AUDIT REPORT

Casarita

Date of Visit: 11th & 12th of February 2025

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Service Name: Casarita **Provider:** Liaise (East Anglia) Limited

Address of Service: 270 Fakenham Road, Taverham, Norwich, Norfolk, NR8 6AD

Date of Last CQC Inspection: Registered on 3rd April 2023

Ratings

CQC's Overall Rating for this Service:	Registered on 3rd April 2023	
SRG's Overall Rating for this Service:	Good	

Key Questions	Rating	Overall Score
Safe	Good	65 (out of 100)
Effective	Good	63 (out of 100)
Caring	Good	75 (out of 100)
Responsive	Good	67 (out of 100)

Depending on what we find, we give a score for each evidence category that is part of the assessment of the quality statement. All evidence categories and quality statements are weighted equally.

Scores for evidence categories relate to the quality of care in a service or performance:

4 = Evidence shows an exceptional standard

3 = Evidence shows a good standard

2 = Evidence shows some shortfalls

1 = Evidence shows significant shortfalls

At key question level we translate this percentage into a rating rather than a score, using these thresholds:

- 38% or lower = Inadequate
- 39 to 62% = Requires improvement
- 63 to 87% = Good
- 88 to 100% = Outstanding

Well-Led	Good 	71 (out of 100)

Overall Service Commentary

INTRODUCTION

An audit based on the CQC Key Questions and Quality Statements, aligned with the Single Assessment Framework, was conducted by an SRG Consultant over two days on 11th & 12th February 2025. The purpose of this review was to highlight in a purely advisory capacity, any areas of the service operation which should or could be addressed in order to improve the provision and recording of care and increase overall efficiency and compliance with CQC Standards and Regulatory Requirements.

TYPE OF INSPECTION

Comprehensive inspections take an in-depth and holistic view across the whole service. Inspectors look at all five key questions and the quality statements to consider if the service is safe, effective, caring, responsive and well-led. We give a rating of outstanding, good, requires improvement or inadequate for each key question, as well as an overall rating for the service.

METHODOLOGY

During the assessment of the service, all the quality statements relating to all of the key questions were looked at.

A variety of methods were employed to gain an understanding of the experiences of people using the service. These included observing interactions between people and staff, speaking with the registered manager, deputy manager support staff and one person who was supported.

For people with communication difficulties and/or cognitive impairments, observations were made to ensure they appeared comfortable and content with the support they were receiving. Additionally, two care plans were reviewed, three staff recruitment files were checked, and records were examined to confirm that staff training and supervision had been conducted appropriately. Medication records and operational documents, such as quality assurance audits, staff meeting minutes, and health and safety and fire-related documentation, were also assessed.

OUR VIEW OF THE SERVICE

Casarita is a residential home providing support for younger adults. The service could accommodate seven people and was fully occupied at the time of the visits. Four people lived in their own flats and three people shared communal areas.

While the home was generally clean, improvements were needed in relation to the environment as some areas needed replacement and refurbishment. It was confirmed that there was a maintenance programme in place.

Accidents and incidents were recorded. Debriefs took place for medium to high-severity incidents. Safeguarding procedures were in place. Staff told us they knew how to raise concerns both within the service and outside.

There were some improvements needed in relation to the environment, but there was a maintenance plan to address this.

Some improvements were needed in relation to recruitment processes. There was a stable staff team with some use of agency staff, but consistency was promoted, and agency staff were supported with an induction. Staff learning and development was in place to ensure staff were properly inducted into the service and their knowledge developed.

Risk assessments were in place, although there was a tendency for these to be of a more generic nature. Improvements were needed in relation to PBS plans; however, support was being provided from The Norfolk PBS service (supporting positively) service.

Medicines were managed safely.

Staff worked well across teams and services to support people. For example, staff worked with the epilepsy nurse and the Norfolk learning disability team, for example.

Care plans need development to promote a more person-centred approach. Staff, however, supported people in a person-centred way.

Staff said they felt supported by the management team.

PEOPLE'S EXPERIENCE OF THIS SERVICE

People were seen to be supported appropriately by a staff team who knew people well.

People were treated with kindness, compassion and dignity and were treated as individuals, their diverse needs were respected.

Support plans included guidance for staff in relation to supporting people to make choices about their daily living activities.

Staff encouraged people to express their views and make choices about their care. Throughout the visit staff were seen to involve people in making decisions.

