



THE WOODBERRY
PARTNERSHIP



INSPECTION REPORT

SLEAFORD HALL

CQC RATING GUIDE: 'GOOD'



Privately Commissioned Inspection for

Sleaford Hall

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Date of Inspection:
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Executive Summary

Tanglewood Care Homes operates several 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 **Sleaford Hall**. Sleaford Hall is a new purpose built residential care home for older people including people living with dementia, located in the town of Sleaford, Lincolnshire. The facilities are 'state of the art' and the environment is amongst the most impressive in the residential care market. The home opened in December 2023 and there were 50 people in residence. This was my second visit to the home following up an initial inspection in September 2024.

The findings of this inspection were positive. The home had continued to grow and develop well over the past year. The atmosphere at the home was calm and cheerful and there was an obviously kind and caring culture amongst the staff group. Residents were complimentary about the care they received, as were visiting relatives. Staff described their working conditions in positive and grateful terms and said they were well supported in their work. Staff were attentive and helpful when interacting with residents. There was a 'residents-come-first' attitude in evidence, which came from the management team and extended through all of the staff.

The environment was clean and well presented. Personal care was of a good standard throughout and was backed up by clear daily care records. The lunchtime experience was well managed. Neither of the lifestyle team were on duty, although there was evidence of plenty of activities having taken place over the year.

Regulatory compliance and governance systems were robust and were now embedded within the home's structure. Care planning was of a high standard. Medication systems were safely managed. Training and supervision were up to date. There were sufficient staff on duty, with staff properly recruited. Further recruitment was due to take place later in the week to try to recruit the final few team members.

A small number of relatively minor points were picked up for consideration and improvement. The team were welcoming of constructive criticism and the home was a pleasant and reassuring place to visit.

CQC Rating Guide

This is a ratings guide for this service on the basis of what was seen, heard, witnessed and experienced on the day of inspection. It is for guide purposes only. The methodology used for conducting the inspection and preparing the rating is discussed in more detail in a separate section at the end of the report:

	Inadequate	Requires Improvement	Good	Outstanding
Safe			X	
Effective			X	
Caring			X	
Responsive			X	
Well-Led			X	

Overall: Good

This was a solid 'Good' rating, with no significant concerns of any note.

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 67 older people, including some people living with dementia. There were 50 people in residence on the day of my visit, with one person admitted that day. The home was laid out over three floors. Staffing levels across the home were as follows:

Ground Floor – (22 people in residence)

(am) 1 senior care assistant and 2 care assistants

(pm) 1 senior care assistant and 2 care assistants

First Floor – (23 people in residence)

(am) 1 senior care assistant and 3 care assistants

(pm) 1 senior care assistant and 3 care assistants

Second Floor – (5 people in residence)

(am) 1 senior care assistant and 2 care assistants

(pm) 1 senior care assistant and 2 care assistants

The night shifts were staffed by 5 staff, typically 1 team leader, 1 senior care assistant and 3 care assistants.

Ancillary Staff

In addition to the care staff there was a lifestyle manager, activity coordinator, kitchen staff (chef and kitchen assistant each day), maintenance manager, gardener (three days per week), front of house manager, head housekeeper and domestic team (including dedicated laundry staff). Hairdressing and chiropody services were

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

The staffing numbers were growing as the occupancy increased and the home was staffed to ensure the occupancy could increase at a sensible rate. From my observations during the day there were enough staff to care for the current resident group. The management team reported that recruitment and retention had been a challenge, but they had not at any point admitted too many residents for the staffing provision that they had available to them. Both the management team and the staff team were of the view there were currently enough staff to care for people and provide them with a quality service.

Staff Vacancies

Given the recruitment challenges the decision had been taken to bring in some overseas staff on sponsorship licences. The manager was full of praise for the seven staff he had who were in these positions, saying they were a key part of the care staffing group. Several were on duty during the inspection. The manager was hoping to recruit more overseas staff later in the week, with interviews planned.

There were enough staff to cover the current occupancy, especially as there were several reliable bank staff who could be called upon. There were further vacancies for three senior care assistants (one for nights) and four care assistants (some of whom were to be part-time roles). Filling these roles would come close to completing the staff team for when the home is fully occupied.

The manager said that no agency staff had ever been used since the home opened.

Staff Recruitment files

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

- Recent photographs

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

Open Safeguarding Cases

The manager advised there were no open safeguarding cases currently.

