CQC review of Castlebeck Group Services

Overview of the provider

The Castlebeck Group comprises Castlebeck Care (Teesdale) Ltd, Mental Health Care UK Ltd (MHC) and Young Foundations & Fostering. The group has 11 independent mental health hospitals and 12 adult social care facilities registered with the Care Quality Commission

The company is a subsidiary of Castle Holdings Limited.

Summary of recent activity within the Castlebeck Group

CQC has reviewed and inspected all the services for people with learning disabilities provided by the Castlebeck Group at its 24 locations in England. One of these, Winterbourne View closed following CQC regulatory action. The reports for each location detail the individual issues we found during the course of our inspections.

Our current overall judgement

Of the 23 locations inspected (in addition to Winterbourne View) 11 services were judged by inspectors to be non-compliant with the essential standards of quality and safety.

These inspections have revealed some serious concerns across Castlebeck's services for people with learning disabilities. We informed the managers of specific areas of concern we found through feedback on the day of the inspections. In addition we have produced a report for each location reviewed, where the outcomes for people accommodated is detailed in relation to compliance with the Health and Social Act 2008 and associated regulations. We have discussed these with Castlebeck and we are taking a range of actions to address these problems.

Why we carried out this review

This was a responsive review across the provider based on safeguarding concerns

How we carried out this review

The inspections focussed on safeguarding and the care and welfare of the people who use the services provided. We visited every location. We reviewed all the information we hold about this provider, observed how people were being cared for, looked at records of people who use services, talked to staff, relatives and people who use services.

What people told us

Within Castlebeck's services, 11 are Independent Hospitals and many of the patients who are receiving treatment are detained under the Mental Health Act 1983 and placed out of area, therefore they may not have chosen to receive treatment within the hospital.

Many of the patients and people who use Castlebeck services have complex needs, but welcomed the opportunity to discuss their experiences of the care and treatment they have received, where they were able to comment. Some of the feedback was positive in nature, patients and people who use services said that they enjoyed living in the hospital/care home. Observation identified that there were good interactions between staff and patients or people who use the services.

However there were also comments made to the Inspectors that not all patients or people who use the services enjoyed living within the services and observation of staff interactions were not always positive. Patients within the hospital settings in particular identified that the regimes could be very restrictive and that sometimes there were not enough staff on duty.

Corporate level findings

Our inspections revealed system failings in the majority of the locations, which include the following areas:

- Lack of training for staff
- Inadequate staffing levels
- Poor supervision of staff
- Poor care planning
- Failure to respond to and learn from serious incidents
- Failure to notify relevant authorities of safeguarding incidents
- Failure to involve people in decisions about their own care.

Themes

We have identified the following key themes that we are particularly concerned about and where significant concerns have been raised by these inspections..

Care and welfare of patients and people who use the services

We identified that there are poor and outdated practices being carried out within the hospitals and care homes. Examples include:

- the restrictive practice of routinely locking bedroom and other doors within the Independent Hospitals without a clear and specific rationale for doing this
- the use of an ‘incentive’ programme across the services. This programme was described to us by staff, patients and people who use services. Some staff, patients and people who use services felt that the incentive programme was used as a way to motivate the patients and people to reach specified treatment goals. However others felt that it was used to enforce boundaries and rules and was for the benefit of staff, rather than a system to improve care and treatment
- We found limited evidence that staff were working with patients to move them out of hospitals into community settings within a reasonable time frame
- we identified that Castlebeck does not follow national guidance in relation to the terminology as recommended in respect of Observation levels
- the use of drinks trolleys in services where there were rehabilitation kitchens
- staff banter not respecting the dignity of patients or people who use the services
- lack of access to independent advocacy services.
- patients and people who use services were not involved in care planning
- lack of personalised care planning and lack of risk assessments.

