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

QUARTER 1 2024-2025

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 April and June 2024 (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, **1** inspection result was 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:

- 0 Adult Services were reported on
- 1 Primary Medical Care Service was reported on (1 rated 'Good')
- 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 **5** reports published between April and June 2024 (inclusive), the overall outcomes of which can be summarised as follows:

- 1 rated ‘Excellent’
- 1 rated ‘Good’
- 3 rated ‘Requires Improvement’

APPENDIX 1

ADULT SERVICES

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

None

PRIMARY MEDICAL CARE SERVICES

Provider Name	**Elm Tree Medical Centre**	
Service Name	**Elm Tree Medical Centre**	
Category of Care	**Doctors / GPs**	
Address	22B Westbury Street, Thornaby, Stockton-on-Tees TS17 6PG	
Ward	**Mandale & Victoria**	
CQC link	https://www.cqc.org.uk/location/1-5154227410/reports/AP1984/overall	
	New CQC Rating	**Previous CQC Rating**
Overall	**Good**	**Good**
Safe	**Not inspected**	**Good**
Effective	**Not inspected**	**Good**
Caring	**Not inspected**	**Good**
Responsive	**Good**	**Good**
Well-Led	**Not inspected**	**Good**
Date of Inspection	**5th March 2024** (focused inspection)	
Date Report Published	**9th April 2024**	
Date Previously Rated Report Published	**13th August 2019**	

Further Information

The CQC carried out an announced assessment of one quality statement, 'equity of access', under the key question 'Responsive' at Elm Tree Medical Centre on the 5 March 2024. It carried out the assessment as part of its work to understand how practices are working to try to meet peoples demands for access and to better understand the experiences of people who use services and providers.

The CQC recognise the work that GP practices have been engaged in to continue to provide safe, quality care to the people they serve. It knows staff are carrying this out whilst the demand for general practice remains exceptionally high, with more appointments being provided than ever. However, in this challenging context, access to general practice remains a concern for people. The CQCs strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. The assessment of the quality statement 'equity of access' includes looking at what practices are doing innovatively to improve patient access to primary care and sharing this information to drive improvement.

Overall, the practice is rated as 'good' and the key question 'responsive' continues to be rated as providing a good service. The CQC found that the practice organised services to meet patients' needs, particularly those who were most likely to have difficulty accessing care. People can access care, treatment, and support when they need it, in a timely manner, and in a way that works for them. The practice seeks out and uses feedback, data, and other information to monitor and improve access. Feedback and data demonstrated peoples experience for access at this practice was very positive.

HOSPITAL AND COMMUNITY HEALTH SERVICES
(including mental health care)

None

APPENDIX 2

PAMMS ASSESSMENT REPORTS

(for Adult Services commissioned by the Council)

Provider Name	**Dale Care Limited**	
Service Name	**Dale Care – Stockton Home Care**	
Category of Care	**Care at Home**	
Address	Concorde House, Concorde Way, Concorde Business Centre, Preston Farm Industrial Estate, Stockton-on-Tees TS18 3RB	
Ward	**n/a**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Requires Improvement**	**Good**
Involvement & Information	**Good**	**Good**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Requires Improvement**	**Good**
Suitability of Staffing	**Requires Improvement**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**26th February 2024**	
Date Assessment Published	**10th April 2024**	
Date Previous Assessment Published	**8th July 2021**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Service-users were seen to be treated with respect and individuality. Staff were respectful and compassionate when interacting with service-users, and offered them choice over their care delivery. All staff gave examples of how to respect the privacy and dignity of their service-users, closing the curtains and covering areas of the body during personal care. Staff fully understood the importance of soliciting the wishes of the service-user and ensuring their requests are adhered to.

Staff spoken with knew that the Mental Capacity Act is in place to protect service-users who may be unable to make all decisions for themselves. They understood the importance of giving the service-user choice whenever possible and when a best interest decision would be made on their behalf. On observation, it was evident that staff were familiar with service-user's preferences and when to request verbal consent versus when to take implied consent. Service-users appeared happy with the way their care was delivered.