Behaviours of concern records showed how staff responded and supported people during such incidents. Staff recognised indicators of when people were becoming agitated or unsettled and were alert to changes in moods and emotions.

DISCLAIMER

The matters raised in this report are only those that came to the attention of the reviewer during this visit. The work undertaken is advisory in nature and should not be relied upon wholly or in isolation for assurance about CQC compliance.

RATINGS

Our audit reports include an overall rating as well as a rating for each of the Key Questions.

There are 4 possible ratings that we can give to a care service.

Outstanding – The service is performing exceptionally well.

Good – The service is performing well and meeting regulatory expectations.

Requires Improvement – The service is not performing as well as it should, and we have advised the service how it must improve.

Inadequate – The service is performing badly and if awarded this rating by CQC, action would be taken against the person or organisation that runs the service.

Please be advised that this represents the professional opinion of the reviewer conducting the audit, based on the evidence gathered during the review visit. This evaluation considers compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and is aligned with the CQC's current assessment framework.

Key Question	Applicable Regulations	Quality Statements and Comments
Safe	**Regulation 12: Safe Care and Treatment** **Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment** **Regulation 17: Good Governance** **Regulation 18: Staffing** **Regulation 19: Fit and Proper persons employed** **Regulation 20: Duty of Candour** **Regulation 15: Premises and Equipment**	**Learning culture –** Score 2 Accidents and incidents were reported and recorded through the RADAR system. The samples viewed, evidenced that there were appropriate actions taken following any accidents and incidents to minimise the risk of events reoccurring. Although, it was noted that staff did not always complete relevant sections of the incident form, such as any triggers, types of behaviours and staff actions. **(SR 1)** There were steps to take to complete, including an investigation, actions, and learning outcomes, dependent on the severity of the incident. There was a tendency to identify that debriefs were not needed as senior staff were often involved and either led by role modelling or feedback was given direct at the time. It would be useful to record the feedback within the report to support sharing of feedback with other staff. **(SR 2)** Staff reported that when there were incidents of medium to high severity, they were supported by debriefs. Staff said that lessons learnt were shared with them at staff meetings. **Safe systems, pathways and transitions –** Score 3 Good working relationships had been developed with external professionals to promote safe pathways of care. Reviews of care were undertaken. **Safeguarding –** Score 3 People were protected from the risk of harm. Effective safeguarding procedures were in place. There was a policy and procedure in place too.

Key Question	Applicable Regulations	Quality Statements and Comments
		The registered manager understood their responsibilities to report any safeguarding issues to the local authority safeguarding team. There was evidence that concerns of a safeguarding nature were acted on immediately and appropriate actions taken. Staff had been trained in how to recognise potential abuse and said they knew who to report any concerns to and were confident that these would be acted on. People who were living in the home, said that they felt safe. **Involving people to manage risks –** Score 2 Individual risk assessments were in place in the care records that were reviewed. These included personal support, support with decision making, medical and health care and support with free and structured time, for example. Each risk assessment identified risks and actions, but there was a generic approach, where risk assessments were not specific to the person. **(SR 3)** In addition, risk assessments did not give detailed guidance about how to support people. There tended to be standard statements such as *'Work with the resident to create a visual chart of weather-appropriate clothing, allowing them to choose outfits based on the day's weather conditions.'* **(SR 4)** Where one person had a known risk for a specific personal behaviour, this was referred to in the support plan, however there was no associated information recorded in the risk assessment, and again there was reference in an incident to this behaviour. **(SR 5)** Not all risks were clearly identified within the support plans and did not always correspond with information within incident reports. For example, incident reports recorded that the behaviour was known and was included in the support plan. However, on review of a sample of support plans and risk assessments,

Key Question	Applicable Regulations	Quality Statements and Comments
		information about known behaviours as seen in incident reports such as incidents associated with bowel management or destruction of property, were not clearly referenced to give staff detailed information on how to manage risks. **(SR 6)** People had positive behaviour support (PBS) plans in place. However, information from these lacked detail on how to manage individual behaviours. The PBS risk assessment for one person took a generic approach in relation to managing behaviours such as talking about general aggression management, and Preventing Trigger-Induced Behaviour, such as to Train all staff to respond uniformly to the person's behaviours, reducing escalation through consistency in interactions, but not what the consistency was. Staff said that the PBS plans did not currently give them the information they needed. The Norfolk PBS service (supporting positively|) had visited the service and spent a day with staff. This was a project funded by Norfolk County Council with the aim to implement positive behaviour support to organisations. Casarita had been chosen to be part of this pilot service. The support provided will be reviewing the current system processes in place, support with PBS plans along with strategies and training. This will be positive as the current PBS plans needs further development. **(SR 7)** **Safe environments –** Score 3 The building was split into four flats, three were self-contained and one shared kitchen facilities. There were three bedrooms in the main house where people had their own rooms and shared communal facilities including the shower rooms, kitchen and lounge area. Improvements were needed in relation to the environment as some areas needed repair and refurbishment. It was confirmed that there was a maintenance programme in place which took into account ongoing repairs and refurbishment. For example, a new shower room was to be installed, and flooring replaced in the main hallway. One person said they' 'liked their flat'.