Safeguarding

- We identified that some people did not feel safe where they were living and there was inconsistent practice in safeguarding people.
- Support staff had not received training in Mental Capacity Act 2005 Deprivation of Liberty Safeguards.
- We noted failures to notify CQC of safeguarding issues reported to the local authorities as required by regulation.
- Safeguarding training was available but this did not always result in correct reporting of incidents across the services.
- Although permanent staff at the locations had received BILD accredited physical intervention training it was noted that on occasion agency staff without the correct training had been involved in restraints and that the required updates had not always been provided.
- The use of restraint seemed common practice throughout the locations with little or no evidence that this was used as a last resort.
- Many staff within Castlebeck services were not clear about the Mental Capacity Act and when it should be used.

Staffing

It was evident that consistency in the arrangements for staff supervision across the services is varied.

We identified that uptake of staff supervision is very poor. Records did not show that qualified nursing staff received clinical supervision in line with their regulatory body’s

standards. Access and uptake of staff appraisal was very varied across the organisation.

While in some services there appeared to high levels of support staff, there was no evidence that a care needs analysis tool had been used to determine staffing levels, including the number of qualified nursing staff required.

Many of the patients in the Independent Hospitals were detained under the Mental Health Act 1983 and would have required Section 17 leave. It was not clear that staffing levels had taken into account the individual risk assessments that should be undertaken to determine the number and grades of staff required to facilitate a period of agreed leave.

In some services, there was a high number of what was described to our inspectors as Red A observations. Observation is used both for the short-term management of disturbed/violent behaviour and also to prevent self-harm. It was not clear that levels of observations had been taken into account when determining staffing levels and grades of staff to provide the observations.

In some services it was evident that staffing levels dictated the activities that could be offered, so that for some only group activities could take place rather than activities based on an individual's assessed needs.

Length of shifts at Castlebeck services, meant that staff worked for at least 12 hours. However, in many cases staff were not able to take a break as they were covering observations or in some services were the only qualified nursing staff on duty.

Staff had received training in mandatory subjects; however support workers in particular identified that they needed further training in relation to the different needs of the people they were looking after. We felt that this was very important because in most services support workers provide direct care with minimal supervision.

Governance

Quality assurance systems nationally are inadequate. While there are local systems in place to monitor and assess the quality of service provision, it was not clear how changes are made in line with current guidance, local systems, and feedback from patients and people who use services to improve either service delivery or provision.

It was also not clear how the local systems feed into the corporate governance systems and conversely how feedback is received at local level when decisions are taken centrally to improve the quality of service provision and the rationale for those changes. There was no evidence that any evaluation took place corporately of any changes that had been implemented.

Staff understood that the organisation had to meet targets and audit deadlines, but there was no understanding about the purpose of these.

A number of registered managers have been moved around the organisation and are no longer working in the homes that they are registered to work in. We are concerned that the leadership arrangements for services are not adequate and that many of the services where significant concerns were raised are where there has been a lack of visible and tangible leadership by a registered manager who has the appropriate skills and qualifications.

Many of the issues identified above contribute to what we believe is a poor culture within the organisation. We identified that staff did not place importance in areas such as supervision, and did not therefore recognise the value of this to improve practice and the quality of service provision.

Poor practices as outlined earlier are as a result of the organisation failing to have adequate governance arrangements in place. Of specific concern was the comments from inspectors who reported that there was a lot of ‘staff banter’ with patients and people who use services. In addition there were reports that staff language was inappropriate and this was recorded in patients meetings/forums. It was concerning that staff did not appear to have identified the ‘boundaries’ of their roles and that banter with the patients or people who use services may not be appropriate given the nature of the relationships and the position of perceived power that staff may be in. What is clear is that this level of concern was not shared corporately via good governance systems.

Where inspectors identified concerns, measures were put in place to address the problems and to ensure the safety of people using services. Where we have had immediate concerns about people’s safety we have taken action and are working closely with both the provider itself and commissioners to ensure the safety and welfare of people using these services as a first priority.

A summary of findings for each service

Arden Vale

Arden Vale in Solihull is a 31 bed hospital providing care for people with a learning disability and challenging behaviour.

