AUDIT REPORT

Crossbrook

Date of Visit: 8th and 9th April 2024

Private & Confidential
SRG CARE CONSULTANCY LIMITED

Contents:

Service Name: Crossbrook **Provider:** Liaise (London) Limited

Address of Service: 65 Crossbrook Street. Cheshunt. Herts. EN8 8LU

Date of Last CQC Inspection: 10 March 2023

Ratings

CQC's Overall Rating for this Service:	Requires Improvement	
SRG Overall Rating for this Service:	Good	

KLoE Domain	Rating		Overall Score
Is the service safe?	Good		71 (out of 100)
Is the service Effective?	Good		66 (out of 100)
Is the service caring?	Good		75 (out of 100)
Is the service responsive?	Good		75 (out of 100)
Is the service well-led?	Good		75 (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:

- 25 to 38% = Inadequate
- 39 to 62% = Requires improvement
- 63 to 87% = Good
- over 87% = Outstanding

Overall Review Summary

INTRODUCTION

An audit, based on CQC KLoE, was undertaken by one SRG Consultant over two days on 8th and 9th April 2024. 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.

Comprehensive inspections take an in-depth and holistic view across the whole service. Inspectors look at all five key questions 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

Several different methods were used to help understand the experiences of residents who used the service. These included observation of interactions between residents and staff, conversations with the Manager, Deputy Manager, senior staff, and observations of interactions with residents and a review of key documentation.

SUMMARY OF OUTCOME

Crossbrook is registered with CQC and provides accommodation for persons who require nursing or personal care. It's category of registration is a care home in; Caring for adults under 65 years with learning disabilities. The service provides accommodation for up to 11 residents. At the time of this audit the home had an occupancy of 9 residents.

We looked at care records for three residents, we checked two staff recruitment files and records to confirm staff training and supervisions had occurred appropriately. We checked medicine records and the records pertaining to the operation of the service, including quality assurance audits, minutes of staff meetings, H&S and Fire related documentation.

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

It is the overall view of the consultant undertaking this review that while several recommendations are made, subject to these being acted upon and concluded that the service would likely achieve those CQC KLoE ratings as specified within each section of the report. Ratings are applied as per those conditions set out within the CQC KLoE Prompts and Ratings Scales.

Please note that this is the opinion of the reviewer carrying out each audit based on the evidence gained during the review visit and using this to evaluate compliance against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

KLOE	Applicable Regulations	Comments
Safe	**Regulation 12 (f) and (g) Safe Care and Treatment** **Regulation 13: Safeguarding users from abuse and improper treatment** **Regulation 17: Good Governance** **Regulations 18 & 19: Staffing - Fit and Proper persons employed** **Regulation 20: Duty of Candour**	**Learning culture:** Score 3 There was a process for recording any accidents and incidents that occurred at the service. Staff recorded behaviours and incidents of concern onto the RADAR system. A sample was viewed to establish if these were being reported appropriately and acted on. Evidence was seen that accidents and incidents were recorded and staff detailed the event. Incidents of concern were escalated appropriately. Investigations took place, which were carried out by the manager and oversight was maintained from the operational manager. Lessons learnt were in place, where needed. For example, how to support and redirect one person, who had behaviours that could challenge. For another person, it was about staff learning and ensuring that they had clear guidance and planning with positive reassurance and prompts for the day to prevent them becoming distressed and focussed on activities that distressed them. Debriefs happened after untoward events. These looked at what happened, what was learnt and what needs to be done in the future. These helped staff to review the event and seek further support if needed. **Safe systems, pathways, and transitions:** Score 2 Where staff recorded marks or bruises onto body maps, explanations were not always in place as to how they may have occurred. These were not always recorded as events on the RADAR system, and although this may not always need to be the case, unexplained marks or bruises need to be monitored and possible explanations explored. **(SR 1)** Restrictive practices were minimised. Areas of the home were only locked where there was a health and safety risks, such as CoSHH, medicine safety and risks associated with sharp objects such as knives. Kitchens and bathrooms were not locked, so people had access as and when they wanted to. Good working relationships had been developed with internal and external professionals to promote safe pathways of care. **Safeguarding:** Score 3

