AUDIT REPORT

Lucas

Date of Visit: 9th and 10th May 2024

Private & Confidential
SRG CARE CONSULTANCY LIMITED

Contents:

Service Name: Lucas

Provider: Liaise

Address of Service: 35 Lucas Road, High Wycombe, Buckinghamshire, HP13 6HP

Date of Last CQC Inspection: Newly Registered

Ratings

CQC's Overall Rating for this Service:	Newly Registered	
SRG Overall Rating for this Service:	Good	

KLoE Domain	Rating		Overall Score
Is the service safe?	Good		62 (out of 100)
Is the service Effective?	Good		66 (out of 100)
Is the service caring?	Good		70 (out of 100)
Is the service responsive?	Good		64 (out of 100)
Is the service well-led?	Requires Improvement		59 (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 9th and 10th May 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 people who use the service and staff, conversations with the Manager, Deputy Manager, with staff and two people using the service, a tour of the building and review of key documentation.

SUMMARY OF OUTCOME

Lucas provides support living and provides personal care to people using the service. The service can accommodate three people and there was full occupation. People live in their own flats.

We read care plans for two people, we checked one 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.

Lucas uses the Blyssful care planning software. RADAR is used to monitor accidents and incidents and quality assurance. QUOODA monitors health and safety. Your Hippo is used for on line training.

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 2 There were systems and processes for monitoring accidents and incidents. Accidents and incidents were reported electronically onto the RADAR system. A sample viewed evidenced that these were detailed and identified what had happened, and the support provided at the time. A sample of incidents were reviewed, and this recorded support provided in line with guidance within the PBS plan. For example, when distressed one person was advised to carry out breathing exercises. Staff were to use protective stances, and these were described and also a 'front arm catch' which is part of the PROACT-SCIPr-UK intervention technique training. This was also included in the care plan and there was evidence from the incident reports that these techniques were being used. One person had been refusing medicines, and although one such event was recorded as an incident, subsequent refusals had not. **(SR 1)** There were some examples of lessons learnt such as a brief action to prevent an event happening again, but those viewed lacked detail. **(SR 2)** Staff reported that they had debriefs and a sample were seen. **Safe systems, pathways, and transitions:** Score 3 It was reported that there were no restrictive practices in place and only protective stances in place, which was reflected in the care plans and incident reports. There were good working relationships with the internal professional team and reviews were being carried out on people using the service. **Safeguarding:** Score 3 Safeguarding matters were reported, and the manager understood their responsibilities in relation to these. There was one open safeguarding that was being reviewed in line with the local authority procedures.

KLOE	Applicable Regulations	Comments
		There were robust whistleblowing procedures which were used effectively to protect people using the service. Safeguarding information was shared with people using the service and they were made aware of who they could contact if they felt they needed to. Two people using the service said they felt safe. One person said, 'I feel really safe here with the staff'. **Involving people to manage risks:** Score 2 Risk assessments were always not detailed and did not give clear guidance about the risk or how to mitigate and reduce such risks. The constipation risk assessment for one person identified the risk as 'changes in health, fever, stomach pain, blood in stool, sickness, lack of appetite'. The guidance was to 'Monitor for any changes in bowel habits, bleeding, consistency, abdominal pain' and 'Monitor duration of constipation. Encourage fluids and nutritional intake especially focusing on fibre encourage an active lifestyle'. There was no additional information with clear measures on how to manage the risk. There was no information on the use of laxatives and no reference in the medication risk assessment. **(SR 3)** There was no support plan in place to help staff. **(SR 4)** In one case, where a risk with behaviour had been identified this had resulted in the person not receiving support to visit the community, the risk assessment identified this as unsafe, but there had been no alternatives sourced, although at the time of the visit, a separator for the car had been delivered. Where some risks were identified, there were not risk assessments in place. There needs clearer evidence that staff understand how risks are managed and why risk assessments are required and in place. **(SR 5)** There needs clearer evidence that staff understand how risks are managed and why risk assessments are required and in place. Some people had behaviours that could challenge and become aggressive with staff and others. There was a PBS (Positive Behaviour Support) plan in place. One viewed was seen to be detailed with information about communication, proactive strategies, and detail about different types of behaviour with