Key Question	Applicable Regulations	Quality Statements and Comments
		The QUOODA system identified that checks, servicing and risk assessments were up to date. Health and safety checks were completed on a regular basis, including daily fire patrols, weekly checks on the fire alarm, carbon monoxide sensor, laundry equipment, fire doors, lighting, window restrictors and plugs. Monthly checks were completed on monthly fire extinguisher, emergency drill, emergency lighting, and the grab bag checks. The grab bag was reviewed and this included equipment to use in an emergency such as foil blankets, flashlights, and reflective jackets. In addition, there was emergency information and individual PEEPS (personal emergency evacuation plans). Appliances and utilities were checked and / or serviced in line with health and safety schedules. An independent water company visited on a monthly basis to review all aspects of water safety including TMV management, water temperatures and general water checks. **Safe and effective staffing –** Score 2 Some people needed one-to-one support or two-to-one support in the community. Staffing levels were reflective of this, and the assessed support needs of each person and according activities were taking place. Observations showed that there were enough staff available to support people in the home and out and about in the community at all times during the visit. There were currently three full time vacancies which were being advertised. This meant that agency was used on occasions, but this had decreased and there was a consistent approach with one agency being used. Profiles were obtained for agency staff, although it was noted that there was no profile for one new agency staff. **(SR 8)**.

Key Question	Applicable Regulations	Quality Statements and Comments
		Checks were made to assess whether staff were being recruited in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Two staff files were reviewed. Those records viewed contained all necessary documentation, including a C.V., interview questions, references, a medical questionnaire and disclosure and barring checks (DBS). Right to works checks were in place along with proof of ID and address. For gaps in employment, in line with Liaise HR practices there was a text document saved in the staff file in a note pad form. But there was no record of who had provided the information such as contact details or a name. **(SR 9)** Employment dates provided by one member of staff did not always agree in different documentation completed or with information provided by a referee. There was no robust record of how this had been discussed. **(SR 10)** It was positive to note that more recent applicants were now completing the providers welcome pack in more detail, which included sections for full employment histories, reasons for leaving previous employment and gaps in employment history. New staff were supported with an induction, through the induction booklet. This was mapped to the care certificate and the in-house training programme. Staff were supported with observations of care practices work exercises to demonstrate competency and understanding of their role. The Registered Manager confirmed that they reviewed all inductions and signed these as completed once staff had been assessed as competent. Two members of staff who had either completed the induction or were working their way through said they felt the induction was comprehensive. Agency staff were also supported with an induction. This included orientation into the home, health and safety, relevant policies, introduction to people using the service, any training and any specific needs.

Key Question	Applicable Regulations	Quality Statements and Comments
		Ongoing training was in place through Your Hippo and online e-learning was in place. Staff completed mandatory and required training as part of the training programme. Mandatory training included autism, equality and diversity, privacy and dignity, Mental Capacity and Deprivation of Liberty Safeguards, health and safety, food safety, fire safety, GDPR, infection control, manual handling, Safeguarding, medication awareness, and learning disability. Mandatory training was at 100% compliance. Required training included medication administration, mental health, nutrition, oral health, British sign language, COSHH, diabetes, PBS, PROACT-SCI, person centred care, duty of candour, and duty of care. Required training was at 98% compliance. It was noted that epilepsy and IDDSI training was not included on the training matrix. It may be that these are provided by another source or were not included on the matrix provided. However, as there are people being supported with both these needed, it is suggested that checks are made to ensure that this training is either in place or is on the matrix. **(SR 11)**. Medication competency assessments took place. These included checks on staff understanding of storage, administration, following of directions, using MAR Charts, recording and reporting errors, for example. Medication competency was at 90% compliance at the time of the visit, with due dates booked in. Supervisions were at 100% compliance at the time of the visit. A sample of supervisions were reviewed. Supervisions were happening every three months, and these were highlighted through the RADAR compliance workflow to alert when they were due. Supervisions considered staff wellbeing and were seen to address work performance issues but also review for solutions to improve where there were concerns.