KLOE	Applicable Regulations	Comments
		There were safeguarding processes in place that staff followed to keep people safe from abuse and avoidable harm. Staff completed safeguarding training which helped them understand how to identify and report potential abuse and to reduce the risk of harm. People were safe living at the home because staff knew when and how to report concerns. Two staff spoken with knew how to report any concerns and who they should report them to. They were, however, a little unsure of who to report to outside of the organisation and needed some prompting. **(SR 2)** Three people living in the home said they felt safe. There was one open safeguarding, which had been referred appropriately. Any investigations had been carried out in line with local authority procedures. New systems had been put into place following this. **Involving people to manage risks:** Score 3 Risk assessments had been transferred and updated into the new Blyssful system. Level of risk was identified with the likelihood and consequence for which risk and included actions needed to support the person to manage the risk. Assessments of risk included communication, accessing the community, constipation, domestic skills, personal care and oral care, families, medical conditions, diet and nutrition and finances. Risk assessments identified the need and how to support people. Guidance was linked to care plans. Where people had specific conditions, such as one person was diagnosed with Pica and another was at risk of brain bleeds, there were individualised risk assessments in place. These identified the risk and how to manage. Where one person was at risk of eating inedible objects due to their condition, how to distract and what to offer in replacement was identified in the care plan along with their sensory profile. Staff supported people to stay safe. They supported them to access the community and maintained one-to-one support where needed. PBS (positive behaviour support) plans were in place. These included an overview of the person, goals for the plan, behaviours of concern, triggers, active strategies, and reactive and crisis intervention. PBS

KLOE	Applicable Regulations	Comments
		plans were reviewed regularly. There were high level support and intervention from the PBS specialist who visited regularly and supported staff to develop these. The manager reported a good example of where the specialist had been at the service and staff had needed to use intervention strategies as described within the care plan and these had been positively implemented in line with the guidance. **Safe environments:** Score 3 There were systems in place to monitor the safety of the environment. Health and safety checks included: • Daily fire patrol: 9/4/24 • Monthly emergency light check: 4/5/24 • Monthly fire door alarm: 18/4/24 • Monthly fire door check: 17/4/24 • Carbon monoxide check weekly: 11/4/24 • Monthly fire drill: 6/4/24 (overdue) • Weekly fire alarm test: 11/4/24 • Monthly fire extinguisher: 8/5/24 • Weekly laundry equipment: 10/4/24 • Monthly first aid kit: 5/4/24 (overdue) • Lighting check monthly: 10/4/24 • Weekly nurse call point: 11/4/24 • Weekly plant room checks: 11/4/24 • Weekly water flush: 11/4/24 • Weekly window restrictor checks: 11/4/24 • Monthly grab bag: 27/4/24 • Quarterly extract fan: 1/7/24 • Quarterly garden equipment: 1/7/24 • Quarterly pathway check: 1/7/24

KLOE	Applicable Regulations	Comments
		All but two of the checks were up to date, but the deputy manager who oversaw the checks was aware of this. **(SR 3)** Checks were carried out in food safety management and records maintained in the kitchen were completed with checks on temperatures of fridges and freezers, safer food, better business checks and cleaning schedules in place. It was noted that some of the paperwork had been photocopied multiple times and some of it was blurred or illegible and it is recommended that this is updated and replaced. **(SR 4)** Servicing of appliances and equipment took place. • Fire extinguisher maintenance: 10/12/24 • Water monthly temps 12/4/24 • Water showers descale: 12/6/24 • Water TMV servicing: 24/5/24 • Fire alarm servicing: 10/6/24 • Emergency lighting: 31/7/24 • Fire door inspection: 14/6/24 • Electrical: 5/5/25 • PAT testing: 3/9/24 • Gas safety: 12/6/24 • Nurse call: 12/9/24 Appropriate risk assessments had been completed for: Fire (due: 25/9/24) Water (due: 9/3/25) Health and Safety (due: 25/9/24) Care home risk assessments were in place and been reviewed on a regular basis. These included, chlorine products, cleaning and washing chemicals, contractor control, display screen equipment,

