CARE QUALITY COMMISSION (CQC) INSPECTION OUTCOMES & STOCKTON-ON-TEES BOROUGH COUNCIL (SBC) PROVIDER ASSESSMENT AND MARKET MANAGEMENT SOLUTIONS (PAMMS) ASSESSMENT REPORTS

QUARTER 2 2025-2026

The CQC is the national inspectorate for registered health and adult care services. Inspection reports are regularly produced, and these are published on a weekly basis.

The CQC assesses and rates services as being 'Outstanding', 'Good', 'Requires Improvement', or 'Inadequate'. Where providers are found to be in need of improvement or inadequate, the CQC make recommendations for improvement and / or enforcement action. Specific actions taken in each case can be found in the relevant inspection report.

Where inspections are relevant to the Borough, a summary of the outcome is circulated to all Members each month. An update from Adult Services is included which summarises the position in relation to service provision and any actions taken at that time.

Quarterly Summary of Published CQC Reports

This update includes inspection reports published between July and September 2025 (inclusive). These are included at **Appendix 1** and contain the results of all inspections of services based in the Borough (irrespective of whether they are commissioned by the Council).

During this quarter, **4** inspection results were published. Please note: there is a time lag between dates of the inspection and the publication of the report. In addition, where concerns are identified by the CQC, re-inspections may take place soon after the initial report is published. When the outcomes are made available within the same quarter, the result of the most recent report is included in this update.

The main outcomes from the reports are as follows:

- 3 Adult Services were reported on (1 rated 'Good'; 2 rated 'Requires Improvement')
- 1 Primary Medical Care Service was reported on (1 not rated)
- 0 Hospital / Other Health Care Services were reported on

A summary of each report and actions taken (correct at the time the CQC inspection report was published) is outlined below. Links to the full version of the reports, and previous ratings where applicable, are also included.

PAMMS Assessment Reports

SBC are utilising the Provider Assessment and Market Management Solutions (PAMMS) in the quality assurance process. PAMMS is an online assessment tool developed in collaboration with Directors of Adult Social Services (ADASS) East and regional Local Authorities. It is designed to assist in assessing the quality of care delivered by providers. The PAMMS assessment consists of a series of questions over a number of domains and quality standards that forms a risk-based scoring system to ensure equality of approach. The PAMMS key areas are:

- Involvement and Information
- Personalised Care and Support
- Safeguarding and Safety
- Suitability of Staffing
- Quality of Management

Following the PAMMS assessment, the key areas are scored either ‘Excellent’, ‘Good’, ‘Requires Improvement’ or ‘Poor’, and an overall rating is assigned to the assessment using these headings. **Appendix 2** shows **9** reports published between July and September 2025 (inclusive), the overall outcomes of which can be summarised as follows:

- 8 rated ‘Good’
- 1 rated ‘Requires Improvement’

APPENDIX 1

ADULT SERVICES

(includes services such as care homes, care homes with nursing, and care in the home)

Provider Name	**T.L. Care Limited**	
Service Name	**Mandale Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	136 Acklam Road, Thornaby, Stockton-on-Tees TS17 7JR	
Ward	**Mandale & Victoria**	
CQC link	https://www.cqc.org.uk/location/1-146749347/reports/AP12578/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Requires Improvement**	**Good**
Safe	**Requires Improvement**	**Good**
Effective	**Not inspected**	**Not inspected**
Caring	**Not inspected**	**Not inspected**
Responsive	**Not inspected**	**Not inspected**
Well-Led	**Requires Improvement**	**Requires Improvement**
Date of Inspection	**1st – 16th May 2025**	
Date Report Published	**31st July 2025**	
Date Previously Rated Report Published	**27th January 2025**	

Breach Number and Title
Regulation 17: Good Governance
Level of Quality Assurance & Contract Compliance
Level 3 – Major Concerns (Enhanced Monitoring) This is due to the home being removed from the Responding to and Addressing Serious Concerns Protocol on 9 July 2025.
Level of Engagement with the Authority
The provider engages well with the Quality Assurance & Compliance (QuAC) Officer, with any requests responded to in a timely manner.
Engagement and Support from Transformation Managers
Mandale House always engage with the Transformation Team, getting involved in activities, workshops and training, and most recently being interested in research in care homes. The Manager attends networking and other meetings with peers across Stockton.

The Manager joined Cohort 6 of the Well Led Programme but was only able to complete 50% of the programme. The Transformation Team will continue to support the care home and identify where further support and training can be provided.

Supporting Evidence and Supplementary Information

The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. At the last inspection in December 2024, the service was rated overall 'Good'.

There was not always robust record-keeping in place to provide assurances that all health and safety checks were being carried out effectively or regularly. Gaps were found in several areas, including environment safety, required maintenance checks, domestic and kitchen cleaning, checks of people's mobility equipment, and care records. Communal areas and bathroom cleaning had improved since the last assessment, however, there were gaps in cleaning records and the cleaning schedules were not sufficiently detailed to maintain standards. Cleaning records for the kitchen had gaps and the fridges were not cleaned to an acceptable standard.

Staff recruitment was carried out safely and robust checks on new staff were in place. During the visit, the inspectors observed adequate numbers of staff available to support people and meet their needs effectively. Staff were trained in safeguarding awareness, and were able to share examples and understood how to keep people safe, and how to spot and raise any concerns.

The provider did not always work well with people to understand and manage risks. Risks were not always identified at the service due to gaps in record-keeping. A 'Resident of the day' programme was in place to support individuals in a more person-centred way, identify any risks in their care, or changes in their needs. This was not always carried out effectively by the staff team or Registered Manager.

Medication was not looked at during the visit.

The provider did not have clear systems of accountability for oversight and good governance. They did not act on the best information about risk, performance and outcomes, or share this securely with others when appropriate. The Registered Manager and providers' oversight and auditing processes were not effective. They failed to identify the issues found at this assessment regarding gaps in records and shortfalls which placed people at risk of harm. This meant they were unable to ensure effective governance of the service.

The provider had inclusive leaders at all levels who understood the context in which they delivered care, treatment and support, and embodied the culture and values of their workforce and organisation. Leaders had the skills, knowledge, experience and credibility to lead effectively. They did so with integrity, openness and honesty. Staff received equality and diversity training, and the staff team was made up of people of many different backgrounds and cultures. Staff had regular team meetings and one-to-ones that were meaningful and felt that they were valued and felt supported in their work.

Participated in Well Led Programme?	**Yes**	
PAMMS Assessment – Date (Published) / Rating	**27/02/2025**	**Good**

Provider Name	**T.L. Care Limited**	
Service Name	**Ingleby Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	Lamb Lane, Ingleby Barwick, Stockton-on-Tees TS17 0QP	
Ward	**Ingleby Barwick South**	
CQC link	https://www.cqc.org.uk/location/1-146749395/reports/AP9135/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Requires Improvement**	**Requires Improvement**
Safe	**Requires Improvement**	**Requires Improvement**
Effective	**Good**	**Requires Improvement**
Caring	**Good**	**Requires Improvement**
Responsive	**Requires Improvement**	**Requires Improvement**
Well-Led	**Requires Improvement**	**Inadequate**
Date of Inspection	**2nd – 30th June 2025**	
Date Report Published	**7th August 2025**	
Date Previously Rated Report Published	**29th November 2024**	

Breach Number and Title
Regulation 17: Good Governance
Level of Quality Assurance & Contract Compliance
Level 3 – Major Concerns (Enhanced Monitoring) This is due to CQC breaches and to monitor and support the new regional and home managers.
Level of Engagement with the Authority
The provider engages well with the Quality Assurance & Compliance (QuAC) Officer, with any requests responded to in a timely manner.
Engagement and Support from Transformation Managers
The Transformation Team have kept regular contact with Ingleby, especially through manager changes, to maintain engagement and support. Visits have been conducted and discussion of opportunities and initiatives to support their quality improvement. This engagement will continue.
Supporting Evidence and Supplementary Information
In the report published in November 2024, the following breaches were found: • Regulation 9: Person-Centred Care • Regulation 12: Safe Care and Treatment

- Regulation 17: Good Governance
- Regulation 20: Duty of Candour

Whilst sufficient improvements had been made to meet three of the breaches, there remained a breach in relation to good governance as the provider had not made sufficient progress in relation to assessing, monitoring and improving the quality of the service. This related to maintaining accurate and complete records for people, and ensuring staff received appropriate support and appraisal. There had not been a Registered Manager in post since December 2023. Since then, there had been several managers involved in the running of the home, including peripatetic home managers and regional managers, none of whom registered with the Commission which was a condition of the providers registration. This was being addressed with the provider outside of the inspection process.