The care plan template prompts gathering of information such as 'what makes a good day for me' and 'my goal setting', as well as details around the support required to maintain activities of daily living including how to deliver this to maintain independence. Detail is also recorded regarding diagnosed medical conditions and the impact that the symptoms have on the individual; there is also a section which details 'trigger points to alert to potential changes' – this

includes a list of common symptoms to look out for and advises / prompts staff to escalate concerns.

Staff spoken with confirmed that they received regular training on infection control. One staff member explained the importance of changing PPE between each care intervention. However, correct infection control procedures were not always evidenced during observational visits. Observation showed that appropriate hand hygiene was not being followed during medication administration; staff wore gloves to administer and did not change gloves at the required times.

Staff spoken with said they felt confident administering medication; practical training and regular competencies ensure that staff are fully aware of the procedure. Staff were aware of the difference between prompt, assist and administering medication, and could explain the process they would follow for PRN medication. Care plans record what level of support the individual requires with their medication, including ordering and collection from the pharmacy – however, detail was not recorded of how they like to take their medications (for example, with water, one tablet at a time). There were no covert plans required.

Recruitment files were viewed for four staff, including a recent recruit and staff who had worked for the service for a longer period. Application forms with a full employment history were held on file together with interview notes. All files evidenced that the provider had checked the employee has the right to work in the UK; this was identified by a copy of the individual's passport or birth certificate. Other forms of ID are also held on files in the form of driving license and utility bills. DBS checks had been carried out and the results obtained before induction commenced. A signed contract was held on each file; however, there were no copies of the job description.

Observation and discussion with staff highlighted that travel time between calls was not included in the rota, resulting in calls shorter than planned for the service-users. Rotas of additional call rounds were requested at the office, and these also had no travel time factored into the day. This was discussed with the manager who will look into rectifying this as it is a contractual obligation, and this will be monitored via compliance visits.

Staff spoken with could recall having a recent supervision but were unsure how often they meetings took place. None of the staff could recall having an annual appraisal and one was unsure of the difference between a supervision and an appraisal. There was a lack of evidence in the staff files to support that regular 1:1 supervisions and an annual appraisal were taking place.

Audits are carried out on care plans, MAR sheets, call logs and notes. Any required actions are noted and followed-up by office staff. Management carries out visits to the service-users' homes to observe and record the quality of service delivery. Audits have clear robust criteria to ensure consistency throughout the service.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan to address the areas identified as requiring improvement; progress will be monitored and validated by the QuAC during contractual meetings.

Level of Quality Assurance & Contract Compliance Monitoring

Level 2 – Moderate Concerns (Supportive Monitoring)

Level of Engagement with the Authority		
Dale Care went through a period of limited engagement, but in recent months, they have been engaging well with the Transformation Team. They attended one-to-one engagement regarding the Care at Home tender but not the wider network engagement. Dale Care management are now regular attendees at Provider Forums and the Leadership and Peer Support Network. They have engaged well with the technology in Care at Home promotion and have taken part in focused work around recruitment and sector skills development alongside TVCA. The new manager of the service is proactive and engages well with general initiatives and communications from the team.		
Current CQC Assessment - Date / Overall Rating	**15/04/2023**	**Good**

Provider Name	**Families First (North East)**	
Service Name	**Lorne House**	
Category of Care	**Learning Disabilities**	
Address	66 Yarm Road, Stockton-on-Tees TS18 3PQ	
Ward	**Ropner**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Requires Improvement**	**Good**
Involvement & Information	**Requires Improvement**	**Requires Improvement**
Personalised Care / Support	**Good**	**Good**
Safeguarding & Safety	**Requires Improvement**	**Good**
Suitability of Staffing	**Requires Improvement**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**19th & 20th February 2024**	
Date Assessment Published	**23rd April 2024**	
Date Previous Assessment Published	**3rd April 2019**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans were all electronic. They contained appropriate details to the individual and were reflective of residents' needs, preferences, abilities for independence, and life history. The electronic system was not always used correctly, and this led to some inconsistencies across care plans and some incorrectly recorded information. Pictures were included, though not dated. Quality of monthly reviews was not consistent across all files viewed, with some containing generic responses repeated every month. Care plans were signed on the residents' behalf and recorded justly, though there was no evidence of involvement of resident families.

