THE WOODBERRY PARTNERSHIP

INSPECTION REPORT

OADBY MANOR

CQC RATING GUIDE: **'GOOD'**

Privately Commissioned Inspection for

Oadby Manor

Conducted by:

Simon Cavadino

Date of Inspection:

24th June 2026

Contents

Executive Summary	4
CQC Rating Guide	6
CQC Key Question – Safe	7
CQC Key Question – Effective	12
CQC Key Question – Caring	15
CQC Key Question – Responsive	17
CQC Key Question – Well Led	20
Required and Recommended Actions	23
Inspection Methodology	25
Introduction to Author	26

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 **Oadby Manor**. Oadby Manor is a new purpose-built residential care home for older people including people living with dementia, located in Leicester. The home's facilities are excellent and the environment is amongst the most impressive in the residential care market. The home opened in April 2026 and already had 16 people in residence. This was a full inspection and was my first visit to the home.

It was very early in the home's life-cycle and the findings of this visit were mostly positive, encouraging and reassuring. The atmosphere of care and support was happy, relaxed and cheerful at all times. Staff described working at Oadby Manor in an upbeat way and spoke highly of the support they had received from the manager. They were all still getting to know each other and getting used to the necessary systems and processes. All of the care interactions witnessed between staff and residents were caring, compassionate and friendly. Residents were complimentary about the care delivered by the team.

There was evidence of meaningful activity taking place and the lunchtime experience was well managed. The environment was clean and well presented. Personal care was of a good standard, backed up by good daily care records. There were plenty of staff on duty who had been recruited in line with regulation. The home had grown well so far and was in an excellent position for continued growth.

Regulatory compliance and governance systems were strong and quickly becoming embedded. There was a clear focus on attention to detail throughout the necessary recording systems. Medication was safely managed and care planning was of a good

standard, although a couple of observations were made for further improvement. PRN protocols required more information and there was some evidence of copying and pasting in the care plans, which let down the overall presentation.

The team responded well to the inspection process and were keen to learn and to continuously improve. If the team can sustain this level of performance and take on board the areas of constructive criticism then a bright and successful future awaits for Oadby Manor.

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. The home is in a good position for continued growth and development.

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 to provide residential care for a maximum of 60 older people, including some people living with dementia. There were 16 people in residence on the day of my visit. The home was laid out over three floors. Only the ground floor was open at the time of the inspection apart from one person living on the first floor. The home's occupancy had grown well in the short time since opening and was already proving popular in the local area.

The current minimum staffing levels were as follows:

(am) 1 team leader, 1 senior care assistant and 2 care assistants
(pm) 1 team leader, 1 senior care assistant and 2 care assistants
(nights) 1 night team leader, 1 senior care assistant and 1 care assistant

The manager said that as the team was being built for further growth there were often more staff than the minimum on duty. On the day of inspection there was a new staff member shadowing a more experienced staff member and an additional late shift.

Ancillary Staff

In addition to the care staff there was a lifestyle assistant, front of house manager, maintenance manager, head housekeeper and domestic team (including dedicated laundry staff). There was a chef or sous chef on duty each day, with kitchen assistants being recruited. Hairdressing and chiropody services were contracted externally. The registered manager was supernumerary to the care staff as would be the forthcoming care manager once recruited.

From my observations during the day there were more than enough staff to care for the current resident group. There were many examples of staff having the time to speak with people, listen to them and engage with them in addition to completing personal care tasks. Both the manager and the care staff were of the view there were comfortably enough staff to provide a quality service.

Staff Vacancies

Phase one of the recruitment was complete and recruitment was underway for phase two. Eight staff had been appointed pending start dates and these were five full time care assistants (two to work nights), one part time care assistant, a kitchen assistant and a housekeeper. Further vacancies were for a care manager (interviews underway), a kitchen assistant, a housekeeper and a further lifestyle assistant.

No agency staff had ever been used.

Staff Recruitment Information

I looked at the recruitment information held on file for 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. Information seen included:

- Recent photographs
- Application forms and full employment histories
- Medical information to ensure people are fit to work
- Contracts & terms and conditions
- Suitable ID
- Suitable references
- Job descriptions
- Interview notes
- DBS information

Open Safeguarding Cases

The manager advised that there were two open safeguarding cases relating to the home, both of which had been reported appropriately. Feedback was awaited.