People and their legal representatives were not included in the care planning process. Inconsistencies in care records and risk assessments meant the monitoring of care was not robust. One person was living with epilepsy yet there was no care plan or risk assessment in place. Safety checks of the premises and equipment were completed. The provider had identified some issues with window restrictors and had ordered new window restrictors; however, the incorrect restrictors had been received. The provider confirmed during the inspection the correct window restrictors were now in place. The home was clean and tidy. Task-orientated schedules were in place for cleaning, including the cleaning of specialist equipment. Personal protective equipment was appropriately worn and staff understood procedures for safe donning and doffing.

Improvements had been made in relation to the recording of people's food and fluid intake. However, records of people's fluid intake showed it was low and there was limited evidence action had been taken in relation to this. Staff worked well together and involved other healthcare professionals as needed, acting upon their guidance and advice. The provider supported people to manage their health and wellbeing to maximise their independence, choice and control. Staff supported people to live healthier lives and, where possible, reduce their future needs for care and support. The monitoring of people's health care needs had improved since the last inspection. District nursing teams were positive about the staff and said, '*Skin integrity is on the ball. Referrals are made when required; while they are waiting for us to come out, they start protocols. That's the sign of a good home.*'

The staff treated people as individuals and made sure people's care, support and treatment met their needs and preferences. They took account of people's strengths, abilities, aspirations, culture and unique backgrounds, and protected characteristics. Staff knew people well and understood their preferences and how they wanted and needed to be supported. Activities for people had improved and time was spent with people who remained in their rooms. However, there was a reliance on the Activities Co-ordinator for activities, and they did not work weekends or evenings. There continued to be shortfalls in relation to the delivery of staff supervision and annual appraisals. The Interim Manager explained they would all be completed by the end of June 2025. However, this process needed to be embedded and consistently implemented.

Care records had improved. However, they still lacked personalised detail, for example, in relation to people's histories, preferences and support strategies if people were distressed or anxious. Care records were electronic but not yet accessible for people. There was no evidence people were involved in the reviewing of their care plans. The provider did not always make it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support. People were not always supported to plan for important life changes, so they could have enough time to make informed decisions about their future, including at the end of their life.

The provider did not have a clear shared vision, strategy and culture which was based on transparency, equity, equality and human rights, diversity and inclusion, and engagement. They

did not always understand the challenges and the needs of people and their communities. Changes in management meant leadership was not consistent or robust. Staff commented that there were too many managers involved, and they needed a permanent manager in post. People told us they did not know who the manager of the home was. Audits were evidence-based, and there was space within the audits to record comments on the evidence used to assess the quality of the service, but this was not always documented. Some audits had clear Action Plans, with the roles of the people responsible and target dates; others did not.		
Participated in Well Led Programme?	**No**	
PAMMS Assessment – Date (Published) / Rating	**17/03/2025**	**Requires Improvement**

Provider Name	**T.L. Care Limited**	
Service Name	**The Beeches Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	Green Lane, Newtown, Stockton-on-Tees TS19 0FH	
Ward	**Newtown**	
CQC link	https://www.cqc.org.uk/location/1-146749363/reports/AP14231/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Requires Improvement**
Safe	**Good**	**Requires Improvement**
Effective	**Good**	**Requires Improvement**
Caring	**Good**	**Good**
Responsive	**Good**	**Good**
Well-Led	**Good**	**Requires Improvement**
Date of Inspection	**15th July – 18th August 2025**	
Date Report Published	**24th September 2025**	
Date Previously Rated Report Published	**13th October 2022**	

Breach Number and Title
n/a
Level of Quality Assurance & Contract Compliance
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)
Level of Engagement with the Authority
The manager has a positive relationship with the Quality Assurance & Compliance (QuAC) Officer, maintaining honest and open communications and responding to requests for information in a timely manner.
Engagement and Support from Transformation Managers
The care home engages fully with the Transformation Team and have always been open to working together on opportunities and initiatives. The Activity Co-ordinator attends all the networking meetings and events in the community alongside other local care homes, and the home have started to participate in research projects. The Transformation Manager will continue to work with the care home to maintain quality and look at new projects to take part in.
Supporting Evidence and Supplementary Information
The CQC found that care records confirmed that people had access to a range of health and social care professionals when needed. This included district nurses, the community matron, dieticians, GPs, and dentists. Assessments undertaken by professionals were documented in individual files and, where needed, a care plan was put in place.

People were safe from harm and abuse. Safeguarding processes were in place to record and act if abuse was suspected. Any safeguarding concerns were reported appropriately to the Local Authority. Staff demonstrated a clear understanding of the different types of abuse and their responsibilities. Residents and relatives confirmed that staff treated people well and people felt safe at the service.

Risk assessments were in place and contained person-centred information. Further development was needed for one person who had diabetes. They did not have a risk assessment informing staff of action to take if their blood glucose level was too low or too high. The Registered Manager confirmed that they would take immediate action to address this.

The provider made sure that medicines and treatments were safe and met people's needs, capacities, and preferences. Staff involved people in planning, including when changes happened. Medicine administration records and medicine care plans provided information to ensure people received their medicines safely as prescribed. Staff responsible for administering medicines were trained to manage medicines safely.

People's needs were assessed before they moved into the service to make sure staff could provide the care and support they needed. This assessment considered how people wanted to be supported and any needs in relation to culture, religion or ethnicity. Care records were reviewed regularly. Where people were at risk of losing too much weight, their weight was regularly monitored and action taken if needed. Care plans were person-centred and supported staff to provide the right care to people.

The Registered Manager ensured staff understood people's needs and preferences and put the right processes in place to support people and staff. People confirmed that staff got to know them and supported them as they needed. One person said, '*All the staff are just wonderful. They know everything about me and cater for all my needs.*'

The Registered Manager had worked hard to ensure improvements were made in areas highlighted at the last inspection. They ensured staff were supported to keep up-to-date with developments in best practice to ensure they were providing good quality care. Staff surveys had been completed in May 2025 and, although responses were few, staff were very positive. They felt listened to in meetings and commented there was a friendly atmosphere at work. Where the scoring of some questions indicated a shortfall, action had been taken to address this.

Participated in Well Led Programme?	**Yes**	
PAMMS Assessment – Date (Published) / Rating	**16/01/2025**	**Good**

PRIMARY MEDICAL CARE SERVICES

Provider Name	**Dr. James Robson**	
Service Name	**Identity Dental Care**	
Category of Care	**Dentists**	
Address	78 Wolviston Road, Billingham, Stockton-on-Tees TS22 5JF	
Ward	**Billingham West**	
CQC link	https://www.cqc.org.uk/location/1-196169482/reports/AP11965/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**n/a**	**n/a**
Safe	**Regulations met**	**n/a**
Effective	**Regulations met**	**n/a**
Caring	**Regulations met**	**n/a**
Responsive	**Regulations met**	**n/a**
Well-Led	**Regulations met**	**n/a**
Date of Inspection	**21st August 2025**	
Date Report Published	**16th September 2025**	
Date Previously Rated Report Published	**16th February 2013**	

Further Information

Identity Dental Care is in Billingham and provides private dental care and treatment for adults and children. At the time of the CQCs inspection, there was a total of six staff employed at the practice, of which there was one dentist, three dental nurses, one dental hygienist, and the practice manager.

The CQC gathered feedback from staff and spoke to a range of staff during its announced on-site inspection, including one dentist, two dental nurses, one dental hygienist, and the practice manager. Two weeks before its inspection, the CQC asked the practice to encourage patients to share their views of the service with the CQC. Feedback was received from one patient. On the day of the inspection, the CQC spoke with and saw patient feedback from a further seven patients.