No mental capacity assessments were seen in care plans. DoLS were in place for all residents. Staff had a good understanding of the MCA and were able to talk around the principles and how the MCA links to DoLS. Staff gave good examples of how to respect the privacy, dignity, and wishes of residents in differing scenarios. Staff spoke of how they support residents to complete tasks for themselves and with making choices.

Interactions observed around the home were positive. There was limited observation of staff asking how residents like things to be done, though it was noted that both resident and staff have been in the home for many years and had good relationships and familiarity built. Staff had a very good understanding of all resident needs and gave clear instructions of certain behaviours that may present, what they mean, and the response the individual is looking for. Staff always spoke calmly and politely, and consent was always sought. Residents all appeared to be relaxed, comfortable, and secure in the home. Staff were confident in explaining safeguarding procedures and knowing signs to look out for. In general, the home followed good safety practices and followed correct infection control protocols. The home is currently undergoing refurbishment; this is taking place a room at a time to limit disruption. The home was generally clean and tidy, though tired in some places and showing signs of building age. There were several fixtures and fittings seen to be damaged or broken across bathrooms, the kitchen, and in corridors. Windows on the front of the building, and on higher floors, were missing safety restrictors.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medicines Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. The report acknowledged improvements made since the previous assessment. Medications were found to be handled safely and stored securely. Medications ready for disposal are stored away from others. The controlled drugs count was correct at 0. Administration was scored as partially met; feedback was given to the home around the correct hand hygiene procedures and the appropriate use of gloves. The report and assessment both found no cross-referencing between labels and the device, multiple gaps on EMARs, or medications being recorded at incorrect times of day. Current audits in place in the home did not identify the gaps found in the EMARs.

Recruitment checks and staff files are in place, however, require some improvements to be more robust. Not all staff files had two verified references or a copy of their job description, though all files had a signed contract and fully completed inductions. Supervisions were not always completed regularly or on time. The visiting chiropodist had out-of-date paperwork including DBS and insurance – this was raised with the manager to be rectified as a priority. There was always plenty of staff visible throughout the home, and rotas were scheduled well with appropriate coverage of supervisors.

Team meetings had not regularly been occurring at the time of assessment, though a schedule had begun to be put in place. Staff spoken with confirmed that the home was a positive place to work, and they felt confident raising concerns with management should they need to. Resident and family surveys were viewed, and feedback again was positive. Review of the complaints file showed no complaints had been received in the last six years. The home employs an external company to complete thorough audits, and this was at 100% compliance at time of assessment.

Plans and Actions to Address Concerns and Improve Quality and Compliance

An Action Plan has been created by the provider to address the identified areas for improvement. The QuAC Officer will monitor and review the evidence for compliance through contractual visits.

Engagement with the Transformation Team has been limited. The Registered Manager cited that he felt support has been more focused on older persons services, but a recent invite to the newly established Learning Disability network has been declined. One-to-one support has not been previously provided but a visit has been arranged for week commencing 13th May to establish the needs of the service and future support from the Transformation Team.

Level of Quality Assurance & Contract Compliance Monitoring

Level 2 – Moderate Concerns (Supportive Monitoring)

Level of Engagement with the Authority

The Registered Manager has attended some Provider Forums and occasional Leadership and Peer Support Networks. Lorne House is not engaged in the Activity Coordinators Network, and the manager has not completed the Well-Led Programme. Lorne House have not engaged with wider training offers across the network.

Current CQC Assessment - Date / Overall Rating	**03/11/2022**	**Good**

Provider Name	**Real Life Options**	
Service Name	**Real Life Options – Darlington Road**	
Category of Care	**Residential Home – Learning Disability**	
Address	54 Darlington Road, Hartburn, Stockton-on-Tees TS18 5EW	
Ward	**Hartburn**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Excellent**	**n/a**
Involvement & Information	**Good**	**n/a**
Personalised Care / Support	**Excellent**	**n/a**
Safeguarding & Safety	**Excellent**	**n/a**
Suitability of Staffing	**Good**	**n/a**
Quality of Management	**Good**	**n/a**
Date of Inspection	**15th April 2024**	
Date Assessment Published	**13th May 2024**	
Date Previous Assessment Published	**n/a**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans and risk assessments were very well written and included highly detailed knowledge of residents. Each plan was individualised and person-centred, and there was a comprehensive range of support plans to cover all aspects of care needs. Care plan reviews were seen to take place regularly and evidenced that the residents and their families had been included.