KLOE	Applicable Regulations	Comments
		electrical , emergency procedures, first aid, food preparation cooking and service, infection control, legionella control, ligature, lone working, manual handling, slips, trips and falls and staffing levels. Policies and procedures were in place to support the maintenance and safety of the environment. A 'grab bag' was available with up-to-date PEEPS (personal emergency evacuation plans), the service continuity plan, emergency response plan, fire safety policy, safety data, key codes, and telephone numbers. There was also equipment to help people stay safe, such as foil blankets, flashlights, and reflective jackets. **Safe and effective staffing:** Score 3 A more stable staff team had been introduced, with a larger staff team made up of full time, part time, permanent and bank staff. This was due to a positive recruitment drive and sponsorship of staff from overseas. Agency usage had continued to decrease and was now only used for annual leave or sickness. 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 to activities 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. Recruitment continued to be managed by a central team from head office. They carried out all checks as required by regulation. Evidence of recruitment was kept electronically. A check was made on two new staff members recruitment records. At visits to other services, it has been identified that there was a theme with gaps in employment not being identified and addressed. The two new starter files reviewed at this visit, both identified that any gaps in employment had been followed up for both of these new members of staff. This was positive. Staff records viewed also contained other necessary documentation, such as interview questions, references, a medical questionnaire and disclosure and barring checks (DBS). Right to work checks were in place along with proof of ID and address.

KLOE	Applicable Regulations	Comments
		New staff were supported with an induction. The new induction workbook was being rolled out and would be made available to new staff. This replaced the original standard induction. As yet this had not been introduced. It is suggested that this is made available for new staff. **(SR 5)** Staff were supported with training. This was primarily online through the training provider Your-Hippo. Some training such as PROACT SCIPr was provided face-to-face. Mandatory training was at 99% and included safeguarding, medication awareness, Mental Capacity and Deprivation of Liberty Safeguards, health and safety, food safety, autism, equality and diversity, privacy and dignity, fire safety, GDPR, infection control, manual handling and learning disability. Required training was at 95% and included British sign language, CoSHH, diabetes, duty of candour, mental health, oral health, and PBS. Dementia training had just been introduced and the uptake by staff had been positive with 52% already having completed this training. Overall training compliance including both e-learning and face-to-face was at 97%. Two staff spoken with reported that they found the training useful and felt it supported them in their role. Assessments of individual knowledge and understanding of staff competencies in relation to Health and Safety/Fire, IPC and Food Hygiene, MCA and Safeguarding and medication were in place. These started at induction and then were renewed on an annual basis. These were all recorded at 92.7% on the day of the visit. Face-to-face supervisions were at 82.9%, however some of these were not yet due and were planned, which meant that the percentage report did not fully reflect the actual compliance rate. Appraisals were planned and booked in. **Infection prevention and control:** Score 3 People were protected from the risk of infection as staff were following safe infection prevention and control (IPC) practices. There was an IPC policy to safely manage and reduce the risk of infection.

KLOE	Applicable Regulations	Comments
		Observations of the home, including the communal areas demonstrated that staff maintained a clean and hygienic environment with appropriate cleaning materials used to reduce risks of infection. **Medicines optimisation:** Score 3 People received safe support in relation to their medication. Medicines were stored in locked medication cabinets either in people's bedrooms or flats or in the central office if it was not safe to keep in people's rooms. There were safe systems for the ordering, returning and disposal of medicines. Temperatures were checked on a daily basis. A sample of MAR charts were viewed. These were seen to be completed appropriately with signatures and correct codes used. Countdown sheets were in place to monitor the number of medicines in place. The countdown sheets tallied with the number of tablets recorded as administered. Each person had a medication profile which included the individual diagnosis and any allergies. The profile also included any specific communication needs, the preferred way of taking medicines and actions to take if medicines were refused. There was an easy read medication guide, which was a pictorial guide for individual medicines. This included a picture of the medicine, what it looked like, why it was needed, any side effects and when to take it. Care needs to be taken to ensure that these are up to date with the current prescribed medicines, as the easy read for one person was different from their current MAR chart. **(SR 6)** PRN (as and when medicine) protocols were in place and these included information about the directions, reasons for use, signs and symptoms, things to try before the use of the PRN, what the effect should be, side effects and when to seek further help. • This service scored 71 (out of 100) for this area.