We inspected Arden Vale on 3, 13 and 14 June 2011. Concerns had been raised about the care of people living at Arden Vale by a former member of staff. We carried out this review because concerns had been identified in relation to respecting and involving people who use services, consent to care and treatment, the care and welfare of people who use services, safeguarding people who use services from abuse, and management of medicines.

We found that Arden Vale was not meeting one or more essential standards and that improvements were needed.

What we found

- People's communication needs were being assessed but effective action was not consistently being taken to meet those needs. This limited people's ability to understand the care and treatment choices available to them and to express their views about them. People's independence, privacy and dignity were restricted by staff control of bedroom and bathroom facilities, without a clear and specific individual rationale for doing this.

- People living at Arden Vale had restricted access to people who could help or support them with making an informed decision. Appropriate consent was not always obtained from people living at Arden Vale for their care and treatment. The wishes of people living at Arden Vale were not always respected. People living at Arden Vale could not be confident that their human rights would always be respected or taken into account.

- People living at Arden Vale did not experience effective safe and appropriate care, treatment and support that met their individual needs and protected their rights.

- People living at Arden Vale were not always adequately safeguarded from physical and emotional harm. In particular the provider of this service was not ensuring that restraint was always appropriate, reasonable, proportionate and justifiable to that individual.

- People were not fully protected against the risks associated with the unsafe use and management of medicines by means of making appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.

- The premises and grounds were not adequately secure in some instances. The premises were not accessible or safe and did not promote the well being

of people living there. Arden Vale should review its risk assessment in relation to possible ligature points, as people who use the service should be protected from harm at all times.

- Standard recruitment checks are in place but they do not meet the specialist needs of people living in the home.

- People did not have their needs met by sufficient numbers of staff at the times they need them. The long hours worked by staff may reduce the ability of staff to care for people safely at all times.

- Staff were not properly supported to provide the appropriate care and treatment to people living at Arden Vale. Staff had not received all the training required to undertake all aspects of their work well and safely. Supervision arrangements were inadequate. This created significant risks to people living at Arden Vale given the complexity of some people's needs the experience of some staff members and the closed nature of the environment.

- People did not benefit from a safe quality care or support due to poor management of issues and concerns raised. Castlebeck's quality assurance systems at the local and national level were not effective. People living at Arden Vale had experienced adverse outcomes as a consequence of this.

- Not everyone was aware of how to make a complaint. People living at Arden Vale could not be confident that their comments and complaints were listened to and acted upon effectively. The closed and controlling nature of the regime operated at Arden Vale and the communication difficulties experienced by some people limited their ability to express concerns and in the case of relatives and advocates, to identify concerns. Complaints procedures at Arden Vale did not adequately compensate for this.

- Records were not an accurate reflection of the care and treatment people were receiving. Other records in relation to the running of Arden Vale were not used effectively to ensure the health and well being of people was being met.

Action required

We have talked through the seriousness of our concerns with Castlebeck and a range of actions have been and are being taken.

Where we have had immediate concerns about people's safety we have taken action and are working closely with both the provider itself and commissioners to ensure the safety and welfare of people using these services as a first priority.

We are taking enforcement action, but for legal reasons we cannot go into details at this time. We will report fully on these actions later.

Briar Court Nursing Home

Briar Court Nursing Home in Hartlepool is a registered care home with nursing. The home provides accommodation for 16 younger adults with learning disability.

We inspected Briar Court on 13 June. We found that it was not meeting one or more essential standards and that improvements were needed.

What we found

- People who use the service have their medicines in a timely and safe way, with appropriate information being made available to them. However, the service should ensure that all people who use the service can have easy access to their medicines in a way that promotes their dignity and is in keeping with the principles of person centred care.

- Whilst there is some evidence of staff being appropriately supported to do their work, the frequency and quality of staff supervision and appraisal has deteriorated and would clearly benefit from review in the light of staff attitude and incidence of safeguarding referrals.
- People who use services are generally safe and well cared for, but Briar Court must ensure it always notifies the Care Quality Commission directly of any safeguarding alerts which have been made to the local authority.