Care plans were reflective of resident's specific needs and abilities, and how to support them to be independent. In addition to support plans, the home has begun to create learning videos for staff which are specific to individual resident needs, abilities, and behaviours, to educate staff in supporting residents to become more independent.

Residents appeared to be relaxed and secure, and feedback from family was very positive, speaking highly of the staff and the organisation. Families confirmed they were kept well informed and involved. Observations of interactions around the home demonstrated good relationships, staff were seen to speak in a friendly manner and always asked for consent to complete tasks and continuously engaged throughout.

Staff knowledge of the MCA was good. Staff had good knowledge of DoLS and the specifics of residents with restrictions. Staff confirmed they have regular training around MCA and safeguarding, and are confident with their policies and practices as these are tested regularly as part of team meetings.

Team meetings occur regularly, and staff are given the opportunity to raise topics or concerns in advance. Staff have regular supervisions and one-to-one meetings. Staff spoke of having a positive work environment and supportive management.

The environment was well kept with a homely feel. Communal areas were laid out with consideration to the different needs of the residents. Bedrooms were highly personalised and were seen to have toys and activities, sensory equipment, and decorations chosen by the

resident. Good practices were followed in relation to infection control and food hygiene. Externally, the premises are safe, secure, and managed appropriately. The home is up-to-date with the relevant safety certification, servicing, and maintenance. The manager has a range of audits in place which feed into an overarching Action Plan.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medicines Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. The home scored 83.5% for their medication optimisation assurance audit. There was good practice seen of front covers, which were of a high standard. Protocols contained detailed resident information. No gaps or missed medications were found in MARs. Observations evidence staff following recommendations made by the Medicines Optimisation Team and followed appropriate PPE usage. Medications are stored safely, temperatures are taken twice daily, and two staff sign off all medications administered.

Plans and Actions to Address Concerns and Improve Quality and Compliance

No areas were identified for improvement to ensure full compliance.

Level of Quality Assurance & Contract Compliance Monitoring

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

Level of Engagement with the Authority

Since 2021, management from RLO services have participated in the Well-Led Programme, and subsequently continued to engage with initiatives and opportunities presented to them by the Transformation Team.

Darlington Road engage with peers from across other Stockton-on-Tees homes, including fellow LD homes, as well as OP homes, to learn from others, and hear and share good practice. They also routinely attend the Provider Forums, and engage with the Activity Coordinator Network, which brings together Activity Coordinators and Wellbeing staff, to understand how to develop innovative or meaningful activities.

Darlington Road maintain regular contact with the Transformation Team, giving us opportunities to visit their services and interact with the people that use their services, as well as their wider staff teams.

Current CQC Assessment - Date / Overall Rating	**24/02/2023**	**Good**

Provider Name	**Willow View Care Limited**	
Service Name	**Willow View Care Home**	
Category of Care	**Residential / Residential Dementia**	
Address	1 Norton Court, Norton Road, Stockton-on-Tees TS20 2BL	
Ward	**Norton South**	
	New PAMMS Rating	**Previous PAMMS Rating**
Overall Rating	**Requires Improvement**	**Requires Improvement**
Involvement & Information	**Requires Improvement**	**Requires Improvement**
Personalised Care / Support	**Requires Improvement**	**Requires Improvement**
Safeguarding & Safety	**Requires Improvement**	**Requires Improvement**
Suitability of Staffing	**Good**	**Good**
Quality of Management	**Poor**	**Good**
Date of Inspection	**8th – 12th April 2024**	
Date Assessment Published	**29th May 2024**	
Date Previous Assessment Published	**19th December 2022**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

The home moved to an electronic care planning system (PCS - Person Centred Software) in October 2023, however, the system was not being utilised fully. Care plans lacked person-centred information and several errors and inconsistencies were seen, some of which posed potential risk to the resident such as incorrect IDDSI levels and information around mental capacity / DoLS. The PCS system identified several instances whereby 'must do' care tasks had not been delivered. Daily notes lacked detail to reflect the care delivered and it appears that not all care delivery is being recorded; some notes relating to activities were poor and included routine personal care tasks such as grooming. Food records were poor with little to no quantifiable data recorded; generic statements were used and did not record what food had been offered / consumed and regularly lacked information on portion size. Monthly weights are recorded for all residents and MUST scores calculated alongside this. Whilst staff demonstrated knowledge of residents and their needs associated with medication administration (for example, how they like to take their medication and where), care plans lacked this detail.