Medication Management

The medication trolley was kept in a secure medical room on the ground floor. There were other medical rooms on the upper floors for when they opened. I found the systems to be well-managed with the only recommendation relating to PRN protocols. 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.
- Bottles of liquid medication were dated upon opening.
- Medication was delivered regularly in original packaging – a non MDS approach.
- Controlled drugs were stored correctly, counted regularly and a spot check showed correct stocks.
- Do not disturb tabards were worn when administering medicines.

The home used an electronic medication system (EMAR). The system prompted all prescribed medication administration and so it was not possible to 'forget' any medication or not sign for it. The key to demonstrating the system is being used correctly is to ensure the stock present in the boxes and packets matches exactly the amounts recorded on the computer system. I undertook ten random stock audits and all were correct.

PRN Protocols

PRN protocols were in place for 'as required' medicines. However, some of them were generic, meaning they did not contain sufficient information to enable consistent administration. For example, Resident 1 was prescribed Lorazepam on a PRN basis. The PRN protocol stated, *"To manage distressed reactions."* Resident 2 had the same prescription and the PRN protocol stated, *"To manage unsettled behaviours."* These are vague terms and the protocols needed to be much more specific and describe the actual behaviours and reactions. The protocols should also describe what interventions should be tried first before the PRN medicines are used. The care plans also needed updating with this information.

The following is added for additional guidance:

When medicine is prescribed a definite number of times per day, the staff member administering merely has to follow the instructions. When medicine is prescribed on a PRN or 'as required' basis, the staff member administering has to make a decision as to whether to administer or not. The factors to consider in making that decision will be different for every individual case. To ensure safety and consistency staff need clear PRN protocols to assist them in that decision-making.

The PRN protocols must refer to individual circumstances in every case:

- Does the person have capacity to consent to their medication? If not, how would staff know when to administer? How would this be established?
- If it is pain medication, where do they normally have pain, it is localised, is it general, can they tell you etc?
- If medicine is to regulate bowel functioning, details of what is normal or abnormal for the person are required.
- Where dosage directions were variable (e.g. take 1 or 2 tablets up to 4 times per day), information needs to be clear as to when the different amounts should be administered.
- Where medication is prescribed for 'agitation' there needs to be a clear protocol as to how the agitation manifests itself and in what circumstances different amounts of medicine are to be given.

A good rule of thumb is that a competent agency staff member should be able to give all PRN medicines safely and correctly to people without having to ask anyone for clarification or refer to any other documentation. This would be the case because of the clarity of the PRN protocol in place.

See Recommended Action 1.

Premises Safety & Management

The home was spotlessly clean and well presented. No unpleasant odours were noted anywhere. Domestic staff worked safely with their cleaning materials. There were dishwasher tablets stored in the cupboard underneath the sink in the downstairs kitchenette area. These items can be harmful to people living with dementia and must be kept locked away at all times when not in use. The sluice room was unlocked and the staff could not locate the key. It might be preferable for a keypad lock to be fitted to the sluice room.

See Recommended Actions 2 & 3.

The day of inspection was an exceptionally hot summer's day. Staff used fans to try to cool the environment, but it was somewhat of a struggle and it was unfortunate in such a newly constructed building that there were no inbuilt cooling facilities in the communal areas.

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

Kitchen
Kitchen practices were not assessed 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

The home employed around 30 staff. The home used a system called Coolcare to monitor compliance with supervision. The manager commented about being surprised that supervisions for new staff were not coming up on the system as due until the six-month period. She said she had implemented induction checklists and additional supervision to ensure that new staff received the necessary support in their early stages of employment.

The home had not been open long enough for appraisals or probationary period meetings to be due.

Staff Feedback & Morale

The home was very early in its life-cycle, having only been open a few weeks. However, all staff spoke positively about their experiences so far. Comments included:

"The management are approachable. We have good facilities and I have no concerns so far."
"The residents are lovely, so it's a nice to work here."
"It's starting to feel like a home. We're all still getting to know each other. My colleagues appear nice and seem to be competent. It's good that we've all started together from day one."
"The new lifestyle person has made a good impact and there are plenty of activities now."
"It's only my fourth shift, but everyone has been friendly and helpful so far."
"It's a good opportunity to be here, but it's so new at the moment."

Mandatory Training
Not assessed at this inspection.

Mental Capacity - DoLS
*(On 2nd June it was announced that the Cheshire West ruling made in 2014 had been overturned by the supreme court. This will probably mean, in time, that far fewer DoLS applications will be required as the criteria for submitting them will be very different. Further guidance and clarification is awaited.)