CQC view of the service

- The CQC found the practice had met regulations.
- The practice had effective systems to identify and manage risks, including infection prevention and control.
- Staff had the skills, knowledge and experience to carry out their roles.
- Recruitment procedures reflected current legislation and there was effective leadership and a culture of continuous improvement.
- Staff provided care and treatment in line with current guidance. They treated patients with dignity and respect and ensured access to care, support, and treatment when required.

People's experience of this service

- Patient feedback provided a positive view of the dental team and care provided by the practice. Comments included, '*Exceptional service from friendly staff. [name] and the team at Identity take time to get to know their patients and are always considerate and helpful with their care and support. As a family, we know we're in good hands and each one of us feels that we have a unique support plan in place with Identity*'.
- Patients commented positively about the standards of cleanliness.
- Patients felt able to book appointments within an acceptable timescale for their needs and said they had enough time during their appointment without feeling rushed.
- Patients stated they were given clear information to help them make an informed choice about their treatment and any associated costs. They were involved in decisions about their care. '*Always receive outstanding service at Identity. Staff are understanding and explain all treatments etc thoroughly. Very happy with the service I receive*'.
- Patients stated that when they were prescribed medicines, sufficient information was given. '*Advice is great and if suggestions don't quite work alternatives are suggested*'.
- Patients stated that they were supported to maintain their oral health and were provided with appropriate information and resources.
- The practice shared patient feedback with the team. The CQC was told this was reviewed and where suggestions had been made, appropriate action would be taken.

HOSPITAL AND COMMUNITY HEALTH SERVICES
(including mental health care)

None

APPENDIX 2

PAMMS ASSESSMENT REPORTS
(for Adult Services commissioned by the Council)

Provider Name	**Oxbridge Care Limited**	
Service Name	**Windsor Court Residential Home**	
Category of Care	**Residential**	
Address	44-50 Windsor Road, Oxbridge, Stockton-on-Tees TS18 4DZ	
Ward	**Ropner**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**16th & 17th June 2025**	
Date Assessment Published	**1st July 2025**	
Date Previous Assessment Published	**16th August 2024**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans were completed to a good standard; they were person-centred, with good detail on resident likes, dislikes and preferences. There was good evidence of consideration of the resident's preferences and good detail was given on specific needs, level of independence, and behavioural triggers. Resident and family involvement was evidenced in care plans. Care plans and risk assessments were reviewed regularly, and there was also evidence of plans being updated timely where changes were necessary. An accessible format form was seen in place detailing resident preferences on how staff should communicate with residents. Life histories and 'about me' information was in place.

There was a good activities timetable in place; the home is part of the Local Authority activities group and takes part in the monthly Elm Tree Social Club shared timetable. Risk assessments were in place for each activity, evidenced as being renewed annually. Activity logs were kept for each activity that takes place with specific resident information on what they can take part in and their preferences involvement. Monthly logs were kept of all activities that take place, including family visits and events. Activities were varied and included singers, walks to the park, quiz games, armchair exercises, and garden parties with families.

Throughout the assessment, staff were observed asking for consent from residents often. Time was given to residents to respond, and staff were patient, though also well-versed, in reading non-verbal cues. Staff spoke to residents throughout delivering care, explaining what they were

doing, what they would do next, and checking they were okay. Residents spoke of how polite staff were, how kind they were, and how they always knocked on bedroom doors and checked on them.

Staff had training on Mental Capacity Act, safeguarding, and Deprivation of Liberty, which was refreshed annually. Staff were able to give explanations for each, and their purpose. Infection control practices around the home were good; staff explained the processes the home had in place to prevent the spread of infection, good hand hygiene practices were seen, and staff wore suitable personal protective equipment and were bare below the elbow with hair tied back.

Medication observations were completed to a good standard. The medication room and medication trolley were both locked when not in use. The medication room was found to be clean, tidy and well organised, and medications were stored suitably. Medication Administration Records had no gaps or missed signatures and were completed using the correct administration codes. Front covers and protocols for medications taken as and when required were both in place to a good standard. Care plans explained how residents preferred to take medications if they could do this for themselves or preferred support. Medication audits were completed monthly, and competencies were completed in line with contractual requirements.

The home had adapted to be dementia-friendly; clear signposting with consideration to residents with dementia was used, and all staff had completed the Dementia Friends accreditation. Bedrooms were personalised with items from home.

The home was well-kept, clean and tidy. Appropriate environment risk assessments were in place, were seen to be reviewed annually, and all were in date at the time of assessment. A range of robust internal audits took place regularly, with evidence of good managerial oversight. All appropriate servicing certification was in date at time of assessment. Staff supervisions were seen to be completed bi-monthly alongside an annual appraisal. Staff said management were supportive and felt there was an improvement in management listening to feedback. Regular staff and resident and family meetings took place, as well as annual staff and resident surveys, and the home evidenced a good feedback structure.

Plans and Actions to Address Concerns and Improve Quality and Compliance

No areas of improvement were identified in this assessment.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

The provider has a good level of engagement with the Local Authority. The manager is responsive to both Quality Assurance & Compliance (QuAC) Officer and other Local Authority teams.

Engagement and Support from Transformation Managers

Windsor Court engages fully with the Transformation Team in all aspects of the opportunities and initiatives presented. They attend all Provider Forums, Leadership Networks, activity meetings, and training opportunities. They have started to engage in research projects alongside other Stockton care homes with National Institute of Health and Care Research (NIHR), and support other care home managers through peer workshops.

Current CQC Assessment - Date / Overall Rating	**05/10/2018**	**Good**

Provider Name	**Gradestone Limited**	
Service Name	**Roseworth Lodge Care Home**	
Category of Care	**Residential / Residential Dementia / Nursing**	
Address	Redhill Road, Stockton-on-Tees TS19 9BY	
Ward	**Roseworth**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Requires Improvement**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Requires Improvement**
Safeguarding & Safety	**Good**	**Requires Improvement**
Suitability of Staffing	**Good**	**Requires Improvement**
Quality of Management	**Good**	**Requires Improvement**
Date of Inspection	**12th – 14th May 2025 & 24th June 2025**	
Date Assessment Published	**7th July 2025**	
Date Previous Assessment Published	**22nd August 2024**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans were seen to be person-centred and included information such as life history and what was important to the person. Information was seen to be consistent from assessments through to the care planning stage. Both residents and relatives confirmed that the home communicated well with relatives to ensure they were kept up-to-date with their loved one's presentation. Visitors were welcomed into the home at any time and residents accessed the community with the Activity Co-ordinators and family. Visitors were seen to be offered food and drink to join their loved one when visiting during mealtimes. Observation and discussion confirmed that residents were treated with dignity and respect, and privacy was respected. A relative described the home as 'one big family' and commended the staff for their kindness.

Resident / relative involvement in care planning was clearly recorded in care plans. Care plans documented individuals' preferences, strengths and weaknesses. Dietary likes and dislikes / allergies or other nutritional needs were recorded in assessment and care plan documentation. Family and friend links were regularly referenced in care plans, including where certain people were preferred to be consulted about decisions (both when formal and informal processes in place) or simply in reference to a person's importance in the resident's life.

Capacity assessments were seen to be in place and recorded those involved in the decision-making, with care plans referencing how to support individuals in decision-making and respecting choice. DoLS were scanned onto the system and corresponding care plans / records were in place. Staff were observed to seek appropriate levels of consent when interacting with residents. Residents were given choices and treated with respect when making decisions. Staff were familiar with residents' preferences for things such as drinks, but were noted to confirm this with residents before serving.

Several needs assessments were on file and with associated care plans where required. Daily records were seen to be written respectfully, however, were variable in detail; while most were seen to contain the specifics of meals eaten and support delivered, some used only the generic

pre-set options on the electronic care planning system. Overall records were of good quality, however, there were areas such as fluid charts, repositioning logs and oral care which were seen to be lacking.

Observation of staff interaction demonstrated that residents were safe and their needs were being met in a timely manner. Residents appeared settled and well cared for. Those spoken with confirmed they felt safe and well looked after, and relatives confirmed the same of their loved ones. They confirmed they were informed if there were any concerns and kept up-to-date where necessary.

Medication rounds were seen to be carried out in a safe and person-centred manner, with good hand hygiene observed. Medication trolleys and rooms were clean, tidy and secure, and appropriate record-keeping seen.