Medication Management

The medication trolleys were kept in one the secure medical rooms, located on each floor. I audited the medical room on the first floor. I found the systems to be safe and well-managed. Good practice included:

- Keys were kept by the senior member of staff in charge.
- Storage temperatures were monitored daily for both the medication room and the refrigerator. Records indicated that the storage temperatures were within safe ranges.
- Specified room cleaning schedules were completed daily.
- The trolleys were tidy, well organised and attached to the wall when not in use.
- Medication was delivered regularly in original packaging – a non MDS approach.
- Controlled drugs were stored correctly. A random stock audit tallied.
- PRN protocols were in place and well written.
- ‘Do not disturb’ tabards were worn by staff administering medication.
- Plastic pots and spoons were either disposed of after use or sterilised in a machine purchased for that purpose.

The home used an electronic medication system (EMAR). The EMAR system involved scanning the medication boxes prior to administration and the system generated a MAR chart. The system prompted all prescribed medication administration and so it was not possible to ‘forget’ any medication or not sign for it. The key to demonstrating the system is being used correctly is to ensure the stock

present in the boxes and packets matches exactly the amounts recorded on the computer system. I undertook ten random stock audits and all were correct.

Latanoprost eye drops were stored in the refrigerator after opening. These eye drops can be stored at room temperature after opening and then disposed of after 28 days. This means that liquid dropped into peoples' eyes is closer to room temperature.

See Recommended Action 1.

Premises Safety & Management

The home was warm, clean and well presented. No unpleasant odours were noted anywhere. Sluice rooms were locked at all times. COSHH products were stored safely throughout the home for the most part, although there was one occasion when a domestic staff member left a trolley with their potentially hazardous cleaning materials unlocked and unattended in one of the corridors.

There were some examples where call bell ropes in communal toilets and bathrooms had been tied up and so they did not reach the ground. This meant that they would be inaccessible to someone who had fallen.

See Recommended Actions 2 & 3.

Laundry Room

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

Kitchen

The home's last environmental health inspection scored 5 – 'Very Good,' which is the highest score available.

Kitchen practices were not assessed further at this visit.

CQC Key Question - Effective

The following CQC quality statements apply to this key question:

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

Supervision & Appraisals

The provider used a system called Coolcare to monitor the frequency of supervision and appraisal meetings. The system showed that most supervisions were up to date with the few overdue being for people who were either bank staff or people who were on annual leave. These meetings would take place in the next few days. Minutes of supervision meetings were kept on personnel files and were signed by both parties.

Staff spoken with indicated they were happy working at the home and felt confident in the support they received from the management team. One staff member said, *"It's a good team here, all the staff are really good and it's a nice group of residents."* Another staff member said, *"The overseas staff have settled in well. They work hard and have made the team better."*

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

Training

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

Mandatory training compliance figures were very high, at **96%**. Mandatory training subjects included safeguarding (adults and children), Oliver McGowan learning disability and autism course, basic life support, COSHH, fire safety, dementia awareness, GDPR, equality and diversity, dignity and respect, food safety, health and safety, infection control, moving and handling and MCA/DoLS.

Mental Capacity - DoLS

The management team had a good understanding of DoLS processes. A clear matrix was in place and showed that 25 DoLS applications had been correctly made for people who fell into all 3 of the following criteria:

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

12 of the applications been determined (approved) by the local supervisory body and the team had submitted CQC notifications as required. Other cases were chased periodically.

Eating and Drinking

I witnessed the lunchtime experience in the first-floor dining room, which was a positive, sociable experience. Good practice included:

- Staff ensured pleasant background music was playing during lunch. Some residents sang along to some of the old songs.
- Tables were nicely laid.
- Correct menus were on display.
- Staff were wearing appropriate protective equipment.
- Residents were offered napkins and other clothing protectors if they wished to wear them.
- Plenty of staff assisted with the lunchtime experience and they interacted with residents well at all times, leading to a relaxed atmosphere. Where residents made specific requests (such as for an extra cardigan) staff helped them quickly and without fuss.
- Choices of drinks were given to people.
- Choices of main courses were given to people, including by the use of 'show plates' where that was appropriate. There were also choices of desserts and dessert choices were also made through show plates.
- One-to-one support was given to individuals and from a seated position.
- The kitchen staff were closely involved in the serving out process.