During conversations the manager evidenced a good understanding of both the old DoLS systems and the probable new situation. Two DoLS applications had been submitted prior to the change the in legal position. It looked unlikely that there was anyone of the current resident group who would require a DoLS application under the new rules.

Eating and Drinking
I witnessed the lunchtime experience on the ground floor. There was plenty of good practice seen, including:

- People were given choices of where to sit.
- Tables were nicely laid.
- Staff were wearing appropriate protective equipment in the form of washable aprons.
- Napkins and clothing protectors were available.
- Choices of different drinks were given to people, including wine.
- Choices of main courses were given to people
- Plenty of staff were around to assist.
- One-to-one support was given as necessary and from a seated position.
- The chef assisted with the serving out process.

Given the excessive heat the menus had been changed to a lighter lunch. The published menus on the tables had not been updated and still showed the previous two options that were no longer available.

See Recommended Action 4.

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area. The manager's office was easily accessible at the side of the main reception. Information such as the home's registration certificate and the complaints policy were displayed prominently. The home did not as yet have a CQC rating, but this would be displayed after the first inspection.

Design and Adaptation

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

Communal Rooms

The lounges and dining rooms were welcoming, clean and very nicely furnished. There were a variety of different lounges and dining rooms in the home, including a multi-faith room and a cinema. There was also a fully kitted out hairdressing salon. Snack and hydration stations were available on the open floor.

Bedrooms

The occupied bedrooms were nicely personalised with people's own belongings and photographs of their families. This enabled them to feel settled at the home. The bedrooms were fitted with smart televisions.

Gardens

There were attractive secure garden areas around the home, with some people outside enjoying the hot weather.

CQC Key Question - Caring

The following CQC quality statements apply to this key question:

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

Residents

An attentive and caring relationship between the staff and the residents was apparent everywhere. Staff remained patient and positive despite the intense heat. Staff gave focused attention to people who were experiencing distress due to their needs. Feedback from residents was warm, complimentary and grateful about their experiences of living at the home. This was encouraging given how new the home was. Quotes from residents included:

"This is a beautiful home. Everyone's happy and there are lots of people to talk to and always someone to help."
"Absolutely lovely here. Can't fault it at all."
"Everybody is lovely. The food is lovely and I have no concerns."
"You've just got to press your button and they come straight away. They sometimes say they will be back in five minutes, but they do come back."
"We have a choice every day from two different dinners. The quality is good."
"The staff are very kind. Sometimes we can go outside, which I enjoy."
"Things are lovely and I've nothing to complain about. My bedroom is lovely and I enjoy playing the skittles."
"We are going for a picnic at the weekend to a garden centre."
"I have no worries about the home, but if I did I know I could talk to someone."

One person said there wasn't enough staff, especially in the morning. This was objectively not the case, so the manager undertook to speak with the resident after the inspection to try to ascertain what was concerning her.

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

Visitors
Visiting was able to take place unrestricted. Visiting relatives were similarly complimentary about the staff and the service.

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 peoples' needs and intervened without fuss when there was a risk of dignity being compromised. Call bells were left within peoples' reach when they were spending time alone in their bedrooms.

Moving and handling manoeuvres were undertaken carefully and with a focus on the person's dignity and understanding of the process.

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 is a well-respected computerised care planning package. Care plans were written following detailed assessments of people and covered the usual aspects of daily living. The care plans I read were mostly well written. There were additional care plans in place for specific health conditions, such the management of a moisture lesion. There were informative summaries written on the first page.

Standard 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. Care plans and risk assessment were regularly reviewed, including as part of the home's 'resident of the day' process.

In Resident 1's care plan there was some evidence of copying and pasting, leading to some inaccurate information. In the 'antipsychotic medication' care plan were the following statements:

*"Staff to accommodate [Resident 1] with **her** taking **her** tablets one at a time at his own pace."*
*"Staff are to report to seniors or management team any concerns in regard to **her** medication."*

Resident 1 was a male resident. In Resident 1's medication care plan there was a sentence where Resident 1 was referred to by a female name, which was the name of another resident in the home. This apparent evidence of copying from other care plans somewhat undermined the confidence in the quality of the care plans.

See Recommended Action 5.

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. These were well put together. In one case there were MCAs and resultant best interest decision making records for the specific decisions of:

- Management of medication
- Use of sensor monitoring equipment
- Residing in a care setting behind a locked door

Daily Care Records
Staff had taken well to the PCS system. Daily care records were completed diligently. Hygiene charts were well completed, with records indicating plenty of support with personal care and baths and showers. Fluid records indicated that people received sufficient hydration. Food records were mostly well completed, although there were a few gaps for main meals, for example:

Resident 3 – 19th June – Supper
21st June – Breakfast and Supper
23rd June - Supper
Resident 2 - 19th June – Lunch
Resident 4 - 21st June - Lunch

The application of emollient creams was recorded by care staff on the PCS system, although it was not always clear which cream was being referred to.

