in the medium or longer term they would need replacing.

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.

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

The staff were attentive to residents' needs and there were many genuinely warm relationships in evidence. The team were unfailingly cheerful and friendly. Residents were engaged with kindness and patience. There was plenty of laughter at appropriate points. Staff members allocated time beyond personal care duties to spend meaningful social time with the residents and there were plenty of activities taking place.

Everyone living at the home had a good sense of wellbeing and staff were responsive to moments of distress. The standard of personal care was high. People were supported to be clean, well-presented and were wearing properly fitting clothing. The feedback received from residents praised and complimented the quality of care without exception.

Quotes included:

"We're all happy. You can know that by the fact we are all here."
"This place is beautiful and has increased my confidence. I'm here temporarily but I'd like to stay to be honest, because it's a lovely place."
"It's very, very nice here. I can hardly fault them. They've thought of everything."
"The home is always clean and the food is good."
"There's always a nice atmosphere – friendly people – always smiling – they help you if they can."
"I've been in different places all over the world. This is one of the nicest."
"It's a nice place here and I'm happy."
"I have had my makeup done this morning and I'm pleased about that."

Visitors
Visiting was allowed unrestricted.

One person's relative said to me, *"This place is amazing. They look after [my relative] so well. Everyone's so friendly. The communication with staff at all levels is natural. I trust them, which is obviously good news for everyone."*

The latest Carehome.co.uk rating was 9.8/10 from 43 reviews, which demonstrated a high level of satisfaction about the quality of care.

Dignity & Respect
I saw that the staff routinely knocked on people's bedroom doors before entering their bedrooms, indicating respect for their personal space. General assistance was undertaken in an attentive and dignified way. Staff were alert to situations where peoples' dignity could be compromised and intervened appropriately. Moving and handling manoeuvres were undertaken with dignity, with staff talking people through what was going to happen next in a confident manner. Continence products were stored discreetly.

One person was receiving care in bed. Their catheter bag had been sited prominently in full view by the bedroom doorway. This unnecessarily advertised the person's continence issues. It would be preferable for the bag to be sited on the other side of the bed and covered by a pillowcase or similar.

In one of the communal bathrooms were there were toiletries stored that had not been returned to peoples' bedrooms. It is important to do this to reduce any temptation of them becoming communal toiletries, which would not be dignified.

See Recommended Actions 3 & 4.

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 that presents care plans in a user-friendly and readable format. All people had care plans written up on the system for the standard areas of care. Risk assessments were completed for each person, with scoring systems to ensure that risks to people were identified and managed effectively. This included people's risk of developing pressure ulcers and of becoming malnourished (MUST & Waterlow). Care plans and risk assessments were regularly reviewed. The care plans I read were detailed and of a high standard.

Consent to Care and Treatment

Mental capacity assessments (MCAs) and best interest decisions were completed well in the cases I looked at. The areas considered were decision specific, appropriately assessed and when it was decided a person lacked capacity then a best interest process was completed. For example, in one case MCAs were in place for place of residence, personal care and medication administration.

In Resident 1's care plan summary there was the statement, *"Can become aggressive when being made to shower in best interests."* Then, in the daily life care plan it stated, "*Staff to act in best interests with regard to personal care."* The manager agreed that the wording of this was problematic and there was no additional information in the personal care plan about exactly how staff should act in the person's best interests or when.

This was likely a training need for the staff member who wrote the care plan. If it is necessary to provide personal care in someone's best interests against their

momentary will (for example, if they are soiled and distressed, but refusing care due to dementia) then a very clear best interest process must be described in the care plan, having been agreed in a formal best interest meeting. Sometimes staff misunderstand the concept of 'acting in someone's best interests' to mean just doing what the staff member thinks is in the person's best interests in that moment, rather than specific planned actions following a formal best interest process.

See Recommended Action 5.

Daily Care Charts

Fluids taken by people on fluid watch were well recorded. Records of food eaten were clear. Hygiene charts were kept up to date diligently and indicated good levels of personal care. Repositioning charts were also kept up to date, notwithstanding the issue described below:

In Resident 2's care plan summary it stated she required repositioning every 2 hours. In the skin integrity and death and dying care plans the instructions were for repositioning every 2-4 hours. This was inconsistent. The person's repositioning charts showed repositioning activity roughly every 4 hours, but not every 2 hours. The manager clarified that the summary statement needed correcting.

See Recommended Action 6.