The home was seen to be clean, tidy and free from malodour. The kitchen was clean and tidy, and food had date of opening / use by recorded. Staff were seen to follow appropriate practices in relation to infection prevention and control, and food hygiene.

The premises was seen to be safe, with fire escapes and corridors free from hazard blockage. The home had been awarded their dementia-friendly accreditation, and this work identified some areas in which they could improve upon their dementia-friendly environment (which are being actioned). Equipment was seen to be stored appropriately, and appropriate service certification was in place, including LOLER testing, fire safety, fixed wiring, gas servicing, etc., with the required regular checks seen to be conducted.

The appropriate recruitment documents were noted within staff files, including evidence of right to work checks (including visa documentation) and references which had been verified. A DBS matrix was in place, and all were seen to be up-to-date, with the contractual three-yearly updates scheduled; this included visiting professionals. A matrix was also in place for monitoring of nursing pins and all were seen to be in date, with the pins recorded appropriately.

A dependency tool was in place and the staffing levels were noted to exceed that which was required per this calculation. Rotas evidenced appropriate staff knowledge / skill mix per shift across all roles (nurses, seniors and care staff, domestic, maintenance and kitchen). Staff advised that plenty of training was available, including refresher training, and this allowed them to carry out their role safely, alongside 'hands on' experience in the role. A training matrix was reviewed which identified training compliance to be at 96%.

There was evidence that the provider continually gathered and evaluated information about the quality of services delivered which included satisfaction surveys, meetings for staff, residents and relatives / visitors, monitoring of complaints / compliments and analysis of accidents / incidents and several audits. A range of audits were conducted by both departmental staff (kitchen, maintenance, domestic) and the managerial staff. The managerial audits included a specific review of the departmental staff audits. The audits were noted to identify where gaps had occurred and recorded follow-up actions taken, giving assurance of managerial oversight and a responsive approach.

Plans and Actions to Address Concerns and Improve Quality and Compliance

An Action Plan will be created to address the one area identified as ‘requiring improvement’, as well as areas which were overall ‘good’ but with recommendations made for improvement. This will be monitored closely by their Quality Assurance and Compliance (QuAC) Officer to ensure completion within the imposed timeframes.

Level of Quality Assurance & Contract Compliance Monitoring		
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)		
Level of Engagement with the Authority		
The provider is responsive to requests from and liaises closely with their QuAC Officer. Performance Dashboard submissions are made in a timely fashion, and queries are responded to promptly.		
Engagement and Support from Transformation Managers		
Engagement with the offered peer support networks, including Leadership Network and Activity Network, are limited, however, the care home support the residents to attend community events that are led by the Transformation Team and other community partners, and respond to communications. The Transformation Team will be working with the manager to improve routine engagement and support, and look for new opportunities to participate in.		
Current CQC Assessment - Date / Overall Rating	**14/07/2023**	**Good**

Provider Name	**Akari Care Limited**	
Service Name	**Ayresome Court**	
Category of Care	**Nursing Residential**	
Address	Green Lane, Yarm, Stockton-on-Tees TS15 9EH	
Ward	**Yarm**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Excellent**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Excellent**
Quality of Management	**Good**	**Good**
Date of Inspection	**27th – 29th May 2025**	
Date Assessment Published	**18th July 2025**	
Date Previous Assessment Published	**26th June 2024**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans viewed were seen to be person-centred with very good detail on the residents likes, dislikes and preferences. There were very good instructions given on how to care for the resident, how they liked things to be done, and behaviours they may or may not present depending on their feelings. Resident-preferred names were used throughout. 'Resident of the Day' meetings were used every month to engage residents and their families in their care planning, with a champion in place to ensure this was completed. All paperwork was in accessible formats and pictorial signage was used around the home.

Residents spoke very highly of the staff who supported them and were very happy and appreciative of the care team. Observations saw staff encouraging residents to be independent and promoting choices. Staff were observed patiently allowing time for residents to respond. All staff had completed the Dementia Friends accreditation and had utilised resources well. Residents confirmed feedback was sought routinely. Activity and mealtime feedback was taken, surveys were completed annually, and resident meetings were scheduled bi-monthly.

There was a varied activities calendar each month, and one-to-one time for those who could not, or choose not to, leave their room was also considered. Families and friends visited frequently and were also observed joining in with mealtimes and activities. Families had recently taken part in Dementia Friends training with staff. All the above points contributed to the 'Excellent' rating in the 'Involvement and Information' domain.

Care plans had good evidence throughout of how independent each resident was, and what they were and were not able to do for themselves for each task; how to support and encourage residents to remain independent was also detailed. Care plans were reviewed monthly, and those viewed were seen to be reviewed timely, with evidence of updates made when needed. Keyworkers were clearly identified, and consideration for keyworker allocations included relationships built between residents and staff.

Daily notes, handover logs, and personal care logs all made note of consent. Daily notes and handover logs for support given also encouraged staff to log levels of independence. Daily notes and handover logs were seen to be completed timely and daily, though staff did not always utilise the free type fields to add information additional to the pre-populated dropdown fields, to allow for more consistent and personalised notes.

Staff were confident in both Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act, and could explain how these impacted on care delivery. Staff were fully able to explain safeguarding and whistleblowing practices. Observations in relation to Infection Prevention Control practices were of a very high standard and all staff seen were bare below the elbow. Health and Safety certification and audits were all in date at the time of assessment. Home and environment risk assessments were in place and reviewed monthly.

The medication room and nurses' station were clean and tidy; both the medication trolley and room were locked and secured appropriately. Medication rounds were good, with both Nurses and Seniors knowing residents and their medications well; rounds were carried out in a safe and person-centred manner with good hand and trolley hygiene practices observed. Medication Administration Records were completed to a good standard. Staff were found to be appropriately trained. Staff competencies were completed in line with contractual requirements.

Safer recruitment practices were evidenced; all staff files included signed copies of job descriptions and contracts of employment, and completed comprehensive inductions in line with Skills for Care and the Care Certificate. Training completion was at 99% at the time of assessment, and this was a mix of face-to-face and online learning. At the time of assessment, some supervisions and appraisals from the previous year were not available, though the Manager had brought these back in line with contractual requirements.

The Manager kept a clear and concise filing system of audits, incident logs, and service certifications. Staff meetings took place bi-monthly, and meeting feedback forms were collected following each meeting for feedback on how supportive and inclusive meetings were. Staff feedback on management was good, and they reported feeling supported. Staff said they would not feel nervous to raise concerns as this was encouraged. Resident and family feedback was also positive; no residents spoken with had raised a complaint previously, but spoke of the Manager visiting them frequently to check-in.

Plans and Actions to Address Concerns and Improve Quality and Compliance

An Action Plan was in progress to address the one area of improvement found. This will be monitored by the Quality Assurance and Compliance (QuAC) Officer for compliance.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

The provider has a good level of engagement with the Local Authority, responsive to both QuAC and Transformation Teams, and engages well with forums, initiatives and training that is offered. Monthly reporting is submitted timely.

Engagement and Support from Transformation Managers

Ayresome Court engage regularly and positively with the Transformation Team – attending Provider Forums, peer meetings, training and workshops. The Activities team are involved in the Activity Co-ordinator Network and staff bring residents along to events and opportunities in

the community. The care home has been involved in previous research studies and are engaging in current studies with local researchers in the North East.		
Current CQC Assessment - Date / Overall Rating	**26/02/2020**	**Good**

Provider Name	**Anchor Hanover Group**	
Service Name	**Millbeck**	
Category of Care	**Residential**	
Address	High Street, Norton, Stockton-on-Tees TS20 1DQ	
Ward	**Norton Central**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Requires Improvement**
Quality of Management	**Good**	**Good**
Date of Inspection	**7th July 2025**	
Date Assessment Published	**21st July 2025**	
Date Previous Assessment Published	**26th September 2024**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans were seen to be personalised and detailed personal information. Every resident had a front page with picture, room number, and do not attempt cardiopulmonary resuscitation decisions. The status of Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards was displayed on the front page. The care plan provided an overview, including risks to be mindful of, preferences for conversation topics, a medical summary, a summary of care needs, necessary equipment, and contact details.