The audit trail within the PCS system evidenced that reviews were being completed monthly, however, on review of the audit documents there were errors noted that had been present throughout several reviews and had not been highlighted, evidencing that whilst review is being recorded as completed, an adequate review is not taking place. Where changes in need had been identified, it was not seen to be reflected consistently across related plans.

Information available to residents was not always up-to-date, accurate or available in appropriately accessible formats. Care plans did not evidence that residents were involved in their care and support planning. A key worker system has recently been introduced with evidence available to confirm that residents have been consulted about their allocated workers.

Handling of medication was assessed during the PAMMS assessment, and the NECS Medicines Optimisation Team undertook an assurance visit on 29 April 2024. The overall score of this assurance visit was 80.5%, and the provider was noted to have rectified some concerns raised

at the time of the PAMMS. Medication was stored securely and appropriately; the room was clean and tidy and medicines for disposal were stored correctly. The medication round was conducted in a person-centred manner, with excellent rapport observed; not all time sensitive medications were administered in line with instructions. Fridge and medication room temperatures are scheduled to be recorded twice daily, however, the room temperature was recorded as the air-conditioning setting rather than the ambient temperature. There were also numerous occasions when temperatures had not been taken or recorded. This has previously been identified on external audits. Covert medication was seen to be noted in the resident's care plan and instructions are included on the medication labels, however, no covert plan was found to be in place at the time of the PAMMS. Whilst this was implemented prior to the meds assurance audit, more than one external audit had identified this as an issue. Not all PRN and variable dose medicine had a protocol in place and the quality of PRN protocols was inconsistent; some contained good person-centred detail while others lacked the required information to allow staff to make informed decisions on administration. This is an area of improvement that has been identified on several external audits. Medication competencies are being conducted annually, however, the SBC contract states they must be completed six-monthly.

An up-to-date business continuity plan was in place, the contents of which were appropriate. Emergency grab bags were in place. These held the required contents and included a folder for each unit's individual PEEPs. PEEPs were seen to contain the required detail for residents. A copy of a detailed fire evacuation plan was stored in the grab bag, however, this had not been reviewed since November 2022; a recent external audit identified this requiring attention.

Staff spoken with at the time of the assessment demonstrated the appropriate skills and knowledge to conduct their role. They confirmed receipt of mandatory training and were able to discuss topics such as safeguarding, mental capacity and infection control with confidence. All staff, with the exception of two new starters, have completed 100% of the mandatory training courses, however, the SBC contract stipulates that staff must undertake the Care Certificate (Skills for Care) within 12 weeks of employment and the provider reports zero staff have done so. Recruitment records were seen to be in place and appropriate, as were agency staff profiles / checks.

Visiting professionals spoke positively of the engagement and co-operation from the provider. Care and support plans contained the contact details for involved professionals, including specialist services such as neurologists.

Residents and relatives spoken with during the assessment spoke highly of the care and support received at Willow View with little negative to comment upon. The atmosphere in the home was a positive one and observation of staff interaction with residents was also positive and respectful. Residents spoken with were aware of how to make a complaint and reported feeling comfortable to do so if necessary.

Staff also reported an improvement in the working environment in recent months and felt supported by the current manager. Responses in relation to regular supervisions, appraisals and staff meetings were inconsistent, with some staff reporting these do take place, and others not. Records confirmed that supervisions and appraisals have not been taking place in the timeframes set out in the SBC contract and regular staff / resident / relative meetings are not taking place.