The team had implemented a new electronic medication system and there was some uncertainty about where application of emollient creams were recorded. Following some discussion the management team settled on PCS. There were some good TMAR charts on PCS, but other situations that needed reviewing and tightening. For example, Resident 3 was written up for Aveeno cream – "*apply to dry areas twice daily*." There were only 3 signatures in the past 28 days. For Resident 4 the instructions stated, *"Cream applied to undressed leg."* These instructions did not say what particular cream and how often it needed to be applied. All of the emollient cream records should be reviewed to ensure that there are accurate TMAR charts that can be relied on.

See Recommended Action 7.

Activities Arrangements

A member of staff from the lifestyle team was on duty each day. Activities were seen to take place at various times during the day, including nail pampering in the morning and games of dominoes in the afternoon.

The lifestyle manager described people having a go on pottery wheels, woodwork events, learning to crochet and making various other crafts, such as ‘crystal dream catchers.’ There were trips out to local garden centres and churches. The team were looking forward to getting out in the garden for some gardening activities with residents when the weather got a bit warmer.

Activities advertised for the week included:

- Candle making
- Various games
- Choir practice in the cinema
- Hymn singing
- Film afternoons
- A Valentine’s quiz
- Arts and crafts

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 made appropriately and were kept on file.

Registered Manager

The manager, Kelly Coulthard, was registered as manager although this was displayed on the CQC website as Kelly Davies, which is her maiden name. The process for requesting a name change is usually relatively straightforward and does not require a full re-application.

CQC Rating

The home received its first inspection in January 2023 and was rated ‘Good’ for all key questions and ‘Good’ overall.

Management Governance

The provider’s management and governance systems were historically strong. Auditing was wide-ranging, regularly repeating and robust. When auditing and governance work identified necessary action points they were added to the home’s central improvement plan and implemented. I looked in detail at the auditing system for January 2025, which had been completed properly.

Auditing and governance work completed included:

- ARB (active response beds) reporting
- Pressure ulcer tracker

- Wounds review
- Bed rails audit
- Bed log
- Weights and weight management information (most residents weights stable)
- MUST scores
- Medication audits
- Medication reviews list, with further list of antipsychotics, covert regimes and benzodiazepines
- Infections review with trend analysis
- CQC notifications review
- Safeguarding review
- Whistleblowing cases (none)
- Complaints review (none)
- Accidents and incidents log with graphical and trend analysis
- Dependency tracker
- Care plan audits (minimum of 10%)
- Health and safety audits
- Staff file audits
- Various meeting minutes, such as health and safety, lifestyle team, nutrition meetings and residents' meetings

There were also call bell response times audits. These had been completed diligently, although the results indicated some room for improvement in the call bell response times recorded. Around 17% of call bells were taking longer than 5 minutes to answer and there was an opportunity to drive that number down.

See Recommended Action 8.

Provider Visits

The regional manager conducted an in-depth written governance report each month from a visit (or visits) to the home. All of this information was read, reviewed and monitored by senior Tanglewood staff.

The home's allocated regional manager was about to change.

Management and Leadership Observations.
The home was being well managed. The key finding of this inspection was that the home had grown and developed in a safe and consistent way over the past year and was nearly fully occupied. It can be a tough period of growth from around 40-60 residents, but the manager and her team had achieved good outcomes through that journey.

The home presented well in all aspects. Feedback from residents about their care was complimentary, as was feedback from relatives. Staff members spoke positively about the support they received from the management team. The team presented as kind, caring, cheerful and they interacted well with the residents. There were meaningful activities taking place at different times on both floors. The lunchtime experience was well managed, with some excellent practice observed.

Regulatory compliance was of a good and reassuring standard. Quality auditing systems to monitor and improve the quality of care had been implemented and were wide-ranging. Staff recruitment was conducted in line with regulation and mandatory training and supervision was up to date. Care planning was mostly of a high standard. Medication management had improved, despite ongoing challenges with getting the correct medication delivered on time from the local pharmacy.

There were a few matters identified for improvement and/or correction. These are detailed throughout the report and in the recommended actions. None of these issues were indicative of any serious concern. The manager and the team remained open to constructive criticism and were keen to keep learning and improving.

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 improve the PRN protocols so they are less generic and contain person-centred information to enable consistent administration from all senior staff.
2	Please remind staff not to open windows in communal lounges on cold days where residents are sitting.
3	Please ensure catheter bags are sited discreetly in peoples' bedrooms when they are being cared for in bed.
4	Please remind staff to return toiletries to peoples' bedrooms after use in communal bathrooms, so there is no temptation for the toiletries to become for communal use.
5	Please update Resident 1's care plan summary and daily life care plans in relation to the comments about providing personal care in the person's best interests.
6	Please update Resident 2's summary relating to her required frequency of repositioning.
7	Please review all of the Topical MAR charts (TMAR) on the PCS system for accuracy.

8	Please ensure there is a renewed focus on improving the current call bell response times.

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

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