Actions required

Our inspectors discussed their findings with Castlebeck during and immediately after the inspection so that improvements could be put in hand right away. We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Cedar Vale

Cedar Vale is based in Nottingham. It provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We inspected Cedar Vale on 7 June. We found that Cedar Vale was not meeting one or more essential standards and that improvements were needed.

There were 16 male patients aged between 18 and 65 at the hospital; some of whom were detained under the Mental Health Act 1983, and one was subject to a Deprivation of Liberty Safeguards (DoLS) authorisation.

Overall we found that patients were well looked after and were taking part in recreational activities. We carried out our visit with a mental health act commissioner. The mental health act commissioner has produced a separate report that was given to the provider. When we visited, the registered manager was on

maternity leave. She was due to return to work in early July and came to the hospital whilst we were there to support the acting manager. On the day of our visit an independent advocate, employed by the registered provider, was in the hospital interviewing all the patients about their experience of care and treatment. Independent advocates represent the interests of people who may find it difficult to be heard or speak out for themselves, including people with learning disabilities. We did not wish to interview people twice on the same day.

What we found

- Patients did not always experience safe care. Detained patients did not always have proper leave authorisation in place to enable them to access emergency medical treatment, or to have adequate staff supervision outside the hospital, under Section 17 of the Mental Health Act 1983.

- Patients may not be protected from abuse because staff do not always follow reporting procedures.

- Patients were not always protected from harm because equipment required for medical emergencies was not available and accessible for use as quickly as possible.

- When patients attend activities outside the hospital they do not always have their health, welfare and safety needs met by sufficient staff.

- Patients may not always benefit from safe quality care, treatment and support because the provider does not consistently monitor the quality of care and does not have sufficient ways of taking into account patients' comments and complaints.

- Patients could not be confident that important incidents affecting their health, safety and welfare were reported promptly to the Care Quality Commission so that if necessary action could be taken.

Action required

We have talked through the seriousness of our concerns with Castlebeck.

Where we have had immediate concerns about people’s safety we have taken action and are working closely with both the provider itself and commissioners to ensure the safety and welfare of people using these services as a first priority.

We are taking enforcement action, but for legal reasons we cannot go into details at this time. We will report fully on these actions later.

Chesterholme

Chesterholme in Hexham provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We inspected Chesterholme on 21, 22 and 23 June. We found Chesterholme was not meeting one or more essential standards. Improvements are needed.

What we found

We heard a range of views about the service people receive here. People told us they felt respected by staff, and that their privacy and dignity was upheld. Several people told us that they did not feel safe. People also told us they were not actively involved in planning their care. There was dissatisfaction expressed about the food on offer.

- Arrangements to offer people using this service a voice had recently been strengthened, and staff were aware of patients' communication needs. Despite this, patients were not always fully informed about their care, treatment and detention, which may have affected the decisions they made and consent they offered.

- The planning of care was comprehensive, but there was little direct involvement from patients, and both the planning and delivery of care was not person led or person centred. The delivery of care has not always been safe, effective, appropriate and flexible enough to meet individual needs.

- Meal time arrangements have not promoted choice or created a positive mealtime experience.

- Arrangements for reporting and responding to allegations of abuse had been significantly strengthened, but patients did not always feel safe here.

- Many areas of the hospital had been improved, but some were unsafe, or unfit for habitation.

- Where staff had worked outside the policies and procedures of the service, or their professional boundaries, action had been taken to ensure this was appropriately dealt with. Arrangements to confirm a staff member's 'fitness' were not demonstrably robust.

- Staff training and support arrangements were inconsistent.

- Quality assurance arrangements had been strengthened, but could be further improved by external managers regularly canvassing the views of patients

and front line workers. Quality Assurance had not identified and addressed the areas of concern identified during our inspection.

Action required

The provider must send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

However, our inspectors discussed their findings with Castlebeck during and immediately after the inspection so that improvements could be put in hand right away.

Croxton Lodge

Croxton Lodge in Melton Mowbray provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We inspected Croxton Lodge on 6 June. We found that Croxton Lodge was not meeting one or more essential standards and that improvements are needed.