Key Question	Applicable Regulations	Quality Statements and Comments
		Some agency staff worked in the home on a regular basis. It's suggested that a supervision is considered as agency staff are supporting the home on a long-term basis. **(SR 12)** Appraisals had either been completed or were booked in. Staff members completed a pre-appraisal where they could identify their own performance, strengths and weaknesses and review with the manager and identify any future aspirations or plans. **Infection prevention and control –** Score 3 There were systems in place to manage risks associated with infection control. Monthly infection control audits were completed. There were cleaning schedules in place. National colour-coding guidance for cleaning materials, equipment, and food safety to maintain infection control procedures were in place. PPE was available as needed. **Medicines optimisation –** Score 3 The arrangements for the management of medicines were appropriate. There were systems for ordering and returning any medicines. When medicines were delivered these were checked in by the management team to ensure that the correct medicines had been delivered. Processes were in place for people to take their medicines out with them when they went out for the day or to visit family. Medication countdown records were maintained to ensure that the correct number of medicines were kept for each person. Daily checks were taking place to maintain safe systems for managing medication.

Key Question	Applicable Regulations	Quality Statements and Comments
		Medicines were kept in a clinical room in a locked cabinet. Temperatures were taken of the room on a daily basis. A sample of medication administration records (MAR) charts were reviewed, those viewed had been completed accurately. It was noted that one tablet had previously been dropped, and the pharmacist would not replace it. This meant that staff needed to start the new cycle for this particular tablet a day early. Staff were not then recording that 27 were brought forward rather than the standard 28 cycle. To ensure that there is an accurate record of tablets in the home, ensure that the number of tablets is recorded on the MAR chart. **(SR 13)** PRN (as and when medicines) protocols were seen and these included the medication details, reasons for use, signs and symptoms to be managed, alternative suggestions, conditions to administer, when medical advice should be sought any side effects and actions taken after. Reasons for administration were recorded on the MAR charts. Cream charts were in place for when staff administered creams or applied specialist lotions. There was a system for reviewing these on a monthly basis, but this had not been completed for one person. **(SR 14)** Staff were trained and assessed for competence for administering medication. There were signature sheets to evidence who could administer medicines. • This service scored 65 (out of 100) for this area.

Key Question	Applicable Regulations	Quality Statements and Comments
SRG RATING: Good: This service maximised the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. **"Characteristics of services the CQC would rate as 'Good' Safety is a priority for everyone and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation".**		

Key Question	Regulations	Quality Statements and Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: Need for Consent** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 18: Staffing**	**Assessing needs –** Score 2 Peoples care needs were assessed. Staff involved people and their representatives in assessment of their needs. Staff assessed people's needs and reviewed them regularly. People were supported with ongoing reviews and assessments and evidence was seen that information was updated when there were changes in need. Although, as identified elsewhere within this report, more information is needed with risk management and support plan protocols **Delivering evidence-based care and treatment –** Score 2 Where people had specific conditions, there was no information in the support plans about these conditions. There was only limited information about how a specific condition may affect a person in their day-to-day living. **(ER 1)** Where one person was at risk of constipation, the support plan and risk assessment identify risks associated with constipation and the treatment, but there was no reference to how staff will know when the person was suffering or in discomfort and no clear guidance about when to contact GP. **(ER 2)** One person suffered with epilepsy. There was a risk assessment in place, this included information on seizure management, and actions to take in the event of a seizure. This was supplemented by a support plan specific to epilepsy. Although key points were identified within the risk assessment and support plan, and there was some nice person-centred detail in the support plan and this considered aspects specific to the person, both the support plan and risk assessment lacked the level of detail included in the Emergency Medication Epilepsy Care Plan from Norfolk Community Health and Care NHS Trust.