KLOE	Applicable Regulations	Comments
Outcome: The service is considered safe 'Safe' is defined by the CQC as meaning "**people are protected from abuse and avoidable harm."** **Characteristics of services the CQC would rate as 'Good' in this area are those displaying evidence through systems, processes and practice which reflect:** People are protected from avoidable harm and abuse. **SRG RATING: Good**		

KLOE	Regulations	Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: The need for Consent** **Regulation 12: Providing Safe Care and Treatment** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 15: Premises and Equipment.** **Regulation 17: Good Governance** **Regulation 19: Staffing**	**Assessing needs:** Score 3 One person had moved in in February 2024 and a review of their assessment was undertaken. Assessment included personal care, continence care, health, nutrition, communication, mobility, and behaviours. An assessment of risk was carried out to establish if there more detailed risk assessment needed. Part of the admissions assessment included an assessment of the environment and whether any adaptations were needed, transportation to the service, a review at their previous location, staffing requirements and training. Arrangements for transition were reviewed as to what was important to the person, how they were to keep in contact with family, any visits to the service prior to moving in. The transition process was adapted for each person. If needed, additional support from the internal professionals was obtained and where necessary meetings were set up for appropriate assessments, for example the SALT and/or PBS team. **Delivering evidence-based care and treatment:** Score 3 Each person had a 'purple folder' which was distributed to people with a learning disability by Hertfordshire County Council. This was to be used for key health information, health care plans, health action plan and appointments. There was an expectation with the local authority that this was kept in use and maintained. Files viewed were not up to date. However, much of the information was out of date and no longer relevant. A sensory care plan was dated March 2022, a health action plan was dated May 2022 and consent to access files was still on Sequence paper and dated 2019. New folders had been provided, but these needed to be updated and maintained with current information. **(ER 1)** Some people had individual conditions which required staff knowledge and specialist support. There were individualised care plans in place for individual conditions. For epilepsy, for one person this described different types of seizures such as clonic, atonic and absence seizure. Support was to offer reassure during any seizure, if a tonic clonic seizure lasted more than 3

KLOE	Regulations	Comments
		minutes, then 10mg of buccal was to be administered and if not abated with 10 mins, then a second dose of 10 mg buccal to be administered. However, there was no reference as to what the tonic clonic seizure looked liked and how staff could recognise it. The care plan also identified myoclonic seizures at different levels including 'without significant impairment of consciousness' to offer clobazam. If there is an impairment of consciousness, then buccal to be administered. Again, a lack of detail of how to identify the different types of seizure. There was no linked detailed risk assessment or if there was an epilepsy nurse involved. It would be best practice to detail possible indicators of different seizures, especially if the treatment is different. **(ER 2)** Where one person had diabetes there was a detailed care plan with information about high and low blood sugars and signs of either hypoglycaemia or hyperglycaemia. Where one person had receptive and expressive dysphagia, information was included in the care plan along with aims and objectives. One person took anticoagulants and there was a risk assessment in place. In addition, they suffered from regular nosebleeds. Staff had made appropriate assessments and took correct action in the event of a nosebleed. **How staff, teams and services work together:** Score 3 Staff accessed internal and external support to ensure that people were supported with appropriate care and treatment to meet their needs. Internally staff were able to access the SALT (Speech and language therapy) team and the PBS (positive behaviour support) team. They provided support with assessments and reviews and provided guidance on how to support people safely. The manager reported that this was a good resource which helped improve quality outcomes for people. Currently there was no internal O.T. support, but this was accessed externally. Staff had worked with the DoLS (Deprivation of Liberty Safeguards) assessor for one person when they moved in, so a suitable assessment could be made.

KLOE	Regulations	Comments
		People were also supported to visit the GP, attend hospital appointments, diabetes appointments, and access the learning disability team. A communication book was in place which helped to share information. For example, when one person refused to use their epilepsy mat, this was communicated so all staff were aware. **Supporting people to live healthier lives:** Score 3 People were supported with an annual health check, medication reviews, blood tests, where needed, diabetic eye screening and psychiatry. Physical health reviews for mental health medications were taking place. This was associated with the STOMP initiative and was aimed at reducing the over medication of people. A health action plan was in place. This included details of any allergies, vaccinations, screening appointments, overview of weight, diet, mobility, smoking, exercise, alcohol, substance misuse, hearing eyesight, teeth and what people could do for themselves. Pain profiles were in place to help identify any support needs when people were in pain. There was information about the person usually was, why they may be in pain, how they might indicate they are in pain such as facial expressions, changes in body language, behaviour, and bodily functions. There were pictures in in place so the person could point where they were in pain. Risks associated with nutrition and fluid were assessed and information was contained within the care plans and risk assessments. Where the medication allergy section stated none. In the 'other' section it was recorded that they were allergic to penicillin, cephalosporins and cefalexin. **(ER 3)** **Monitoring and improving outcomes:** Score 2 There are systems in place to monitor individual needs including weights, fluids, food, and general observations. There was some inconsistency of recording for observations, for example, there were systems to record continence care, oral hygiene, morning routine, dressing, bath temperatures, day time observations and handover. These were intermittently filled in. For example, one person was quite independent with their