Premises Presentation

Entrance and Reception Area

The home had a bright and welcoming entrance and reception area with many places to sit and wait to be seen. There was a sink on the way in for use by anyone who wished to wash their hands. The manager's office was easily accessible at the side of the reception area. Information such as the home's registration certificate, employer's liability information and the complaints policy were displayed prominently. The home did not as yet have a CQC rating, but this would be displayed after the first inspection.

Design and Adaptation

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

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 wellness suite, music café, activity room, sports lounge (including cinema facility) and a family room. There was a balcony on the first floor for people to sit out during warm weather. There was also a fully kitted out hairdressing salon and nail parlour. Snack and hydration stations were available on all 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. The bedrooms were fitted with smart televisions and refrigerators.

Garden

The secure gardens around the home were well kept and presented. Some of the ground floor rooms had areas outside their patio doors for individual people to access the garden areas.

CQC Key Question - Caring

The following CQC quality statements apply to this key question:

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

Residents

There was kind and caring relationship between the staff and the residents. Several of the staff wore big smiles as they worked, which could not fail to create a cheerful atmosphere. Staff were seen to break off conversations in order to attend to residents needs first. This had been the case at my previous visit to the home and was a clear sign of a good culture of care. Feedback from residents was positive and grateful about their experiences of living at the home. Quotes included:

"Yes, the staff are kind. Of course they are kind. They always are."

"All of the carers are lovely. They are so good to me. I've certainly got nothing bad to say about any of them."

"It's a good club to be a part of."

"The staff sometimes do dancing with us and I really like that."

"I've got no fears here. There's no complaints from me."

"The food is really good, and that's me being honest."

"My room is lovely and the cleaners keep it so clean for me."

"They're a good lot here. I wasn't so well when I came in, but they've fed me well and I'm feeling better now."

Other people were not able to converse meaningfully due to their needs, but everyone had a good sense of wellbeing. The standard of personal care was high throughout the home. People were supported to be clean, well-presented and wearing properly fitting clothing.

Visitors

Visiting was able to take place unrestricted. Feedback from visiting relatives was highly complimentary. One person said, *"I work in the care sector actually and I think this home is exceptional – second to none. They been so kind to [my relative] and*

looked after him so well. It's a high-spec home with great facilities. They all care so much and even the manager always comes in and says hello when he's walking around." Another person said, *"The staff are very attentive here. They care and are observant. There seems to be no issues between the staff, no 'us and them' culture or bad attitudes. I have no concerns, in fact quite the opposite."*

The carehome.co.uk website rated the home as 9.8 out of 10 from 25 reviews, which was indicative of very high satisfaction levels from people who used that website for feedback. Reviews were written in the most complimentary terms.

Privacy and Dignity

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

Dignity screens were used when people were receiving care in communal areas. Moving and handling manoeuvres were undertaken with respect. Call bells were left within reach of people spending time alone in their bedrooms.

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, is a well-respected electronic care planning system. Care plans were written following detailed assessments of people and contained plenty of person-centred information, including detailed life histories. All of the care plans I read were well-drafted and informative. Specific care plans were in place for individual health conditions.

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

Consent to Care and Treatment

Mental capacity assessments (MCAs) were in place where there was a doubt about individual people's capacity to consent to various specific aspects of their care. The MCAs were well written and best interest decision making documents had been prepared when people lacked the capacity to consent to a specific decision. For example, in one case (Resident 1) there were separately considered MCAs for:

- Medication
- Fluid and nutrition
- Personal care
- Opening post

It would also be beneficial to undertake an MCA about the person's capacity to consent to living at Sleaford Hall. Sometimes known as the 'acid test,' this is seen as one of the most important issues, since the person would not be free to leave the home unsupervised.

Resident 2's case was discussed with the management team. There were several references to staff and family members acting in his 'best interests.' As the person had capacity to consent to all aspects of his care the term 'best interests' was not correct, as this is only for people who lack capacity to consent to aspects of their care. The person must give his consent to all aspects of his care, with staff and family members assisting him with this as required, but not acting for him.

See Recommended Actions 4 & 5.

Daily Care Records

Daily care records were available for monitoring peoples' fluid intake and food intake when they were on hydration and/or nutrition watch. These were well completed. There were hygiene charts to record personal care given and repositioning charts to record when physical interventions were made to help people move when in bed.

Recording of the application of topical creams was recorded on the PCS system. There was some room for improvement in this area of practice. Resident 3's application instructions were, "*Add a thin layer of cream.*" The instructions did not say what specific cream, where the cream should be applied or how often. There had been some applications recorded between 1st & 4th September, but nothing since. Resident 4's instructions merely stated, "*Cetraban cream,*" with no other instructions. There had only been 4 applications in the last 28 days. Resident 5's application instructions were similar, with only 9 applications.