What we found

- People living at Croxton Lodge do not always experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights due to the method in which care is communicated.
- People living at Croxton Lodge are not safeguarded against potential abuse as the systems and processes as well as the understanding of staff of these are not robust.
- People living at Croxton Lodge are not safe and their health and welfare needs are not met by sufficient numbers of appropriate staff.
- Staff are aware of the care that the people living at Croxton Lodge require but this is not reflected in the care plans and risk assessments currently held at the unit.

Action required
We have talked through the seriousness of our concerns with Castlebeck.

Where we have had immediate concerns about people's safety we have taken action and are working closely with both the provider itself and commissioners to ensure the safety and welfare of people using these services as a first priority.

We are taking enforcement action, but for legal reasons we cannot go into details at this time. We will report fully on these actions later.

Hollyhurst

Hollyhurst in Darlington is a hospital providing services to people who have a learning disability, some of who have complex needs in relation to their behaviour.

We inspected Hollyhurst on 15 and 20 June. We found Hollyhurst was not meeting one or more essential standards. Improvements are needed.

What we found

- The risk assessment process meant that people experienced adequate care in relation to their behavioural needs. However, records did always provide evidence of their health care needs being met. The care plans were not always person centred and actions and goals had not been identified. And the provision of the day time activities programme was not linked to individual person centred plans.
- Effective steps were not in place, through staff reporting procedures, to minimise the likelihood of abuse occurring. The management of risks was focused on all service users, rather than the individual that an incident related to. There was also a high number of incidents between service users, and although reported appropriately, is a cause for concern
- People who used services did not always benefit from a comfortable environment that met their needs.
- Although people were safe and their health and welfare needs were met by competent staff, staff had not received regular supervision.
- People who used services benefited from adequate quality care and support through the monitoring of the quality of the service that they received. However, issues identified through the quality monitoring process had not been fully addressed.

Action required

We discussed the actions that needed to be taken during and immediately after our inspection. We asked the provider to send us a report within 14 days of receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a

variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Newbus Grange

Newbus Grange in Darlington provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We inspected Newbus Grangeon 6 June. We found Newbus Grange was meeting all the essential standards of quality and safety.

What we found/ Action required

Newbus Grange is compliant with essential standards. We have not requested any follow up action.

Oaklands

Oaklands, which is in Hexham, provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We inspected Oaklands on 21 June. We found that Oaklands was not meeting one or more essential standards and that improvements are needed.

What we found

- Individual records are in place to help give individual care to patients but institutionalised care was also apparent.
- There are systems in place to help protect patients living in the location from abuse but these systems need to be strengthened. Deprivation of Liberty assessments were not in place for people who lacked capacity but were not detained under the Mental Health Act.
- Staffing levels at the service were adequate at the time of the site visit, but no formal processes were in place to review staffing levels as patient's needs changed, and they required more intensive 1:1 support. Support workers required further training to understand the different needs of patients they worked with and none had received training about Deprivation of Liberty.

Actions required

We discussed the actions that needed to be taken during and immediately after our inspection. We asked the provider to send us a report within seven days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made. Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to

challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Redlands Residential Care Home

Redlands in Darlington is a care home without nursing.

We inspected Redlands on 23 June. We found that Redlands was was meeting all the essential standards of quality and safety.

What we found/ Action required

Redlands is compliant with essential standards. We have not requested any follow up action.

Rose Villa

Rose Villa is a 9 bed home operated by Castlebeck Care (Teesdale) Ltd, an independent provider of healthcare and support for adults with complex learning disability and mental health needs

We inspected Rose Villa on 3 June and carried out further visits on 7, 14 and 16 June and 1 July. We found that Rose Villa was not meeting one or more essential standards. Improvements are needed.

What we found
We received information detailing safeguarding allegations on 2 June 2011 and attended a multi agency safeguarding meeting on 6 June and on 21 June. The manager has been suspended pending investigation. Castlebeck agreed that while investigations were completed in relation to the safeguarding information that had been received, there would be no further admissions to Rose Villa.