KLOE	Regulations	Comments
		continence care, however some staff recorded that they had monitored bowels movements and other staff did not. Staff had recorded on 2nd, 5th, and 6th April that they had passed urine and had a bowel movement, but not on the other days, therefore it was not possible to establish if the person had been to the toilet or not. **(ER 4)** When recording meals there for one person, staff recorded different levels of texture, such as 'regular' or 'easy to chew'. **(ER 5)** One person had a diabetic review on 5th April 2024, and it was recommended that a two-week food diary should be maintained. A check on the system found that staff were not always recording meals in the food diary section. For example, there were no meals recorded on the 6th and only breakfast and lunch on the 7th. Although it was reported that they were waiting for a food diary, there needs to be a consistent approach when recording meals. **(ER 6)** **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 particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. MCAs had not transitioned over to the new system, but staff had saved them to a central location, so they were still accessible. They need to be updated onto the system. **(ER 7)** Assessments viewed included medical health, personal care, finances, medication, domestic and daily living skills, diet and nutrition and health appointments. On the sample viewed, there was little in the way of evidence to demonstrate the conversations which were held, how the information was explained, such as use of communication aids and how people were supported to be assessed as to their ability to retain information. MCA assessments need further development. **(ER 8)**.

KLOE	Regulations	Comments
		Within the new Blyssful system there were risk assessments and care plans for mental capacity and DoLS. These lacked detail and did not identify where people lacked or had capacity and how staff could support people. **(ER 9)** Where people could make decisions for themselves, they were supported to do so. Staff were seen to ask for consent before providing any care and support. 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). However, two had recently been refused, which meant that these people were not subject to a DoLS, and this was respected. • This service scored 66 (out of 100) for this area.

Outcome: The service is considered effective

'Effective' is defined by the CQC as meaning **"people's care, treatment and support, achieves good outcomes, promotes a good quality of life and based on the best available evidence"**

"Characteristics of services the CQC would rate as' Good' in this area are those displaying evidence that people's outcomes and feedback about the effectiveness of the service describes it as consistently good."

SRG RATING: **Good**

KLOE	Regulations	Comments
Caring	**Regulation 9: Person-centred care** **Regulation 10: Dignity and respect**	**Kindness, compassion, and dignity:** Score 3 There was a calm atmosphere within the service with people being supported in a compassionate and dignified manner to manage their day. At previous visits it had been noted that some people were often either agitated or restless, this was not seen at this visit. This was because people were occupied and engaged. 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. People spoken with all said they thought staff were kind and caring and listened to them. It was seen that on one occasion one person's care records were left unattended in a communal area, which did not promote privacy. **(CR 1)** **Treating people as individuals:** Score 3 People's bedrooms were personalised to their individual needs. Some people could damage or destroy items, so communal areas and bedrooms were arranged accordingly. People were supported on an individual basis in accordance with their assessed needs. Care plans and risk assessments were individualised to the person. Key workers were developed, and consideration was given to likes, dislikes, age, culture, and personalities. This helped people to develop positive relationships. Care plans identified particular things people liked such as activities, pastimes, and foods. **Independence, choice, and control:** Score 3 There was evidence that people were supported to maintain their independence. Support plans included information about what people could manage for themselves, such as managing their own personal care. People were supported to take part in daily living activities, such as laundry, helping to prepare lunch, and maintaining their bedrooms.