Each resident had an 'About Me' section which outlined what was important to them, the people who were significant in their lives, how to best communicate with the resident, and their personal do's and don'ts. Live updates of care were updated as the day progressed, displaying an amber colour if overdue and turning green once completed. Care plans could not display signatures from residents or their families because they were electronic; however, any discussions with residents or families were seen to be recorded in the monthly reviews.

Discussions with residents revealed a high level of satisfaction and a feeling of support within the home. They mentioned that the staff were approachable and helpful in every regard. Importantly, even when residents had their doors open, staff always knocked prior to entering. Observations validated that the wellbeing of residents was a top priority, with all individuals seeming to be well looked after. Residents conveyed that their personal rooms contained all the essentials they required.

Care plans included associated risk assessments, and residents had personal evacuation plans in place. Food and fluid intake charts were filled out throughout the day, noting the offerings and the amounts consumed. A health passport containing all relevant information could be generated from the care planning system. Care plans and risk assessments were reviewed monthly.

Residents spoken to felt that they would be happy to raise a complaint if needed and would speak to the staff. The Manager was noted for maintaining an open-door policy for residents to discuss issues. The residents interviewed had not needed to lodge a complaint but believed they would receive support if it became necessary. Staff reported feeling able to report issues of poor performance or risks to people and felt they would be supported by management if they did so. They were all aware of whistleblowing and advised of the posters displayed in the home with direction on how to do this.

A variety of suitable audits were conducted by the Manager and Deputy Manager. The quality assurance process was supported by the Regional Support Manager. Daily fire safety checks were carried out, including the checking of escape routes, fire warning systems, emergency lighting, and firefighting equipment. The Manager contained a matrix for scheduled maintenance services and checks.

None of the residents interviewed were aware of whether they had been involved in a safeguarding process. However, when asked, they confirmed feeling safe and satisfied within the home. Staff were able to give examples of different types of abuse and described how they would act upon them. Staff were aware of safeguarding and whistleblowing policies and knew where to access current versions. They were aware of external agencies to whom they could report concerns.

The medication room was clean, tidy and secure. Controlled drugs were stored in locked cupboards and medications were stored per resident. Trolleys were secured in a locked medication room and trolleys were secured to the wall.

Fire exits were free from obstruction, signage was clear, and fire extinguishers were seen around the home. Staff were identifiable by both ID badges and uniforms. The premises was well kept both internally and externally. Access to the home was secure and passcodes on keypads were used for access between ground and first floor. Staff were observed using moving and handling equipment, ensuring to obtain direct consent from the residents prior to use. They communicated the process to the residents, patiently waiting for their response and interpreting their cues.

The home was designed to be dementia-friendly. It was not a specialised dementia care facility, yet it featured various colour-coded handrails, bedroom doors, and bathroom signage. The upper floor included themed areas such as a beach-themed ice cream area and a 'chatty bench.' The home was collaborating with the Council’s Community Link Worker to enhance its surroundings for individuals living with dementia. They had finalised and submitted documentation for the Local Authority's dementia-friendly guide, which was set for an annual review.

The medication policy was established and current, incorporating both home remedies and covert medications. Staff competencies were fulfilled in accordance with the Stockton-on-Tees Borough Council contract, occurring at least every six months. Evidence was documented in the care plan of the provider, which supported the resident in receiving annual health checks and medication reviews.

The home utilised electronic medication administration records. Administration records were observed to be complete, with no gaps; if any gaps occurred, the electronic system alerted the staff. The Manager conducted regular audits, which included checks of Medication Administration Records and controlled drug counts. Comments and actions taken were documented appropriately.

The staff files were examined and found to include the necessary employment verifications, such as Disclosure and Barring Service certification with renewals occurring every three years, and an annual declaration was submitted each year. It was noted that references had not been verbally

verified; this matter was discussed with the Manager, and it will be addressed moving forward. Residents were observed to be engaged in the recruitment process; one staff member's file contained a set of interview notes indicating that a resident participated in the interview. However, there were no recorded comments from the resident to convey their thoughts and feelings regarding the interview.

The online training and development system had a number of pre-set induction programmes dependent on the role the person was undertaking. The initial induction for care assistants included the care certificate. Induction programme content included policies and procedures, and a mixture of face-to-face courses and eLearning.

A supervision matrix had been established that identified when an individual was on probation, undergoing induction into their role, or on maternity leave. Dates for supervisions were noted to have a specified due date. Staff members were observed to receive supervision on a bi-monthly basis. Appraisals were conducted on an annual basis.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan for all questions assessed as 'Requires Improvement' and the Quality Assurance and Compliance (QuAC) Officer will monitor this for progress through contractual visits.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

The provider has a good relationship with the QuAC Officer and responds to requests for information in a timely manner.

Engagement and Support from Transformation Managers

Millbeck's Manager and wider staff team engage with the Transformation Team with regard to Provider Forums, activities and training, and communicate regularly with the team. The Transformation Team will continue to work with the Manager to start looking at further opportunities, such as participation in care home research and other projects, pilots and initiatives.

Current CQC Assessment - Date / Overall Rating	**13/12/2018**	**Good**

Provider Name	**HC-One Limited**	
Service Name	**Highfield (Stockton)**	
Category of Care	**Residential / Residential Dementia**	
Address	Highfield Care Centre, The Meadowings, Yarm, Stockton-on-Tees TS15 9XH	
Ward	**Yarm**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**11th – 13th August 2025**	
Date Assessment Published	**1st September 2025**	
Date Previous Assessment Published	**28th January 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

The home had recently transitioned to an electronic care planning system; consequently, the care plans were still a work in progress. However, the care plans that were reviewed appeared to be person-centred, containing concise information regarding the residents' likes, dislikes and preferences. Instructions were provided on how to care for each resident, detailing their preferred methods of care and the behaviours they may exhibit based on their emotional state. The names of the residents were consistently used, along with their preferred names.

Throughout the assessment, numerous positive examples of the relationships between residents and staff were noted, showcasing how residents were treated with dignity, respect and kindness. Observations indicated that staff actively encouraged residents to maintain their independence; they always knocked before entering, whether doors were open or closed, and were often heard introducing themselves and engaging in friendly conversations with residents. These observations affirmed that the wellbeing of residents was a primary focus, with all individuals appearing to be well cared for.

The manager performs comprehensive audits and carefully documents every action in the Home Improvement Plan, all of which were finalised with signatures upon completion.

Recent fire safety checks had been conducted, encompassing fire alarms, heat detectors, emergency lighting, and firefighting equipment. A fire risk assessment was completed in September 2024 and was due for review in September 2025. There was documentation available for conducted fire drills.

To ensure all maintenance services and checks were organised, the manager kept a detailed matrix. There was also evidence of Legionella risk assessments and water temperature

checks. Maintenance audits for mattress inspections were seen to be recorded, along with checks for window restrictors.

The fire exits were kept clear and unobstructed, marked with clear signage, and fire extinguishers were conveniently located throughout the building. Staff could be easily identified by their ID badges and uniforms. The facility was well-kept, both inside and outside, and access was secured with passcodes.

During observation, staff were observed using moving and handling equipment. They made sure to obtain direct consent from the residents before using it. Moreover, they communicated the process clearly with the residents, patiently waiting for their responses and interpreting their cues effectively.

The home incorporates dementia-friendly design features, such as coloured handrails, distinct bedroom doors, and clear bathroom signage. The manager was presently engaged in finalising the Stockton Dementia Friendly Care Home Guide and recognised that it was a component of the Local Authority contract. Throughout the assessment, numerous staff members were noted participating in the Local Authority Dementia Friends training, with an additional training date scheduled for the remaining staff.

The medication policy was established and current, incorporating both home remedies and covert medications. Staff competencies were fulfilled in accordance with the SBC contract, occurring at least every six months. Evidence was documented in the care plan of the provider, which supported the resident in receiving annual health checks and medication reviews. The home utilised electronic MAR charts. All prescribed medications were listed on the MAR charts and were entered through the pharmacy. Upon receipt, the MARs were verified against medication labels, and a second staff member checks them, with both staff members signing or initialling the MAR chart. Administration records were observed to be complete, with no gaps; if any gaps occurred, the electronic system alerted the staff. The administration of PRN and variable dose medications was thoroughly documented, with protocols for PRN and variable doses being current and in place. The manager conducted regular audits, which included checks of MAR and controlled drug counts. Comments and actions taken were documented appropriately. The medication room was maintained in a clean, tidy and secure condition. Controlled Drugs (CDS) were stored in locked cupboards. Medications were stored per resident.