KLOE	Applicable Regulations	Comments
		triggers and functions of behaviour and active and reactive strategies in place on how to support with individual behaviours. It was noted that the PBS plan should have been reviewed after a month, following the person moving in and that a functional behaviour analysis was to be completed within eight weeks of moving into the service, but this had not happened. It was reported that this had been delayed by the PBS team due to behaviours, evidence was seen that this process had started. **Safe environments:** Score 3 Each person had a personal emergency evacuation plan, both within the Blyssful system and in an easier read format. The information in the two of these documents differed slightly, with some more detail in the Blyssful system. For example, this identified that one person was likely to refuse to leave the building, and this was not included in the pictorial version. However, another document recorded how to support the person, in the event of them refusing to leave the building. **(SR 6)** There were systems in place to monitor the safety of the environment through the QUOODA system. Checks were carried out on a schedule of daily, weekly, monthly, and quarterly. Fire checks included emergency lighting checks, fire door checks, fire drill, daily patrol, and monthly grab bag were all up to date, except for the fire alarm test was overdue by one day. **(SR 7)** Carbon monoxide check, laundry equipment, window restrictions, water flushes, extract fans and pathways were all completed. The fire risk assessment, health and safety risk assessment, water risk assessment, electrical hard wiring and PAT testing, fire door inspection, fire emergency lighting servicing and gas safety were all up to date. The fire alarm service was not up to date, although it had been recently due. **(SR 8)** **Safe and effective staffing:** Score 2

KLOE	Applicable Regulations	Comments
		There were three people living in the service, who received a range of one-to-one or two-to-one support hours. It was reported that there were enough staff to support people using the service. Although the manager reported that there was limited support to cover break times. Where people were commissioned for one-to-one, there were no floating staff available to cover breaks. There was an expectation that the manager or deputy manager would cover this, but the deputy manager also worked on shift for two days. They felt that should be a floating member of staff available. **(SR 9)** 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 and two staff files were reviewed. References from previous employers was in place. Proof of right to work, identity and address were generally in place, although it was noted that the proof of address did not have the actual name of the person and was address to the 'resident' of the address. **(SR 10)** DBS (Disclosure and Barring) checks were in place as were medical declarations. Employment histories had been checked to ensure there was a full history available, and staff were requested to provide an explanation for any gaps, but these were often in text messages or a one line in an email and it was difficult to fully follow a complete employment history. There is a welcome pack which can included work history and it would be useful to ensure that this was fully completed to help evidence the employment history and any gaps. **(SR 11)** When staff started, they were supported with three days of training and induction into the service such as reviewing systems, and training such as PROACTSCIPr and CPR training. This was verbally confirmed, but there was no record of any formal induction although there was some feedback from a trainer. **(SR 12)** Training was primarily online through Your-Hippo. Training included: Mandatory: Autism, Equality & Diversity, Fire Safety, Food Safety GDPR & Data Protection, Health and Safety, Infection Control, Learning Disability, Mental Capacity Act and Deprivation of Liberty Safeguards, Manual Handling, Meds Awareness, Privacy and Dignity, Safeguarding.

KLOE	Applicable Regulations	Comments
		Required: British sign language, CoSHH, diabetes, duty of candour, mental health, oral health, Person Centred Care, Medication Administration, Nutrition, PBS Your Role, and Personal Development. Staff training was at 100%. It was reported that there was also training around ligature/self-harm and suicidal training, but no evidence of this. **(SR 13)** Supervision was seen to be in place and compliance was at 63.2 %. Direct observations were at 57.9 %. Actions need to be taken to ensure that staff are supported with supervision and direct observations. **(SR 14)** Competency assessments were also completed in: ➢ Health and Safety / Fire: 89.5 % ➢ Infection prevention and control and food: 89.5 % ➢ Mental Capacity and safeguarding: 89.5 % ➢ Medication: 100 % **Infection prevention and control:** Score 3 There were systems in place to prevent and control infection. This included a regular audit which monitored infection control and cleaning procedures. Cleaning schedules were in place. **Medicines optimisation:** Score 2 People's medicines were kept in locked cabinets in their own flats. Each person had a medication profile which included diagnosis, allergies, any specific communication needs, preferred way of taking medication, list of daily medication and any PRN.