KLOE	Regulations	Comments
		People worked with staff to arrange their own shopping lists and plan their menus. Mealtimes were flexible around people's needs and preferences and people were able to have their meals and snacks at times they chose. Observations showed that staff supported people to be involved and participate in daily living activities, people were seen making their own drinks and helping to make lunch. **Responding to people's immediate needs:** Score 3 People were listened to, and their opinions mattered. One person had refused to have their epilepsy mat at night, as it disturbed them. Staff had listened to this and implemented additional checks. Staff were responsive to individual needs. They recognised when people were unsettled and distressed and supported them in a sensitive and responsive manner. One person had become distressed and upset and wanted to talk about leaving the service. This was a recognised and understood behaviour and staff took time out throughout the day to ensure they listened to the person and gave them reassurance. Where one person had a nosebleed, they were supported in a dignified manner and assurance was given to ensure the person did not become distressed. Reviews of incidents were undertaken to assess how these were managed to ensure that people were supported appropriately. Where an assessment had identified that a person was not eating properly, their care was reviewed by the SALT team with the assessment and care plan updated instantly to ensure that staff had the right guidance to follow. **Workforce wellbeing and enablement:** Score 3 Staff well-being was considered. At staff meetings, staff wellbeing was discussed, and any concerns noted. There was an open-door policy and staff reported that they felt well supported.

KLOE	Regulations	Comments
		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 assistant programme in place, which included occupational health, to support staff. • This service scored 75 (out of 100) for this area.

Outcome: The service is considered as Caring.

'Caring' is defined by the CQC as meaning **"that the service involves and treats people with compassion, kindness, dignity and respect"**

"Characteristics of services the CQC would rate as 'Good' in this area are those displaying evidence that people are supported and treated with dignity and respect and are involved as partners in their care."

SRG RATING: Good

KLOE	Regulations	Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 12: Providing Safe Care and Treatment** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred care:** Score 3 A person-centred care approach had been developed. Care plans were in place for individual areas of care and support. These were linked to the risk assessments and included personal and oral care, mobility, continence care, finances, family, goals and outcomes and individual health care needs. Care plans gave staff guidance on how to support people. There were some task orientated approaches, but overall care plans were specific to the person and in places there were nice person-centred approaches. Staff need to be mindful when writing care plans as sometimes they were written in the first person and at other times in the third person and this would change in the middle of the same care plan. **(RR 1)** Consideration was given to how people spent their day and their time and staff listened to what people had to say. People were able to make choices and people said they felt staff knew them well. **Care provision, integration, and continuity:** Score 3 Staff worked with health and social care professionals, both internally and externally to promote outcomes for people. Internal specialist practitioners who supported the service included the PBS (Positive Behavioural Specialist) practitioner and the SALT (Speech and Language therapist) specialist. They worked proactively with the service to provide guidance and support for staff. Reviews of care were undertaken with the internal and external teams. **Listening to and involving people:** Score 3 Meetings were held with people using the service. These considered events, visits, safeguarding, menu updates and any general concerns. One person using the service took the minutes and recorded any actions. There were no updates to the meetings to record if actions discussed as the previous meeting had been achieved and it would be good practice to do this. **(RR 2)** People were supported with key workers. Key workers were allocated as the lead support worker for an individual person and supported them with reviews, practical matters, and emotional support.

KLOE	Regulations	Comments
		Keyworkers met with people on a monthly basis and discussed support provided in relation to personal care, friends, family and relationships, their home, bedroom and communal areas, health, and medication, managing money, going out, likes and dislikes and any goals. This gave people the opportunity to engage positively with staff and discuss any concerns or what went well and review goals. There was an easy read complaints procedure available, and any concerns and complaints were discussed at meetings. The last formal recorded complaint was May 2023. **Equity in access:** Score 3 Staff supported people to access care, treatment, and support when they needed to and in a way that worked for them. Where people needed this, health care professionals were encouraged to visit the service or staff supported them to attend appointments. Recently it had been agreed that the annual health check would be carried out in the service, where people were more at ease. **Equity in experiences and outcomes:** Score 3 It was positive to see that assurances given at the last visit, in relation to two people who had planned to go on holiday, had happened. There was evidence seen that they had planned and gone on their holiday. Both people fed back that they had enjoyed the experience and were looking forward to planning another one. Another person had wanted to go swimming, and this had been achieved. However, consistent evidence of achieving goals was sometimes limited. For example, one person had a goal of completing daily activities which was repeated on a monthly basis with no record of this being developed or achieved. **(RR 3)** There was a care plan to record goals and outcomes, but this was not always up to date. For example, for one person there were plans to go on holiday, but this had already happened. There was a lack of detail on how people were to achieve these goals, which would be good practice. **(RR 4)** Art therapy had been introduced and regular art classes were held. Evidence of artwork was seen with 'amazing' pieces of artwork with 3D effects and intricate detail which people had contributed to. People