- The registered person has not always taken steps to ensure that people's rights to privacy, dignity and independence are always respected.
- People had their needs assessed and had some involvement in their care planning. However the care records did not reflect individual needs and did not accurately reflect the provision of care to people, which increased the risk of people receiving inappropriate care. We saw decisions had been made about their care that impacted on their liberty and resulted in restrictive practices
- The registered person had not made suitable arrangements that were effective to identify and prevent abuse from happening. Although staff had been trained in recognising abuse we found evidence that the registered

provider had not always safeguarded some people against the risk of abuse and systems had not been implemented effectively.

- The service does not fully protect people against the risks associated with the unsafe use and management of medicines by means of the making of appropriate arrangements safe administration of medicines. This relates to having suitable plans and information in place to ensure medicines are given safely.
- The recruitment procedures and processes were robust and helped to protect people who use the service.
- The registered person has not always ensured that the people living in the home are supported with their care through sufficient information so that they are protected against the risks of unsafe or inappropriate care and treatment.
- Staff are supported, trained, supervised and enabled to develop their skills and knowledge. Training requested by staff has not been delivered. We found that Rose Villa was meeting this essential standard but, to maintain this, we suggested that some improvements were made.
- There are systems in place for identifying, receiving and handling complaints. People are not confident to use these systems to make a complaint. Overall, we found that Rose Villa was meeting this essential standard but, to maintain this, we suggested that some improvements were made.

Action required

We have talked through the seriousness of our concerns with Castlebeck.

Where we have had immediate concerns about people's safety we have taken action and are working closely with both the provider itself and commissioners to ensure the safety and welfare of people using these services as a first priority.

We are taking enforcement action, but for legal reasons we cannot go into details at this time. We will report fully on these actions later.

The East Midlands Centre for Neurobehavioural Rehabilitation

The East Midlands Centre for Neurobehavioural Rehabilitation in Melton Mowbray provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We inspected the Centre on 23 June. We found it was not meeting one or more essential standards and that improvements were needed.

What we found

- Patients were mostly protected from abuse or the risk of abuse but we found that sometimes staff were involved in restraint techniques for which they had not received training.

- We also found that sometimes there were not enough staff on duty to meet people's needs and keep them safe.

Action required
We have asked the provider to send us a report within 28 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

The Gables

The Gables in Scunthorpe provides accommodation and care support including nursing for 12 adults with learning disabilities, including those with complex needs.

We inspected The Gables on 15 June. *We found The Gables was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.*

What we found

- Medicines are generally safely managed. However, we also found that where medicines had not been administered as prescribed that staff had failed to record the reasons why the medicine had been omitted.

- The provider had systems in place to monitor the quality of service provided, however some of the monitoring systems had not been effectively maintained.

Action required

We have asked the provider to send us a report within 14 days of them receiving our report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Thornfield Grange Care Home

Thornfield Grange in Bishop Aukland provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We inspected Thornfield Grange on 23 June. We found Thornfield Grange was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

What we found

- One of the essential standards says that staff should be properly trained and supervised, and have the chance to develop and improve their skills. We found that Thornfield Grange was compliant, but that accurate records of staff supervision were not maintained. We have asked for improvements in relation to this.

Action required

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Toller Road

Toller Road in Stoneygate, Leicestershire, is a care home with nursing. It is a specialist service for adults with learning disabilities and complex needs, which may include mental health needs.

We inspected this service on 22 June. We found Toller Road was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

What we found

- We have asked Castlebeck to review the opportunities for people using the service and staff to made aware of external agencies and organisations that they could contact if they were to be unhappy or concerned about how care is provided or where they think people are at risk of abuse

Action required

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

Victoria House Residential Home

Victoria House in Darlington is a care home without nursing. It provides accommodation and care for up to six people who have learning disability.

We inspected Victoria House on 21 June. We found it was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

What we found

- Although people were safe and their health and welfare needs were met by competent staff, staff had not received regular supervision. This is the area where we want to see improvement.