Key Question	Regulations	Quality Statements and Comments
		This care plan had been developed by the epilepsy team and contained more specific detail in relation to different types of seizures, timescales to administer Buccal Midazolam and clear guidance on how to support the person. This information was lacking in the Blyssful system. One person needed support with a modified diet. There was reference to a SALT plan, but there was no information in the risk assessment or support plan about the support needed. For example, *'Staff should follow the SALT recommendations and help me with eating and drinking safely'*, but not how. More information should be included where health or social care professionals have provided an assessment with accompanied advice or guidance. **(ER 3)** Where one person was identified as a choking risk and had dysphagia, there was no personalised information on how to support the person with this. For example, 'I need help with managing Dysphagia' and 'Ensure all food is cut into appropriate sizes', but not what. There was no information on what to do if there was a choking incident. **(ER 4)** **How staff, teams and services work together –** Score 3 The service worked effectively with health and social care professionals and families. Referrals to outside professionals were made as needed. Support staff were not directly involved in providing health care support. However, staff supported people to access healthcare services. It was confirmed that people were supported with contacting the 111 service, the G.P. or district nurse for example. **Supporting people to live healthier lives –** Score 3 Individual health care needs were well met. There was good evidence to demonstrate that people were supported to access health care professionals and appointments as required.

Key Question	Regulations	Quality Statements and Comments
		Specialist health and mental health support was accessed as required. Mealtimes were flexible around people's needs and preferences and people were able to have their meals and snacks at times they chose. People were supported to get involved with preparing meals and menu planning. However, not everyone had an oral assessment on file. **(ER 5)** **Monitoring and improving outcomes –** Score 3 Daily care notes were completed, so there were records of how people spent their time, and the support provided. This included continence care, food and fluids, activities, health and wellbeing and care routines. Staff recorded monthly health checks and completed monthly key worker reviews. **Consent to care and treatment –** Score 2 The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. There was a lack of information in individual MCA assessments. For example, where people were to detail if past and present wishes had been considered, the response was yes, with no further detail. There was a lack of information about how people were supported to maximise their understanding of the decision, such as whether any aids were used. **(ER 6)**

Key Question	Regulations	Quality Statements and Comments
		Each person had three MCA assessments in place. These were for health and wellbeing, finances, and medication. There were no other MCA assessments in place and conversations with staff evidenced that people lacked on other areas. It is suggested that consideration is given to other areas of capacity and further MCA assessments are developed. **(ER 7)** Mental capacity support plans did not identify where people had capacity to make decisions or lacked capacity or identify if a DoLS was in place. The support plans tended to identify that there was difficulty understanding complex decisions, but not what these were or where people were able to make informed decisions about daily living activities. **(ER 8)** People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Applications had been made where people were subject to limitations on their freedoms under the deprivation of liberty safeguards (DoLS). Where needed people were supported with advocacy. • This service scored 63 (out of 100) for this area.
SRG RATING: Good: This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. **"Characteristics of services the CQC would rate as' Good' People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with**		

Key Question	Regulations	Quality Statements and Comments
people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work".		

Key Question	Regulations	Quality Statements and Comments
Caring	**Regulation 9: Person-centred Care** **Regulation 10: Dignity and Respect**	**Kindness, compassion and dignity –** Score 3 Observations showed that staff worked well with the people they were supporting. They provided unobtrusive care and support by supporting people in a dignified manner. Staff spoke positively of how they supported people and were able to explain individual needs. Staff spoke positively about the people they supported. Staff ensured that they communicated and shared information with people in a way they could easily understand and always respected the informed choices made. People were encouraged to maintain relationships with family and friends. **Treating people as individuals –** Score 3 Staff treated people as individuals and considered individual needs and preferences. They took into account people's strengths, and abilities. Conversations with staff evidenced that they understood about people's likes and dislikes. People were supported with monthly key worker meetings, which gave people opportunities to be involved in their care and support. **Independence, choice and control –** Score 3 Support plans included guidance for staff in relation to supporting people to make choices about their daily living activities. Staff encouraged people to express their views and make choices about their care. Throughout the visit staff were seen to involve people in making decisions, such as asking how they wanted to spend their time and what they would like to eat.

Key Question	Regulations	Quality Statements and Comments
		Staff explained how people were supported to participate in different day-to-day daily living tasks, such as preparing meals or arranging laundry. **Responding to people's immediate needs –** Score 3 Behaviours of concern records showed how staff responded and supported people during such incidents. Staff recognised indicators of when people were becoming agitated or unsettled and were alert to changes in moods and emotions. Daily handover meetings were held to help ensure staff were up to date with any changes in people's needs and their emotional well-being. **Workforce wellbeing and enablement –** Score 3 Staff well-being was considered. At staff meetings and supervision, staff wellbeing was discussed, and any concerns or issued were noted. Above and beyond nominations were in place for staff who have gone the extra mile to support people to help recognise where staff had achieved good outcomes for people. There was an employee assistance programme in place, which included occupational health, and access to confidential mental health support for staff. Adjustments were made to help balance individual work and home life. Staff reported that the management team worked with them to make these adjustments. One person had wanted to change their working weekends, and this had been arranged for them. • This service scored 75 (out of 100) for this area.
SRG RATING: Good: This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing		