KLOE	Regulations	Comments
		spoken with were proud of the artwork they had produced, and these were displayed prominently around the houses. People were supported with a range of activities. These included going out and about in the community such as shopping and visiting local attractions. There were regular Zumba classes, some people attended a day centre and people went bowling. Staff supported people to improve outcomes. For example, one person was now able to make a choice when given the options of different food items, where as previously they had been unable to manage this. Staff were also pleased to report that through a more consistent staff approach with one person, they had been able to join in a party with other people, which had been a positive experience for them. One person had also gone to visit and stay overnight with a relative, which again was a positive experience for them. Competitions and events were arranged on a regular basis such as swallow awareness, where people made fruit based mocktails and the next awareness event was for a spring clean. This was helping people to join in different experiences and develop their skills. **Planning for the future:** Score 3 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 and where people wanted to discuss this, it was included in their care planning. **Providing information:** Score 3 Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

KLOE	Regulations	Comments
		Communication was included in the care and plans. Where aims and objectives were to maintain good communication levels and support with day to day living tasks, for one person with respective and expressive dysphagia, there was guidance on how to support and communication tools which could be used. There were a range of communication tools used including easy read information and social stories were used to aid communication. • This service scored 75 (out of 100) for this area.
Outcome: The service is considered as Responsive. Responsive is defined by the CQC as meaning “that the service meets people's needs.” **“Characteristics of services the CQC would rate as ‘Good’, are those that people’s needs are met through the way services are organised and delivered”.** **SRG RATING:** **Good**		

KLOE	Regulations	Comments
Well led	**Regulation 12: Providing Safe Care and Treatment** **Regulation 17: Good governance / Record Keeping** **Regulation 19 - Fit and Proper persons employed**	**Shared direction and culture:** Score 3 The manager supported staff to promote a positive and open culture at the service. All staff took action to ensure people using the service received safe and consistent good quality care. Staff were complimentary about the manager and said they had time to listen to them if they needed any support. There was a shared goal for the service to support people to reach their goals and let people release their own potential. The aim was to ensure people were happy and had a fulfilling life. This was starting to be explored with the development of goals. The manager understood their responsibility to show clear leadership of the service and demonstrated clear insight into the quality of care, service delivery and staff support. The manager understood their responsibilities in relation to duty of candour and knew they had a legal responsibility to share information with the local authority and the CQC when things go wrong. **Capable, compassionate, and inclusive leaders:** Score 3 There had been a change in the management team since the last visit by SRG, with another manager in post. They had been in post since September 2023 and were aware that changes in the management team had an affect on the service. They stated that they were committed to supporting the service. To this effect they had applied for the registered manager registration with CQC and were awaiting their interview. The manager was supported by two deputy managers, two team leaders and four senior staff, one of whom was always on duty. This also helped to promote a more consistent approach. Staff reported that the management team listened and that there was more support. The deputy manager felt there was more management structure which was impacting positively on the smooth running of the service. The operations manager visited the service on a regular basis and provided both support and guidance. **Freedom to speak up:** Score 3

KLOE	Regulations	Comments
		Staff were supported to able to give their views and contribute to the running of the service. Teamwork was being promoted with discussions at team meetings, with regular meetings taking place. Staff could also contribute their ideas through supervisions. Communication books and handover procedures were in place to help staff share information. Whistleblowing was highlighted and procedures were available to staff. Staff surveys took place and feedback had mainly positive at the last one undertaken. Staff reported that the manager listened to them and there was good support from the management team. **Workforce equality, diversity, and inclusion:** Score 3 The management team worked with staff to arrange flexible working hours and individual cultural needs were considered when staff requested annual leave. There were policies and procedures in place for promotion of equality and diversity. Staff reported that they felt included. **Governance, management, and sustainability:** Score 3 There were systems in place to monitor the quality of the service. The quality assurance audit was maintained electronically. Audits were carried out weekly, monthly, and quarterly and included: • Quarterly operational audits for administration, quality of life and infection control and medication. • Monthly audits for Support Plans and Risk Assessments, Health and Safety/Infection Control, finances, data protection, medication and night time. • Weekly audits for medication, vehicle maintenance and regular walks around the service. It was seen that audits were being completed in line with the schedules. Areas of shortfalls were identified, and actions generated from these.