PPE was readily available throughout the home and staff were, for the most part, seen to use this appropriately. External audits of the environment are noted to have identified actions such as damaged kitchen worktops and paintwork which prevented adequate cleaning; however, it was found that these had not been addressed. Internal audits of the environment were taking place but were not identifying issues, including those outstanding from previous external audits,

and therefore are not being completed robustly. A walkaround of the internal and external areas of the premises was undertaken on day one of the assessment and it was found that several areas required attention to achieve appropriate standards of cleanliness; many were identified as actions in previous audits.

Doorways, walkways, and fire escapes were free from hazard and blockage; there were exit points to the garden of the home which were not locked and the external of the property required some attention to be made safe, such as broken garden furniture. The home has appropriate lighting and room signage was seen throughout. Some work is required to the dementia unit to provide a dementia friendly environment. When asked for non-person specific risk assessments, the manager advised they were unsure if these existed; the following morning some were provided for review. These assessments were found to be generic and required further detail.

Residents, relatives, and staff surveys were circulated in January 2024; the results of these surveys have not yet been analysed. There was no evidence of the survey responses having been reviewed, with one resident expressing low mood and no follow-up action recorded. An accidents and incidents file is held in the manager's office and contains detailed information and evidenced analysis for trends and post-accident / incident monitoring. The complaints procedure, which includes contact details for the manager, NI, SBC and CQC was displayed in several areas throughout the home, as was safeguarding and whistleblowing procedures. A complaints / compliments file was in place which, on review, evidenced complaints were not handled in line with the providers internal complaints policy. There was no evidence of lessons learnt or evidence of service improvements as a result. There were several recent compliments on file. Paper-based data such as staff files was stored in lockable cabinets, however, these cabinets were often unlocked, and offices were frequently left unmanned with entry doors also unlocked.

The manager completes a range of appropriate audits, covering care delivery, staff and the suitability of the premises and equipment; however, the completion of these audits has not been consistent and those completed were not of a standard to identify issues or trends. The audits were also not completed at the frequency set by the provider themselves.

Plans and Actions to Address Concerns and Improve Quality and Compliance

The provider will complete an Action Plan and progress against this will be closely monitored by the Quality Assurance & Compliance (QuAC) Officer. The provider continues to be subject to RASC proceedings and any actions instructed by the Chair of the RASC committee will be undertaken.

CQC plan to reinspect six months from their last inspection (January 2024).

Level of Quality Assurance & Contract Compliance Monitoring

Level 3 – Major Concerns (Enhanced Monitoring)

Level of Engagement with the Authority

Transformation Team: Support from the Transformation Team has been offered to each manager in post over the last year through one-to-one support visits, training, and wider networks. Several of these opportunities were available prior to the current manager returning to the home and attendance in 2023 was good. The current manager and wider staff team at Willow View have always been welcoming and have engaged well with the Team.

None of the recent managers at the home had completed the Well-Led Programme and there has been no attendance from the provider at any of the Leadership and Peer Support Networks

held between April 23-24. Recommendation has been made for the current manager to attend the Well-Led Programme (commencing in Autumn 2024).

Dementia Initiatives: The Dementia Friends accreditation and Dementia Care Home guide have been started / restarted with previous managers, but little progress made. Recommendation has been given to complete this and a further appointment has been made to begin this in June 2024.

NEWS: Compliance with NEWS recording has been variable over the last year, with the lowest recorded % NEWS by bed occupancy being 31% and highest 140%, giving an overall annual average of 92%.

Safeguarding: The provider continues to engage well with the safeguarding team and any enquiries being made. There are currently two safeguarding concerns open for section 42 enquiry.

QuAC Officer: The provider communicates regularly with the QuAC Officer who continues to make weekly visits to the home as instructed by the RASC committee to monitor progress against improvement Action Plans.

Current CQC Assessment - Date / Overall Rating	**22/03/2024**	**Requires Improvement**

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	**Good**	**Good**
Personalised Care / Support	**Good**	**Requires Improvement**
Safeguarding & Safety	**Good**	**Good**
Suitability of Staffing	**Excellent**	**Good**
Quality of Management	**Good**	**Good**
Date of Inspection	**10th – 12th June 2024**	
Date Assessment Published	**26th June 2024**	
Date Previous Assessment Published	**1st February 2023**	

PAMMS Assessment Summary (Positive Outcomes / Observations and Concerns)

Care plans overall were well written. There was evidence of in-depth details of resident likes, dislikes and preferences. Good detail was given on specific needs, level of independence, and behavioural triggers. A small area of improvement was identified around resident involvement in care planning; no resident or families spoken with could confirm their involvement in regular reviews. Care plans and risk assessments were reviewed regularly, and there was also evidence of these being updated timely where additional changes were necessary.