KLOE	Applicable Regulations	Comments
		Start dates were not recorded on boxes. **(SR 15)** Leaflets were not available for not all the medicines in the blister. **(SR 16)** When medicines are 'popped' from the blister pack, but not administered because of refusals it was reported that they are placed in a returns bag and then returned at the end of the cycle. There were systems for signing medicines in and out of the service. One person was refusing medication, but one was an anti-depressant and should not be stopped without talking to the doctor. The psychiatrist and social worker have been made aware - but there was no record of this. This needs to be updated into the RADAR system with evidence of who has been contacted. **(SR 17)** MAR charts were seen to be completed, with no gaps and appropriate codes used. The deputy manager reported that every month staff had to chase medication, for example, the repeat prescription was sent on 1st May and on 8th the home and pharmacy have had to chase up the surgery for the prescriptions to be issued as they have not been sent to the pharmacy. Staff need to think about how to take this further as this is ongoing. **(SR 18)** PRN (as and when medicines) were not always clearly recorded either on the MAR chart. For example: ➢ Two medicines were prescribed for specific conditions, one for constipation and one for migraine. There were PRN protocols, but neither recorded that they were PRN on the MAR chart. ➢ Phenergan was not identified on the box or MAR chart as a PRN but did have a PRN protocol. Ensure there is clear information about which medicines are PRN. **(SR 19)** Guidance for PRN was not always clear. ➢ Sumatriptan was prescribed for migraines. There were two levels of doses, one for 50 mg and one for 100 mg. The MAR chart and the label on the box for the 100mg tablets said that one tablet to be administered and one at least 2 hours after first dose. BUT the PRN protocols stated that no more than 100 mg in 24 hrs and the correct dose needs to be identified.

KLOE	Applicable Regulations	Comments
		➢ One person had macrogol and lactulose PRN, but there was a lack of guidance of when to use which medicine, as they were for the same condition. PRN should identify when to use which medicines if there is more than one medicine for a specific condition. **(SR 20)** PRN protocols were in place for ibuprofen and paracetamol. These identified the strength, frequency, reasons for use, signs, and symptoms, when to administer and when GP advice should be sought, for example. The guidance stated to look for signs of pain. But not what these were. **(SR 21)** The PRN ibuprofen and paracetamol were homely remedies and had not been prescribed by a pharmacist and were not on the MAR chart. There was no record of when the PRN had been administered and both boxes only had a few tablets left (4 out of 16 paracetamol and 6 out of 16 ibuprofen). There was no date of opening on the boxes. The only evidence of administration was on a stock count sheet, but where 2 ibuprofens were recorded as being administered, there was no reason why and these were not on the MAR chart. **(SR 22)** Temperatures were taken on a daily basis, but these were recorded on Blyssfull I am not sure this is the best way to manage as it is more difficult to gain an overview and check for any gaps and monitor correct temperatures. A sample of observations showed that these were not being recorded daily. **(SR 23)** • This service scored 62 (out of 100) for this area.
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 People's care records showed their needs were assessed before they began to use the service. Where possible, detailed assessments were carried out with an organised transition process arranged. There was one particularly good example, where the full assessment had included the reason for referral, a full historical background review, compatibility with the service and other living at the service, personal and healthcare needs, nutrition, communication, mobility, behaviours of concern and personal preferences such as culture, hobbies, and activities. Once the assessment had been completed and finding agreed, a transition programme had been set up. This had included a gradual transition of regular visits, overnight stays and planning of how to set up their new home over an agreed period of time. To support a smooth transition, relevant assessments and documentation were obtained from the previous placement. One person had not received a smooth transition, which had been beyond the manager's control. **Delivering evidence-based care and treatment:** Score 2 Some of the assessments in relation to health care needs had not been completed, for example a nutritional assessment and an oral assessment for one person. **(ER 1)** There were internal specialist practitioners who supported the service. This included the Positive Behavioural Specialist (PBS) practitioner, speech, and language therapist (SALT) and occupational therapist (OT) could be sourced from the community. They supported with various aspects including assessments and involvement in support planning. Where people had specific conditions, there was little information in support plans to guide staff to understand these conditions. **(ER 2)** **How staff, teams and services work together:** Score 3 Hospital passports were in place. A hospital passport tells the hospital about the person's healthcare needs, their disability, communication and how to make things easier for the person.