Key Question	Regulations	Quality Statements and Comments
and communication needs with them. **“Characteristics of services the CQC would rate as ‘Good’ People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity are respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.”**		

Key Question	Regulations	Quality Statements and Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 17: Good Governance** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred Care –** Score 2 People were supported by keyworkers. Observations showed that staff knew and understood individual's needs. Conversations with staff evidenced their knowledge and familiarity with the people that they were supporting. However, support plans were not person centred and took a generic approach. There was limited information relating specifically to the person. **(RR 1)** **Care provision, integration, and continuity –** Score 3 The staff team understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity. People's care and treatment was delivered in a way that met their assessed needs from services that are co-ordinated and responsive. There was evidence that people regularly accessed GP and other community health services. **Providing information –** Score 3 Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way that they are able to understand. The standard applies to all people with a disability, impairment, or sensory loss and in some circumstances to their carers. Not all people using the service could communicate with ease and interacted through nonverbal methods, such as facial expressions and body language, along with verbal communication. Communication support plans were in place but were not specific to the person. Where one person used Makaton, there was no information in the support plan regarding this. **(RR 2)**

Key Question	Regulations	Quality Statements and Comments
		The complaints procedure was available. **Listening to and involving people –** Score 3 Surveys had been sent out and these were returned in November / December 2024, with six out of the seven people using the service responding. Generally, the responses were positive with the majority of people saying they were happy in the home. One person said it was 'ok', but this mainly seemed to be related to the behaviours of another person living in the home, who could display behaviours that challenged and be noisy at times through the banging of doors and shouting. This was something that was also raised at the visit to the visit consultant, when they were asked if they were happy living in the home. There needs to be a record that this has been looked into, and that reassurance has been given. **(ER 3)** Staff met with people each week to discuss activities, and any plans. One person liked to meet and plan their menu for the week. **Equity in access –** Score 3 People could access care, treatment, and support when they needed to and in a way that worked for them. There was a positive approach to ensuring that people were supported to access available resources. This included attending appointments or assessments. Staffing levels ensured that people were not disadvantaged when accessing the community. Most people were supported with activities. **Equity in experiences and outcomes –** Score 3 Staff had discussed and identified goals with people, however, all goals reviewed did not have any progress and little evidence of discussion at monthly key worker meetings. **(RR 4)**

Key Question	Regulations	Quality Statements and Comments
		People could go out and about to activities of their choice. One person enjoyed going to a local club, and other people enjoyed going to a local community centre. People enjoyed shopping and visiting local resources. Staff were supporting one person with a new pastime to help develop their experiences. **Planning for the future –** Score 2 No-one in the home was receiving end of life care at the time of the visit. However, consideration was given to end of life matters. One person had completed an end-of-life plan which included their end-of-life wishes and preferred end-of-life care along with their funeral preferences. For other people, as with other areas of the support plans there was a generic approach. For example, the end-of-life support plans identified to familiarize end-of-life wishes and funeral arrangements to ensure these are respected and followed. However, these had not been included in the support plan or the risk assessment. **(RR 5)**. • This service scored 67 (out of 100) for this area.
SRG RATING: Good: This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. **"Characteristics of services the CQC would rate as 'Good' People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood, and they are actively involved in planning care that meets these needs. Care, support and treatment are easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics".**		

Key Question	Regulations	Quality Statements and Comments
Well-led	**Regulation 17: Good Governance** **Regulation 5: Fit and Proper Persons Employed - Directors** **Regulation 7: Requirements Relating to Registered Managers** **Regulation 18: Staffing** **Regulation 20A: Requirement as to Display of Performance Assessments**	**Shared direction and culture –** Score 3 There was an open and transparent culture which acted on concerns raised and protected people in line with safeguarding and whistleblowing procedures. Discussions with the Registered Manager, Deputy Manager and staff established that the people living in the home were the focus of the service. Shift leader check sheets had been introduced which helped to ensure that all tasks were completed during the shift. This included medication management, activities for people, support with appointments and any accidents and incidents. A senior member of staff reported that this had been useful and felt that it had helped to embed structure into the working day. Handover systems were in place including a review of any accidents and incidents, appointments, staffing matters and what people had taken part in. Staff said this promoted good communication. **Capable, compassionate and inclusive leaders –** Score 3 There was an aim to promote an inclusive culture, with systems of support being provided to staff through supervisions and training to upskill their knowledge and understanding in relation to what good care looked like. The Registered Manager reported that they reminded staff about the importance of promoting a family orientated environment. Conversations with staff evidenced that they put people at the heart of the service and considered their preferences when providing support. The Registered Manager promoted an open-door policy and staff confirmed this. They said the management team were helpful and provided them with support.