There was excellent evidence of an effective key worker system and the provider was able to evidence how resident, families and staff play a role in deciding key workers. All residents have a care staff keyworker allocated, though additional keyworkers of any staffing level are considered, and this is based on relationships, abilities to communicate effectively, and staff with the most positive behavioural impact.

The home was well-kept, with good cleaning practices in place, and new flooring recently fitted throughout. Dementia-appropriate signage was used throughout, including pictorial paperwork, menus and activity boards. Bedrooms had been personalised with items from home. Interactions around the home demonstrated a welcoming environment in which residents were familiar with all staff and were able to laugh and joke. Residents and families all spoke very highly of the home and the staff; they spoke of how they felt respected and are given their own choice and independence.

During this assessment, the medication elements of the PAMMS inspection were assessed alongside the NECS Medicines Optimisation Team and were scored in mutual agreement with the Quality Assurance and Compliance (QuAC) Officer whilst considering the observations and findings. Medications were found to be stored securely in a locked medications room and disposed of safely. The medication observation was graded as ‘met’ in the Med Ops report. Good hand hygiene was observed, good interactions with the resident, and administration was in a safe and person-centred manner. MAR charts had some suggested improvements, including

recording the cautionary and advisory information, clear recording of medication changes to include prescriber details, and consistent recording of non-administration. The majority of administered PRNs has not been recorded appropriately. All MAR charts had clear directions, discontinued medications were clearly identifiable, and no missed signatures were found. A robust ordering and stock-checking process is in place. Audits are completed monthly and competencies are in line with contract requirements.

Staffing levels are good and there was a good level of staffing visibility around the home, including carers, domestics, maintenance and management. There is a comprehensive induction and probation structure in place for new staff, which included use of the Care Certificate. Staff are appropriately trained; training is monitored and RAG-rated by management, with 98% 'green'. Staff were able to confidently describe the MCA principles and DoLS without prompting and give examples of how this is put into practice. Supervisions and appraisals are carried out regularly and timely. A range of robust internal audits take place regularly, and these were evidenced with good managerial oversight.

Residents are encouraged to be a part of the community both inside and outside the home. There was ample evidence of many social activities taking place, including social clubs, parties, days out, fitness classes, and visits from the local sixth form. The Activities Co-ordinator has also set up residents as pen-pals with a Care Home located in the south of the country. There was evidence of support in maintaining relationships with family and friends. Families were keen to provide feedback to contribute to the assessment and those spoken with were happy with the care residents received, and how safe and cared for their family member felt.

Plans and Actions to Address Concerns and Improve Quality and Compliance

A small, one point Action Plan has commenced by the provider to address the one area of improvement found around including residents in care planning more effectively. This will be monitored by the 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. Staff engage well with forums, initiatives, and training that is offered.

Engagement and Support from Transformation Managers

Ayresome Court have a very good relationship with the Transformation Team. They engage with Provider Forums and, where possible, Leadership and Peer Support networks. They have taken part in training and initiatives from the Team including Mental Capacity Act and Dols Training, and Meds optimisation training. Areas of note include:

Well Led Programme: The manager participated in the Well Led Programme 2023/24, completing every session and taking part in the celebration event.

Activities: Since the new Activity Co-ordinator joined the service, she has engaged with all the Activity Co-ordinator network meetings, learning from peers, attends workshops, and brings residents out of the home to participate in community activities.

Research: The home has started to support research in care homes and joined the Enabling Research in Care Homes (ENRiCH) network. Alongside the Transformation Team and another

Stockton-on-Tees care home, Ayresome Court participated in a study called '*experiences of living in residential care for older people*', through My Home Life, and University of London.		
Current CQC Assessment - Date / Overall Rating	**26/02/2020**	**Good**