KLOE	Regulations	Comments
		The hospital passports were produced on the Byssful system and included key points about the person, such as how to communicate, relationships, allergies, any religious or cultural needs and likes and dislikes. The hospital passports also included information on individual medical histories and conditions alongside medication, pain management and mobility. This meant that staff in hospitals would have the information they needed should someone be admitted to hospital or needed to attend an appointment. Throughout the visit it was reported that there had been challenges in relation to professional support for at least one of the people using the service. This also included obtaining medication due to a lack of support from psychiatry and the G.P. There had been challenges in registering with the G.P. One person had no psychiatry support and only recently been allocated a care manager. There was an internal support team including PBS and SALT who were working with the service. **Supporting people to live healthier lives:** Score 3 Care staff supported people to hospital, where needed. People were supported to access appointments in relation to individual healthcare needs, such as the G.P., dentists and optician. Staff confirmed that they knew what action to take in an event of a health emergency or if someone was unwell due to their health conditions. A health action plan assessment was completed, and each person had a health action plan, which is a record of how to support to stay healthy. **Monitoring and improving outcomes:** Score 3 Ongoing monitoring of needs was evident and health and social care professionals were actively involved in providing information to support the assessment of needs with the home. For example, the PBS specialist was actively visiting the service to carry out a functional behaviour assessment for two people using the service. Key worker reviews helped people to monitor their individual support needs. Accidents and incidents were monitored, and actions taken to improve outcomes. Meetings were held with the two people using the service to review their care and support.

KLOE	Regulations	Comments
		Consent to care and treatment: Score 2 The Mental Capacity Act (MCA) 2005 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. There was an assessment from the Continuing Healthcare case manager from Hampshire and Isle of Wight NHS, which had been carried out in July 2023, for one person. This identified that they did not have capacity to decide about where they should live. As a result of this, the placement at Lucas House was chosen. One person was under the Court of Protection, which was issued on 12 January 2024 and also included placement and authorisation of deprivation of liberty. This was in pursuant to arrangements made by the Applicant and set out in the Care Plan, which was presented to the court at the time of application. This was being used as the basis of authorisation for care, and there were no internal MCA assessments, as it was stated that the support plan had been provided which had formed the basis of the DoLS and therefore the MCA assessment process. Usually, the managing authority which is the service where the person lives should have specific MCAs in place for individual decisions and I recommend that this is kept under review, especially as there has already been changes to the person's support plan. For example, changes to medication and these were not updated onto the support plan. **(ER 3)** Where people had capacity, they read and signed their tenancy agreements and any consent agreements around photographs, support with medicines, and individual support plans. Where the risk assessment for one person stated that 'to consider using a Bristol stool chart' if the person was happy for was not supported by an agreement or record of consent of recording of bowel movements. **(ER 4)** • This service scored 66 (out of 100) for this area.