Repositioning charts were in place and were completed properly. Resident 4's 'sleeping' care plan stated, *"[Resident 4] will be on a repositioning chart night and day to help with her pressure areas."* The care plan was not specific about how often Resident 4 needed to be helped to reposition.

See Recommended Actions 6-8.

Access to PCS
I was given login access to the PCS system through the account of a member of staff. A preferable way to give access to external inspectors or local authority representatives would be to set up a 'Guest Professional' login (or similar). This would be read-only access and would not attract any criticisms about the data security of individual staff accounts.

See Recommended Action 9.

Activities Arrangements
Activities were taking place at the home during the day, with the new lifestyle assistant interacting well with the residents. There was a yoga session in the lounge during the morning from an external contractor, which was well attended despite the heat.

In the afternoon the team filled some paddling pools with water so that people could cool their feet and have fun. I went out to see what was going on at one point to be promptly sprayed with water pistols by three of the residents. This indicated they were having a lot of fun.

CQC Key Question – Well Led

The following CQC quality statements apply to this key question:

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

Registered Manager

Tamara Crosswell had submitted her application for registration as manager with CQC and was awaiting interview. Tamara was an experienced registered manager and had commissioned a similar care service before.

CQC Rating

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

Management Governance

A robust internal auditing system was in place, as designated by the provider. The auditing system was robust and covered a wide range of key areas. The sheer amount and depth of the auditing gave confidence the home was well run. Actions identified through the audits were placed on a home action plan. The manager demonstrated the auditing system effectively on the newly updated and bespoke Guardian system.

Information seen included:

- Daily clinical oversight
- Care plan audits by management (10%)
- Catering audit
- Dining experience audit
- Fire drill
- First impressions audit
- HR audit

- Infection control audit
- Lifestyle audit
- Finance audit
- Dependency monitoring audit
- First aid box audit
- Call bell audit (good response times)
- Medication audits
- Complaints audit (none)
- Mattress audits
- Various meetings
- Wounds review
- Infections review
- Weights and weight loss management
- Pressure ulcer audit
- Moisture lesions audit
- CQC notifications review
- Dietary and nutrition review
- Resident of the day process
- DoLS review
- Slings and hoists audit
- Accidents, incidents and near miss audit
- Bed rails audit
- Distressed behaviour tracker
- Root cause analysis documentation

Provider Oversight

The manager said she was being supported on a day-to-day basis by the chief operating officer. There had been some significant senior management changes within Tanglewood and the new senior management structure was being worked on.

Previously each home had received a monthly governance visit (MGV), which was a quality monitoring document designed to look in detail at the home's workings. There was no MGV (or similar) on file for Oadby Manor since it had opened. The manager said she thought someone had completed one a while back, but the report had not been received.

See Recommended Action 10.

Management and Leadership Observations.
It was very early in the home's life-cycle but a solid and promising start had been made. The home had proved popular and there had been a brisk beginning with the occupancy levels.

The manager was experienced with commissioning new homes, having recently commissioned a similar-sized home in Norwich right from the start to when it was full and settled. The manager had a clear sense of what was required and was getting to grips with the need to go right back to the beginning and assume nothing.

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 increase the amount of information in the PRN protocols for Lorazepam for Residents 1 and 2.
2	Please ensure the sluice room is kept locked at all times when not in use, perhaps considering a keypad lock.
3	Please ensure that dishwasher tablets are kept locked away.
4	If the menus are changing, please ensure that new and up to date menus are published and placed on the dining tables.
5	Please correct Resident 1's care plans about medication and speak to staff about copying and pasting text from other care plans.
6	Please remind staff to record food intake (or refusals) for all three main meals each day.
7	Please ensure application directions are transcribed clearly to the PCS system for all emollient creams.
8	Please ensure Resident 4's care plan is specific about how often she requires repositioning.

9	Please consider setting up a ‘Guest Professional’ (or similar) login to the PCS system for use by professional visitors.
10	Please ensure that an MGV (or similar) is completed for the home and the report placed on file.

Inspection Methodology

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

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

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

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

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

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

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

Introduction to Author

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

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

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

www.woodberrypartnership.co.uk

[End]