KLOE	Regulations	Comments
		There was a Quality Assurance Framework (QAF) which monitored governance and overall compliance. Information was taken from compliance with audits, actions from audits, observations, and staff training. The most recent score was at 94%. **Partnerships and communities:** Score 3 The service worked proactively with health and social care professionals in the community and internally as identified within this report. Family involvement was promoted, and key workers communicated with families to keep them informed of people's progress or activities. **Learning, improving and innovation:** Score 3 Meetings at different levels for the management senior management team were happening, which helped to share learning and improvements. Monthly manager meetings happened within the London region. These were carried out at different services to enable managers the opportunities to see other services. Through reviews of accidents and incidents and debriefs, service level learning was in place. A recent PAMMs inspection had resulted in the development of additional guidance and implementation of actions made by the inspector, such as a one-page complaints procedure and a you said – we did board. Feedback from PAMMs on actions taken had been positive. Actions were generated from audits, accidents, and incidents. A sample viewed evidenced that some were repeated on a regular basis, therefore consideration needs to be given to ensure that actions are embedded. **(WR 1)** There were a number of actions that were overdue, the manager was aware of this and was actively addressing these. **(WR 2)**

KLOE	Regulations	Comments
		Quality of life reviews had taken place and guidance and assessments from internal professionals had made positive changes in the support people received. For example, the updating of SALT guidelines and PBS guidance. **Environmental sustainability – sustainable development:** Score 3 Environmental sustainability was considered. Recycling was promoted and one person was the lead for recycling in the home. Food wastage was monitored to help reduce effects on the local environment. Where possible local shops and amenities were used to cut down on transport. Electonric systems were used to help cut down on the use of paper records and to save paper. • This service scored 75 (out of 100) for this area.

Outcome: The service is well led.

Well Led is defined by the CQC as meaning **"that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture."**

Characteristics of services the CQC would rate as Good, are those where **"the service is consistently well- managed and led. The leadership, governance and culture promote the delivery of high-quality, person-centered care, and the service has clear, consistent and effective governance, management and accountability arrangements"**

SRG RATING: Good

ACTION PLAN:

CQC KLoE 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	*Ensure that unexplained bruises are recorded appropriately with possible explanations considered and evidence that progress is monitored.*						
SR2	*Remind staff of who to report any concerns to outside of the organisation.*						
SR3	*Ensure that checks are completed in line with schedules.*						
SR4	*Update and replace poor quality paper records, particularly in the kitchen.*						
SR5	*Ensure that the new induction booklet is available for new staff.*						
SR6	*Ensure that easy read medication profiles are reflective of current prescribed medicines.*						

CQC KLoE EFFECTIVE

By effective, we mean that people's care, treatment and support achieves 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	*Review the purple folder on at least an agreed regular basis to ensure that the information is up to date and current.*						
ER2	*It would be best practice to detail possible indicators of different seizures within the care plans, especially if the treatment is different.*						
ER3	*Ensure allergies are recorded in the correct sections.*						
ER4	*Ensure that there is clear direction of when to record individual care to promote a consistent approach.*						
ER5	*Ensure that correct food textures are recorded.*						
ER6	*Ensure that food diaries are implemented robustly where needed.*						
ER7	*Update MCA assessments onto the electronic system.*						
ER8	*Review information in the MCA assessments, and include more information as to how people are supported to understand the information,*						

	which communication aids are used, and conversations held.						
ER9	*Further develop the risk assessments and care plans in relation to mental capacity and DoLS.*						

CQC KLoE 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	*Ensure that confidential records are not left unattended in communal areas.*						

CQC KLoE RESPONSIVE

By responsive, we mean that services 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	*Promote a consistent approach with writing care plans – use either the first or the third person especially in the same section of the care plans and risk assessments.*						
RR2	*Add into the minutes of meetings, updates to previous actions to help evidence that people's requests had been listened to and acted on.*						
RR3	*Ensure there is a consistent approach to recording the completion of goals.*						
RR4	*Include more information in the goals and outcomes on how people were to achieve individual goals.*						

CQC KLoE WELL-LED

By well-led, we mean that the leadership, management and governance of the organisation 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 actions are embedded before they are signed off.*						
WR2	*Continue to address outstanding actions.*						