See Recommended Action 6.

Activities Arrangements

Neither of the lifestyle team were on duty on the inspection day, which was unfortunate. Nevertheless, there was plenty of evidence of meaningful activities having taken place in recent times. There was an evidence folder available that captured the main events and advertisements for activities for the month.

Recent events included:

- A summer fayre where money was raised for the resident fund
- A trip out to Tattersall Farm Park
- A ukulele band playing
- A variety of arts and crafts activities
- Flower arranging
- Games, such as dominoes and puzzles
- Baking activities
- Portrait painting
- Church services
- And much more

CQC Key Question – Well Led

The following CQC quality statements apply to this key question:

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

CQC Notifications & Duty of Candour

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

Registered Manager

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

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

Management Governance

A robust internal auditing system was in place, as was the case in all of the provider's care homes. This was a robust system that covered a wide range of key areas. The sheer amount and depth of the auditing gave confidence the home was well run. The management team believed in the governance system and felt it helped keep them safe.

Daily clinical oversight and resident of the day processes ensured an ongoing eye on important clinical detail. Actions identified through the audits were placed on a home action plan. Governance work for August 2025 included:

- Accident and incident review, with graphical and trend analysis (low falls)
- Dependency tracker
- Call bell analysis (see below)
- Pressure ulcer audit (none)

- Wounds audit
- Bed rail audit
- Bed log
- Weights and weight loss management audit
- Regular medication review information, along with antipsychotics, benzodiazepines and covert medication list
- Medication review monitoring
- Infections review
- CQC notifications (just one for a death)
- Safeguarding cases (none)
- Complaints review (none)
- Infection control audit
- Finance audit
- First impressions audit
- Staff personnel file audit
- Mattress audit
- Medication audits
- Health and safety audit
- Hoist and sling audit
- Team meeting minutes (nutrition and catering, team leaders, whole team meeting and residents' meeting)

One resident said (on the subject of pressing her call bell to ask for help), *"The staff are nice when they come. Sometimes they do, but sometimes it takes ages."* This was the only somewhat negative remark received from any resident. The call bell data for August 2025 showed that approximately 80% of the call bells were answered in less than 5 minutes, around 10% were answered in between 5-10 minutes and up to 10% took over 10 minutes.

On the surface of it this response time could be improved, with about one in five calls missing the required target and one in ten calls taking over ten minutes. The management team said they were having some issues with the electronic system, as several of the long response times related to the front door in the evenings when there were no reception staff. Nevertheless, some of the long response times related to bedroom calls and a piece of work to sort out the accuracy data and also improve response times would be beneficial.

See Recommended Action 7.

Provider Visits

There was an in depth 'MGV' (monthly management visit) report on file for each month. These had taken place each month and were completed by different staff members such as the regional director and regional support staff. Key sections in the report were environmental management, clinical management, people management and quality assurance. Action plans were set where necessary.

Management and Leadership Observations.

The manager had a successful track record of running a high-quality service in another Tanglewood care home prior to joining Sleaford Hall. The manager presented as hardworking and had a consistent and dedicated leadership style.

The home had continued to grow and develop well over the past year. The atmosphere at the home was calm and cheerful and there was an obviously kind and caring culture amongst the staff group. Residents were complimentary about the care they received, as were visiting relatives. Staff described their working conditions in positive and grateful terms and said they were well supported in their work.

The whole team were welcoming of constructive criticism and the home was a pleasant and reassuring place to visit.

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 store Latanoprost eye drops at room temperature after opening and dispose of after 28 days.
2	Please ensure that call bell ropes in communal bathrooms are not tied up and extend all of the way to the floor.
3	Please remind domestic staff to lock their trolleys when leaving them unattended in corridors so that potentially hazardous cleaning materials are not accessible to residents.
4	Please conduct a mental capacity assessment for Resident 1 in relation to whether they have the capacity to consent to Living at Sleaford Hall.
5	Please review Resident 2's care plans and remove all references to staff and family acting in his best interests.
6	Please improve the application directions for emollient creams relating to Residents 3, 4 & 5, setting up daily planned care actions where necessary.
7	Please conduct a review of call bell response times with a view to increasing the percentage of bells answered in less than 5 minutes and decreasing the number answered in over 10 minutes.

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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