Upon reviewing the staff files, it was confirmed that all essential employment checks, including DBS certification, were duly completed. The files featured a wealth of information, including application forms detailing full employment histories, responses to interview questions, two written references, job descriptions, contracts of employment, and staff health checks. Furthermore, there was clear evidence of each staff member's right to work in the UK. It was noted that references had not been verbally verified; this matter was discussed with the manager, and it would be addressed moving forward.

New employees participate in an induction process that begins off-site and lasts for three or five days depending on job role. This was followed by an on-site induction period of 12 weeks. Throughout the induction, all staff members were required to complete their training. After that, a shadowing period would occur before the employee transitioned to working independently. Additionally, all mandatory training sessions must be completed.

It was confirmed that all staff have had a recent supervision. Additionally, every staff member received an appraisal within the past year.

Plans and Actions to Address Concerns and Improve Quality and Compliance

No areas were identified that were ‘Requires Improvement.’

Level of Quality Assurance & Contract Compliance Monitoring		
Level 1 – No Concerns / Minor Concerns (Standard Monitoring)		
Level of Engagement with the Authority		
The provider has a good relationship with the Quality Assurance and Compliance (QuAC) Officer and responds to requests for information in a timely manner.		
Engagement and Support from Transformation Managers		
The Transformation Team remain in regular contact with Highfield to keep them updated with training, networking, workshops, activities, research, and other opportunities. The manager has engaged in the training opportunities and some networking, and aims to become more active with other initiatives, including the Activity Co-ordinator Network. The Transformation Team will continue to engage with the leadership team at Highfield.		
Current CQC Assessment - Date / Overall Rating	**10/12/2022**	**Good**

Provider Name	**Akari Care Limited**	
Service Name	**Piper Court**	
Category of Care	**Nursing / Residential**	
Address	Sycamore Way, Stockton-on-Tees TS19 8FR	
Ward	**Hardwick & Salters Lane**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**18th – 20th August 2025**	
Date Assessment Published	**4th September 2025**	
Date Previous Assessment Published	**21st October 2024**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans viewed were inclusive and non-discriminatory, and were structured in a way to preserve the wellbeing of the resident. Front pages had a good life history profile of the resident, which included their goal, though this was not always evidenced of being acted on. Care plans were written with the resident in mind and had good detail of preferences, abilities and level of independence, behaviour triggers, and likes and dislikes.

Residents spoke of how happy they were in the home, that they liked the staff, and that they felt settled. Residents particularly liked how staff came and spoke to them and were respectful and polite. Observations throughout the assessment on moving around the home evidenced good relationships and familiarity between staff and residents. Through observation, staff were seen to respect preferences, took time to offer choices, and were overheard considering residents' usual routines.

Though there was evidence of resident and family involvement in initial care plan creation, this was not followed through into monthly reviews. Care plans and risk assessments were being reviewed monthly in line with contractual requirements, however, monthly review notes had limited quality, with frequent examples found of notes being vague and generic. A 'Resident of the Day' meeting structure was used by the home, but there was limited evidence of this being utilised by staff and lacked quality detail when completed. Daily notes were seen to be added throughout the day and were sometimes personalised, but not always, lacking further detail at times.

The home environment was tidy, free from clutter, and fresh smelling. It was noted that communal areas could do with a cosmetic upgrade, and plans had been put in place to begin this process. Bedrooms were personalised with items from home. Dementia appropriate adaptations were seen throughout, including pictorial signage, adaptive equipment, and coloured handrails and toilet seats. The home had not yet started their Dementia Friends accreditation.

Evidence was seen of regular maintenance and safety audits and testing; all audit books were seen to be completed weekly / monthly as required. Appropriate noting was seen for entries not completed, or problems found, with notes being updated and signed off once corrected. Additional audits were completed by the home manager, regional manager, and the Akari Quality Team.

Good infection prevention and food hygiene practices were observed throughout the assessment, including correct use of Personal Protective Equipment, disposal methods, and handwashing. Staff were all seen to be bare below the elbow. There was an Infection Prevention Control (IPC) display in the main corridor, and this named the allocated IPC champions for the home in line with contractual requirements.

Medication rounds observed were completed to a good standard; high standards of hand hygiene were used, and a good level of interaction was witnessed. The staff member knew the residents, the medication, and how they took it, but still cross-referenced this with the Medication Administration Record before administration. Storage of medications, the medication trolley, and the medications room were all appropriate and seen to be locked when not in use. On observation, the trolley was well organised by resident; medication room and fridge temperatures were recorded daily, and medication labels matched the Medication Administration Record with clear labelling. Correct codes were used for most Medication Administration Records viewed; instances of non-administration were minimal. PRNs were noted with the time. Controlled drugs were signed by two members of staff. Staff competencies were viewed and were in line with contractual requirements. There was evidence seen of both the manager and regional manager completing regular medication audits.

Staff confirmed they received annual refresher training, and were well versed in the Mental Capacity Act, Deprivation of Liberty, and safeguarding. Staff all carried Mental Capacity Act cards, along with identifying displays in corridors, and gave good examples of how they put this into practice. All staff, regardless of role, knew of the purpose of Deprivation of Liberty and that they must be aware of any applicable conditions. Staff all knew of safeguarding practices, how to raise concerns of abuse should they need to, and where to locate the whistleblowing policy.

Staffing levels at the time of the assessment were good, and staffing visibility around the home was to a good level. There had recently been an uptake in new staff; all were evidenced to have taken part in a comprehensive induction and probation, which included use of the Care Certificate. Supervisions were not being completed consistently in line with contract at the time of assessment, though all staff had recently had an annual appraisal. At the time of assessment, training completion was at 94%.

Plans and Actions to Address Concerns and Improve Quality and Compliance

A small Action Plan is being created by the provider to address any areas of improvement found. This will be monitored through reviews and contract visits by the Quality Assurance and Compliance (QuAC) Officer.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

The provider has a good level of engagement with the Local Authority. The manager is responsive to both QuAC, Transformation, and Medicines Optimisation Teams.

Engagement and Support from Transformation Managers		
Piper Court engages on a high level with regards to networking and training. The Activity Co-ordinators attend network meetings, have participated in workshops and training, and bring residents into the community for events. The home has previously taken part in some research projects, and this will be encouraged further with the new leadership team.		
Current CQC Assessment - Date / Overall Rating	**04/06/2025**	**Good**

Provider Name	Methodist Homes	
Service Name	Reuben Manor	
Category of Care	Residential / Dementia Residential	
Address	654-656 Yarm Road, Eaglescliffe, Stockton-on-Tees TS16 0DP	
Ward	Eaglescliffe East	
	New PAMMS Rating	Previous PAMMS Rating
Overall Rating	Good	Good
Involvement & Information	Good	Good
Personalised Care / Support	Good	Good
Safeguarding & Safety	Requires Improvement	Excellent
Suitability of Staffing	Good	Good
Quality of Management	Good	Good
Date of Inspection	4th – 6th August 2025	
Date Assessment Published	5th September 2025	
Date Previous Assessment Published	14th August 2024	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

At the time of the assessment, the Registered Manager was on long-term absence from work.

On the whole, care plans were seen to be person-centred containing pertinent details, however, there was some evidence seen of copying and pasting which resulted in two care plans containing incorrect names. Care plans detailed what people could do on good and bad days, and detailed where an individual would require encouragement / support to maintain independence or to engage in care tasks. Care plans evidenced involvement with the resident and / or representatives in pre-assessment documentation and reviews.

Assessments and risk assessments were mostly seen to be in place, though improvement was required to ensure welfare was protected. All residents were seen to have a Personal Emergency Evacuation Plan (PEEP), however, there had not been consideration given to assessments and care planning to ensure that a resident who regularly left the home continued to safely receive the care and support required, and the care plan for a resident who had a modified diet did not contain adequate detail and was contradictory to the information displayed on the landing page of the electronic system. Assessments and care plans were seen to have been reviewed monthly, and where a change in need occurred.