Action required

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

Wast Hills House

Wast Hills House, Kings Norton, provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We carried out inspections of Wast Hill House on 7 June and 7 July. We found that Wast Hill House was meeting all the essential standards of quality and safety.

What we found/ Action required
Wast Hill House is compliant with essential standards. We have not requested any follow up action.

Whorlton Hall

Whorlton Hall in Barnard Castle, County Durham, provides hospital services for people with mental health needs, learning disabilities and problems with substance misuse.

We inspected Whorlton Hall on 21 June. We found Whortlon Hall was meeting all the essential standards of quality and safety, but to maintain this we have suggested that some improvements are made.

What we found

- Several people stated that they felt that they missed out on activities and support because most staff resources were focused on those people with highest needs.

- In some areas of the building the noise levels were very high which several people found disturbing.

Action required

We have asked the provider to send us a report within 14 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made

Willow House

Willow House in Edgbaston provides care and accommodation for up to eight people with a learning disability.

We inspected Willow House on 8 June. We found Willow House was not meeting one or more essential standards and that improvements are needed.

What we found

- Overall we found that the home identified people's care needs, but does not consistently review plans of care to ensure people's changing needs are identified and responded to. People's preferences were not always clearly taken into account when assessing risks and developing care plans
- We found staff had a limited knowledge of safeguarding people and mental capacity, increasing the risk of people using the service not being protected from abuse.

Action required

We discussed the concerns that we identified in relation to how people were being cared for during the site visit. The provider must send CQC a report that says what action they are going to take to achieve compliance with these essential standards. We will check to make sure that the improvements have been made.

Acrefield House

Acrefield House, in the Wirral is a care home service without nursing. It is registered to provide care and support for up to 12 adults with a learning disability. It is run by Mental Health Care (Wirral) Limited, a subsidiary of Castlebeck Ltd.

We inspected Acrefield House on 13 June. We found that Acrefield House was not meeting one or more essential standards.

What we found

- The staff team are not always being provided with the information they need to provide safe and effective care to the people using the service.
- People living at Acrefield are not always protected from abuse.
- The staff team do not have the training, support and skills needed to effectively support the people using the service.
- The quality and safety of the service is not being effectively monitored.
- Important events that have affected the welfare, health and safety of people who use the
- service are not always reported to the Care Quality Commission.

Actions required

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made. Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. Any regulatory decision that CQC takes is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Rockfield House

Rockfield House in Liverpool provides care home services without nursing. It is run by Mental Health Care Limited, a subsidiary of Castlebeck Care.

We inspected Rockfield House on 15 June. We found that Rockfield House was meeting all the essential standards of quality and safety.

What we found/ Action required

Rockfield House is compliant with essential standards. We have not requested any follow up action.

Binley Woods

Binley Woods in Warwickshire provides specialist healthcare and rehabilitation services for adults with learning disabilities, mental health problems and autistic spectrum disorders who present with complex needs and who challenge services. Binley Woods is run by the Young Foundations, a subsidiary of the Castlebeck Group.

We inspected Binley Woods on 4 March. We found Binley Woods was meeting all the essential standards of quality and safety we reviewed.

What we found/ Action required

Binley Woods is compliant with essential standards. We have not requested any follow up action.

The Daltons

The Daltons in Seaham, County Durham, provides care to five adults with learning disabilities aged between 16 and 25. It is run by the Young Foundations, a subsidiary of the Castlebeck Group.

We inspected The Daltons on 21 February. We found that The Daltons was meeting all the essential standards of quality and safety we reviewed.

What we found/Action required

The Daltons is compliant with essential standards. We have not requested any follow up action.

Mowbray House

Mowbray House in Crook, County Durham, is a care home service without nursing.

We inspected Mowbray House on 30 June. We found it was meeting all the essential standards of quality and safety.

What we found/ Action required

Mowbray House is compliant with essential standards. We have not requested any follow up action.

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All of the reports can be found on the CQC web site

http://www.cqc.org.uk/newsandevents/castlebeck.cfm