Key Question	Regulations	Quality Statements and Comments
		Casarita's management team said they were supported by the provider's management team who were available to them whenever it was needed. They said the senior management team were supportive and if they had any questions or queries nothing was too much trouble, in particular the quality team who were responsive and proactive. **Freedom to speak up –** Score 3 Staff had access to regular supervision and support from the management team. Staff meetings were happening on a regular basis. Staff and team leader meeting minutes were not dated so the date of the meeting could only be estimated by the timeline of when it was uploaded to the RADAR system. **(WR 1)** In addition, who was chairing the meeting and which staff attended were also not included. **(WR 2)** Minutes of meetings evidenced that the most recent was now being completed on the standard template. This included areas such as actions from previous meetings, lessons learnt, training, staff wellbeing, single assessment framework, and audits, for example. It was not always apparent about the actions that had been taken and the outcome of any discussion in the team meetings. **(WR 3)** Senior team meetings were happening. These identified accountabilities and responsibilities with expectations of how these would be managed. Staff surveys had been sent out. At the time, some of the responses indicated that not all staff felt that they were appreciated or recognised. A 'you-said, we-did' report had been produced which identified how these areas would be addressed. Feedback from staff at the visit mainly confirmed that staff felt that this had improved, and they felt more appreciated. **Workforce equality, diversity and inclusion –** Score 3

Key Question	Regulations	Quality Statements and Comments
		Policies and procedures were in place for equality and diversity and staff had completed training. Staff said that they felt that there was an inclusive culture within the home. Staff said that they felt that there were support systems in place. **Governance, management and sustainability –** Score 2 Systems and processes were in place to monitor the service. A new system of monitoring systems had been introduced. The Registered Manager explained that these were key performance indicators (KPI's). This was sent through weekly and monitored and reported on staffing hours, use of agency, overtime, sickness, any safeguarding, reviews of care updates, urgent issues, risks of service breakdown, HR updates and assessments and referrals, for example. In addition, individual service was provided with a monthly report about the status of compliance taken from the systems used by the provider, such as RADAR, QUOODA, Blyssful and the training programme. A range of audits and checks were completed on a weekly, monthly and quarterly basis. • Manager Walk Around Audit: 11th February: 100 % (these had been completed weekly and were consistently as 100%) • Weekly Medication Shift Leader Audit: 5th February: 100 % • Health and Safety and Infection Control Monthly: 18th January: 100 % • Out of Hours: 16th January: 100 % • Managers Monthly Medication: 14th January: 96 % • Finance Audit: 10th January: 100% (The February finance audit was completed at the time of the visit)

Key Question	Regulations	Quality Statements and Comments
		• Monthly Vehicle Maintenance Audit. 13th January 100 % • Operations Manager quarterly medication audit: 16th January: 88 % • Manager's Quarterly Support Plans and Risk Assessments: 19th December: 93 % • Managers Operation visit: 18th December 88 % It was noted that some of the audits were at 100%. There was little evidence in the audits to support these findings. Some reference was made in the comments section, but there was limited other evidence such as photographs or uploaded documentation. It would be worth considering providing some evidence within the audits to demonstrate how compliance was met. **(WR 4)** There was a tendency to mark areas as compliant if there is a plan to address these. For example, the monthly infection control audit identified that the flooring was compliant, although the flooring in the hallway needed replacement. As this was due and was booked in for 22nd January (audit took place on 18th January) the question around floor surfaces was marked as compliant but had not been addressed at the time of the audit and also not at the time of the visit from the consultant. It was confirmed that this date had been changed and would now be 28th February. Areas of non-compliance should not be marked as met until any actions are actually completed. **(WR 5)** It was positive to see that there were internal processes for mock inspections to help maintain oversight of the service. **Partnerships and communities –** Score 3 The management team understood their duty to collaborate and work in partnership with health and social care partners. They had developed links with the Norfolk PBS team and local health care professionals.