Staff were observed to support residents in a non-discriminatory manner, promoting dignity and respect by asking for consent before providing care and support, knocking on bedroom doors before entering, using people's names when talking to them, offering choices, etc.

Families were observed to visit the home during the assessment; families and friends were supported to take residents out of the home to access the community. Pets were also seen to be welcomed into the home. The home had a number of communal areas in which families could access when visiting their loves ones, including a coffee shop. The home had a toy box and equipment to support families visiting with young children. The service-user guide

referenced family being able to visit at any time and also had meals with their family member. The home also provided dementia training for families, with dates available on a monthly basis. The home also had volunteers to spend time with residents and support activities. The home was also in the process of working with local voluntary agency to organise an event to set up information stalls for residents and families.

The home had two Activity Co-ordinators. The home produced a week activity booklet that was provided to residents and available in communal areas. The activity booklet included details of the activities planned for the week, with at least two activities per day (am and pm), and also two options of activities. Activities for the week of assessment included a range of in-house and community activities such as daily news and catch-up, quiz, pub visit, bingo, music therapy, chaplain visit, church service, sew n so, sign along, church friendship group and coffee morning, love to move. The activity booklet also contained puzzles and quizzes for residents to complete if they wished. The activity plans for the day were available in a number of areas of the home (i.e. each floor / unit and foyer area) which provided information to visiting family and friends. Activity information was available on display stands in text format. The activity booklet contained images / pictures that supported the activity.

The home encouraged and supported residents to provide feedback in a number of ways such as resident meetings and resident surveys, with suggestion boxes available on each unit and on the reception desk. The most recent residents survey showed an overall satisfaction score of 92% for residents and 89% for family and friends. A poster was also displayed advising the home had a score of 9.8/10 for the reviews in July.

Safer recruitment practice was seen to be in place for the homes staff, with all staff files seen to contain application forms, interview notes, references with evidence of verbal verification checks, right to work and DBS certification with barred list check. Disclosure and Barring risk assessments were seen to be in place where required for positive Disclosure and Barring Service checks and Disclosure and Barring Certificates were renewed every three years. Appropriate checks were in place for visiting professionals such as hairdresser and podiatrist.

The home used two agency staff to cover staff shortages in the home when required, although an agency file was in place which contained agency profile, induction and any competency assessments. Agency profiles were seen to contain Disclosure and Barring certificate date and certificate number; one of the agency profiles contained the level of Disclosure and Barring Service and if Barred list check was included, however, the other did not. One of the agency staff files viewed did not have the profile from the agency. There was no evidence of the home having undertaken their own due diligence, for example obtaining a copy of the Disclosure and Barring Service certificate or Right to Work check.

Staff confirmed they had received appropriate induction at the start of their employment and received regular training, supervision and annual appraisal, however, the frequency of supervision and appraisal were found to not be in line with contractual requirements. At the time of the assessment, overall staff training compliance was 86%.

Staff administering medication confirmed they were qualified to Level 3 and received six-monthly medication competency assessments (as contractually required).

The home environment was seen to be clean and tidy. The décor of the home and furniture was of a good standard. The dementia unit was dementia-friendly, including appropriate signage for bathrooms, memory boxes outside of bedrooms, coloured toilet seats, coloured crockery, sensory area and activity room. Bathrooms were clean and tidy and free from any products. Laundry room was seen to be well organised, with different basket for each room. Appropriate industrial equipment was in place. Laundry and kitchen areas were key coded to prevent authorised access. The kitchen was last inspected on 9 April 2025 and

maintained its five-star food hygiene rating. Local Authority Annual Infection Protection Control (IPC) Audit was seen to be complete and shared with the IPC nurse; audit feedback was 100%. The home had not yet completed the Dementia Care Home Guide, however, has a dementia lead within the company and a dementia-friendly approach with use of contrasting colours and wellbeing related items throughout, including memory boxes displayed outside of bedrooms.

The medication room was clean and tidy and secure. Controlled drugs were stored in separate controlled drug cupboards. On the whole, room and fridge temperatures were seen to be recorded daily, however, a few days were missing. A Medicines Management Policy was in place, in date and was seen to contain information relating to covert medication and homely remedies. Staff medication competency assessments were in place in line with contractual requirements. Front covers were seen to be in place for Medication Administration Record (MAR) charts, with photographs, allergy status and how the resident liked to take their medication. MAR charts were seen to contain all prescribed medication and reference other records such as Topical Medication Administration Record (TMAR). Instructions on MAR charts were seen to match pharmacy labels and, on the whole, MAR charts were seen to be double-signed, however, one resident's MAR chart viewed only had one signature. Pro re nata (PRN) protocols were seen to be in place. Regular managers audit on controlled drugs. The medication management contributed towards the decline from 'Excellent' to 'Requires Improvement' in the 'Safeguarding and Safety' domain.

Although the home had a range of risk assessments in place, control measures were found not to be followed, for example a heated roller grill did not contain any warning signage, cleaning products accessible unlocked in cupboard, and maintenance equipment left unattended in a corridor. Some service certification documentation was also found to be out-of-date. This contributed towards the decline from 'Excellent' to 'Requires Improvement' in the 'Safeguarding and Safety' domain.

The home undertook a range of audits, with an audit schedule in place; most audits were seen to be completed at the required frequency, however, some gaps were found.

Records were found not to be held securely; during the assessment, all three nurse stations were found to be unlocked and unattended, with one having an open laptop logged onto the electronic care plan system, and all having open or unlocked cabinets which contained confidential information (for example, Do Not Attempt Resuscitation).

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address all individual questions identified as requiring improvement – the Action Plan will be monitored through reviews and contract visits by the Quality Assurance and Compliance (QuAC) Officer.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

The provider has a good relationship with the QuAC Officer and responds to requests for information in a timely manner.

Engagement and Support from Transformation Managers

Although Reuben Manor have low engagement with the Transformation Team, the leadership team in the home do acknowledge emails and calls, and responds when necessary. The Activity

Co-ordinator attends the activity networks, has been involved in previous training and workshops, and also brings residents to events in the community. The Transformation Team will continue to link in with the care home around opportunities and initiatives to improve engagement from the care home manager and deputy.		
Current CQC Assessment - Date / Overall Rating	**17/12/2020**	**Good**

Provider Name	**Stockton Care Limited**	
Service Name	**Primrose Court Nursing Home**	
Category of Care	**Nursing Dementia / Complex Mental Health**	
Address	South Road, Stockton-on-Tees TS20 2TB	
Ward	**Norton South**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Good**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**18th – 20th August 2025**	
Date Assessment Published	**17th September 2025**	
Date Previous Assessment Published	**30th October 2024**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans were person-centred and written in a respectful manner, were reviewed monthly at minimum, and were seen to have been reviewed in response to changes in need or to incorporate new information provided by professionals. They clearly documented the individual approaches required for each resident, as well as information relating to what was important to the person such as family and life history. Regular assessments were noted to take place and Personal Emergency Evacuation Plans (PEEP) were seen to contain accurate information and were also reviewed regularly. Information gathered within these assessments was included in care plans and escalation of concerns to other professionals was evidenced. Daily notes were person-centred and contained good detail, including food and fluid records, and an overview of the individuals' presentation that day.

Observation and discussion confirmed that residents are treated individually, and their privacy and dignity respected. Residents, where able, had access to manage the security of their bedrooms independently, and bedrooms were well personalised. Unwise decisions were supported appropriately, and residents' wellbeing appeared to be well maintained. Those spoken with confirmed they felt they / their loved ones were safe and well looked after. Staff were aware of the different types of possible abuse and were able to explain possible changes in an individuals' behaviour as a result of abuse, and how they would handle this.

Staff were noted to follow appropriate practice in relation to food hygiene and infection prevention and control, with hand washing undertaken and PPE worn. They were rated 5 (very good) following a food hygiene assessment conducted by the Food Standards Agency in February 2025. Menus were seen to be healthy and balanced, and residents were seen to be offered choice over meals and portion sizes, and supported with personal requests.

Staff files contained records largely consistent with appropriate recruitment checks, including right to work documents and references, and files contained completed induction checklists which covered policies and procedures as well as training, including the care certificate, and

required sign off by the inducting officer. Appraisals took place annually and supervisions bi-monthly, as per contract. There was a matrix in place for the year with the pre-planned schedule, which was seen to match the completed records on file. A training matrix was in place and identified training compliance to be at 100%.

Medicines were stored securely and appropriately in lockable medicine cabinets, stored in locked medication rooms. Controlled drugs were stored in separate, locked cabinets within the medication rooms. A medication policy was in place and reviewed recently in June 2025; the policy included homely and covert medications. Medication competencies were being conducted annually at minimum (in line with NICE guidance), though SBC contract requires them to be undertaken six-monthly. A monthly medication audit was being conducted using the NECS (North of England Care System Support) Medicine Optimisation Teams' template, and their most recent audit score was 86.5%. Medication documentation, for example front covers, Medication Administration Records (MAR) charts were being completed appropriately. There were a number of occasions where the special instructions on medication labels (for example, do not consume grapefruit) did not match the MAR chart, and on discussing this with the manager, they advised this was something they were already remedying with their new pharmacy supplier following a recent change.

The home was well equipped taking into consideration the needs of their residents, promoting independence and enrichment, and the associated risks considered. There was a dementia-friendly environment with appropriate use of décor and orientation signage throughout. The home had completed the Dementia Friendly Care Home Guide, as required as part of their contract. The premises was secure with corridors and doorways free from obstruction. Equipment was seen to be in good condition and appropriate servicing certification noted to be in date and on file. Safeguarding information was displayed within the home and contained contact details for the regional Local Authorities.

There was a 'managers monthly audit' file in place which contained an index outlining the area of audit and frequency; the audits covered several areas and were seen to be done at the required frequency, or more often. The home's maintenance, domestic and kitchen audits were completed using Acticare books which contained a section for completion by the manager to evidence oversight; however, the provider had developed a separate, more in-depth, audit of these which were completed monthly. The audits reviewed appeared mostly to have been conducted robustly, with areas of improvement identified and recorded, along with follow-up actions such as repair work or staff supervisions recorded, though the 'weekly' tasks in the domestic and kitchen books did not appear to be completed on a weekly basis and this had not been identified. Discussion with staff informed that these tasks were being undertaken at intervals set by the home rather than following the template of the book, and recommendation was given to review this to ensure that the recording template reflected the planned schedules.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address minor areas identified for improvement to ensure full compliance which will be monitored by the Quality Assurance and Compliance (QuAC) Officer.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

The provider is responsive to requests from the Local Authority and liaises closely with their QuAC Officer. Performance Dashboard submissions are made in a timely manner, and queries

are responded to promptly. There have been some recent changes in management, and the QuAC and Transformation Manager are supporting with this.
Engagement and Support from Transformation Managers
The care home engages with the Transformation Team across a number of initiatives. Although the current acting manager has not participated in the Well Led Programme, the care home has collectively engaged with a number of other opportunities over the last year, including the Activity Co-ordinator Network and training. The care home brings residents into the community for events hosted by Stockton-on-Tees Borough Council and other care homes in the Borough. The Transformation Team will link in with the care home managers to discuss leadership development opportunities and peer support networking to ensure ongoing consistency in practices across the service.

Current CQC Assessment - Date / Overall Rating	**04/07/2023**	**Good**

Provider Name	**Teesside Healthcare Limited**	
Service Name	**Churchview Nursing and Residential Home**	
Category of Care	**Nursing / Dementia Nursing / Residential**	
Address	Thompson Street, Stockton-on-Tees TS18 2NY	
Ward	**Stockton Town Centre**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Requires Improvement**	**Good**
Involvement & Information	**Requires Improvement**	**Good**
Personalised Care / Support	**Requires Improvement**	**Good**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**8th – 10th September 2025**	
Date Assessment Published	**23rd September 2025**	
Date Previous Assessment Published	**27th January 2025**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans contained information on how the individuals wanted to receive their care which evidenced their involvement in care planning, and this was reflected in daily notes. The online care planning system had two sections to gather life history and detail on what was important to the individual, 'who I am' and 'about me', which were often lacking in detail or incomplete. This was identified during the last assessment and improvements made had not been sustained. Assessments were seen to contain conflicting information, and information was not always transposed into care plans appropriately (for example, several medical diagnoses were noted to have been captured in some assessments but not others). Daily notes were mostly seen to be of good standard, with detailed food and fluid records, and professional visits / escalation of concerns to professionals recorded.

The audit trail on the online care planning system showed that monthly reviews were being recorded, however, the review notes here were often copy and pasted from previous reviews, with the document itself not appearing to have been reviewed (for example, not updated with change in need, or errors not identified and corrected). There were also occasions whereby the review note contained information that should have been added into the care plan itself. Again, this was identified during the last assessment and improvements not sustained. A key worker system was in place but not being utilised effectively as residents and relatives were often unaware of who their allocated workers were.

Safe care delivery was observed, and those spoken with reported feeling safe and well cared for in the home. There were no reports of involvement in safeguarding concerns, but all spoken with reported feeling able to raise any concerns with staff / management should they need to. Observation and discussion confirmed that residents were treated with dignity and respect, and their privacy was maintained. Choice was seen to be offered and decisions respected, with gentle guidance / encouragement if needed. An activities schedule was displayed, and activities were observed such as 1:1 activities, quizzes, outings, and pet therapy with the resident rabbit.

Appropriate food hygiene practices were observed and a Food Standards Agency inspection done in June 2024 was rated 5 - 'very good'. Residents and relatives confirmed there was access to food and drink outside of mealtimes.

Staff files were mostly seen to contain the required checks and paperwork (for example, a photograph of the individual, right to work checks and references, which were both noted to have been signed and dated to confirm the original document had been seen or the reference verified by phone). Some minor amendments to the process were made during the assessment as a result of feedback given. Staff supervisions and appraisals were seen to be conducted at the intervals set out within the contract.

Medication rooms and trollies were clean and tidy, and storage was seen mostly to be safe and appropriate. Controlled drugs were stored appropriately, and records were seen to be completed, with only a small number of instances whereby a second signature was missing. Overall, medicines were being safely stored and administered, with appropriate records in place. Medication competencies were carried out six-monthly, in line with contract. A monthly medication audit was being conducted using the NECS Medicine Optimisation Teams' template, all of which scored above the 85% threshold set by Meds Ops. Their most recent audit in August was undertaken by the Meds Op Team themselves and was scored at 89%.

The premises was noted to be secure with entry / exit via keypad and doors appropriately locked. Fire escapes and corridors were free from obstruction and staff were identifiable by uniform and some wore identification badges. The home had completed the Dementia Friendly Care Home Guide (as per contract) and had a dementia-friendly environment, but continues to work to improve this. Equipment was seen to be in good condition and appropriate servicing certification noted to be in date and on file.

The homes maintenance, domestic and kitchen audits were completed using Acticare books which contain a section for completion by the manager to evidence oversight; this is completed alongside a separate, more in-depth, monthly audit of each book which had been devised by the provider, as well as several other regular audits.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan for all areas identified that require improvement. The QuAC Officer will monitor progress against this to ensure the expected standard has been achieved. It is noted that improvements made following the assessment in December 2024 have not been adequately sustained, and there will therefore be an additional focus on these areas and the provider will be required to evidence a plan for sustained improvement and oversight of the same.

Level of Quality Assurance & Contract Compliance Monitoring

Level 1 – No Concerns / Minor Concerns (Standard Monitoring)

Level of Engagement with the Authority

There have been further managerial changes within the home which are being supported by the Operational Director and ongoing oversight of this by the QuAC Team. Despite the changes in management, engagement continues to be positive, with timely submissions of information such as monthly performance dashboards.

Engagement and Support from Transformation Managers		
The care home engages with the Transformation Team across a number of initiatives including the Activity Co-ordinator Network and training, such as meds optimisation. The care home brings residents into the community for events and engages with local activities. The Transformation Team will continue to engage with the care home to promote other opportunities, such as leadership development, networking and research projects.		
Current CQC Assessment - Date / Overall Rating	**23/04/2025**	**Good**