Key Question	Regulations	Quality Statements and Comments
		Notifications were made to CQC where needed. **Learning, improving and innovation –** Score 3 The Registered Manager had an ongoing service improvement plan, which had identified some of the areas picked up at this audit. For example, improvements in support plans and risk assessments. There was evidence that the service improvement plan was used to monitor and implement improvements. In addition, there was an action plan in the RADAR system which confirmed that learning took place following audits, incidents and reviews. Learning was shared from the larger organisation following any internal reviews and rolled out to the individual services. The Registered Manager reported that the quality team shared learning and updated to practices with the services. This included a presentation on safeguarding, key working and duty of candour. From this, focused meetings were arranged with staff. Regular manager's meetings took place where learning and updates were shared. **Environmental sustainability – sustainable development –** Score 3 Consideration had been given to environmental sustainability. Where possible recycling was implemented and staff followed local authority procedures. There was an aim to reduce the use of paper through electronic systems and the Registered Manager said that this was shown through the reduced amount of paper archiving that was needed. Lights were being gradually changed over to low energy bulbs and care was taken to turn off electrical items when they were not in use.

Key Question	Regulations	Quality Statements and Comments
		CoSHH products were supplied in recyclable containers. There were plans to build raised bed in the garden and support people to grow their own produce, which would also support people to be involved in a project. • This service scored 71 (out of 100) for this area.

SRG RATING: Good: This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

"Characteristics of services the CQC would rate as 'Good' There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities".

ACTION PLAN:

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
SR1	Staff to complete all sections of incident forms						
SR2	Where staff are supported through role modelling during incidents, this should be recorded and shared with staff.						
SR3	Ensure that risk assessments are specific to the person.						
SR4	Ensure that risk assessments include detailed information on how to manage risks.						
SR5	Where risks are identified within support plans, there needs to be an associated risk assessment in place.						
SR6	Ensure that risks identified in incidents records are updated into the support plans and risk assessments.						
SR7	Further develop the PBS plans in line with support provided from the Norfolk PBS Service						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR8	Obtain profiles for agency staff.						
SR9	Ensure explanations of gaps in employment have evidence of who has provided this information.						
SR10	Ensure that employment dates are consistent that and that any discrepancies are recorded as being discussed.						
SR11	Ensure that training specific to the needs of people using the service such as Epilepsy and IDDSI is checked to ensure that it is happening or is included on the training matrix.						
SR12	Consider introducing supervision for agency staff who work at the service on a long-term basis.						
SR13	Record the correct number of tablets in the MAR charts, in particular where they need to be brought forward from the previous cycle.						
SR14	Systems for reviewing creams or lotions be completed monthly.						

CQC Key Question - EFFECTIVE

By effective, we mean that people's care, treatment and support achieve good outcomes, promotes a good quality of life and is based on the best available evidence.

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
ER1	Further develop information in support plans about individual conditions.						
ER2	Ensure there is clear guidance about how to support people with managing constipation.						
ER3	Include information from health and social care professionals in relation to guidance about managing individual needs such as SALT and epilepsy support.						
ER4	Include detail about how to manage choking risks.						
ER5	Implement oral assessments.						
ER6	Continue to include more information within MCA assessments in relation to maximising people's opportunities to understand the decision.						
ER7	Identify where further MCA assessments are needed and implement.						

ER8	Include more information in mental capacity support plans in relation to where people had capacity or lacked capacity to make specific decisions.						

CQC Key Question - CARING

By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
CR1	X						

CQC Key Question - RESPONSIVE

By responsive, we mean that services are organized so that they meet people's needs.

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
RR1	Further develop support plans to include more person-centred information about the person.						
RR2	Further develop communication needs with support plans						
RR3	Ensure that where people raise concerns that there is a record of actions taken.						
RR4	Further develop how goals are reviewed, and people are supported to achieve any goals or aspirations.						
RR5	Further develop end-of-life plans with a more personalised approach or clearly identify where people or their relatives do not want to discuss this.						

CQC Key Question - WELL-LED

By well-led, we mean that the leadership, management and governance of the organization assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
WR1	Ensure that all meetings are dated.						
WR2	Maintain a record of staff who were involved in team meetings and include in the minutes.						
WR3	Include any actions agreed at team meetings and a review of these.						
WR4	Include more evidence within audits where they are 100% to help evidence compliance.						
WR5	Ensure that areas of non-compliance within audits are not marked as compliant until any actions have been completed.						