KLOE	Regulations	Comments
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 Two people using the service said they felt staff were kind and caring. People were able to make choices and daily living preferences were listened to. Observations showed that staff spoke to people in a respectful manner. **Treating people as individuals:** Score 2 There were some routine practices which did not promote the individuality of people using the service, for example one person had a pain profile, including an easy read pictorial chart which they did not need, as they had capacity and had reading skills. **(CR 1)** There was information about individual likes and dislikes, and this was seen to be included throughout the care plans. People were supported to choose how they wanted their flats or rooms to be decorated or furnished. **Independence, choice, and control:** Score 3 Staff prompted people to undertake tasks such as cleaning, laundry, shopping and preparing and cooking meals. Staff told us they encouraged people to do as much as they could for themselves. Two people spoken with confirmed that were able to describe how they were supported to be independent and make their own choices. Staff respected people's choices in relation to their care and support needs but monitored for safety. **Responding to people's immediate needs:** Score 3 Staff were key workers for people which meant they took responsibility for making sure they knew and understood people. Staff spoken with were able to describe individual support needs. Staff understood signs and triggers of when people were distressed or upset and knew how to support people in these circumstances. PBS plans clearly identified triggers and situations which could cause people distress and how they should be supported in these events.

KLOE	Regulations	Comments
		Workforce wellbeing and enablement: Score 3 There was an employee assistance programme and confidential help lines were available for staff to use, should they need to. Staff were supported with debriefs. Staff were supported with team meetings. • This service scored 70 (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 2 Support plans did not always promote a person-centred approach. Support plans tended to lack detail and give little information in how to support people on occasions, especially where they were unable to communicate their needs. **(RR 1)** Where people were involved, there was good evidence that they led decisions about their care and were fully involved in personalising their care and support to their individual needs. **Care provision, integration, and continuity:** Score 2 It was reported that this was improving, but as identified within this report there had been challenges in sourcing appropriate support for people using the service. There were continued challenges supporting one person to integrate into the community. **Listening to and involving people:** Score 3 Two people confirmed that they felt listened and involved in their care and support. Tenants' meetings were happening. These were usually arranged once a month, but also as and when needed or requested. Minutes of these meetings were in place. Key worker meetings were also happening for two people using the service. Discussions with these two people identified that they felt they were achieving what they wanted to achieve with successes around education and volunteer work. No surveys had been carried out as people had not been living in the service very long. It would be useful to carry out a short survey to find out how people felt the transition and move into the service has been. **(RR 2)** There was information about individual communication within the support plans. For one person who had limited verbal communication there was detail about individual words they may use and how they

KLOE	Regulations	Comments
		summoned support by taking staff by the hand and leading them to an object, item, or place to indicate what they needed support with and their understanding of PECS and now and next boards. There was some information about how the person would behave if they were happy or agitated, but there was no reference to pain, which was something that they could not vocalise. **(RR 3)** Two people spoken with said they knew how to raise any concerns or make a complaint. They felt confident that any concerns would be acted on. One person had made a complaint and put this in writing. This had been in relation to two different areas, one regarding another person using the service and the other relating to staff. There had been an immediate response acknowledging the complaint and the actions to be taken in relation to the concerns in relation to staff, which was positive. However, there was no response in relation to the concerns in relation to the concerns in relation to another person using the service. **(RR 4)** As yet there was no further detail or investigation recorded into what actions had been taken as a result of the follow up, in particular in relation to the staff support. Discussions with the deputy manager evidenced that there was an open investigation, and this was ongoing, with disciplinary action being taken in relation to the staff support, which was positive. Updates, however, should be recorded. **(RR 5)** **Equity in access:** Score 2 One person had limited access to the community due to the risks involved with supporting them in the community. However, the support plan still clearly recorded activities in the community. There had been little adjustment or ways explored to address this is a timely manner, although as previously noted a protector for their car had now been purchased. However, consideration should have been given to how to support the person more appropriately. **(RR 6)** **Equity in experiences and outcomes:** Score 2 Equality and diversity matters were promoted, with one person identifying as transgender, but the focus of care was on their individual mental health needs and not their gender, which was positive.

KLOE	Regulations	Comments
		Two people had been supported with achieving goals such as working/volunteering in a charity bookshop and another person worked at an animal trust. Two people were also being supported with achieving educational goals. For two people steps to achieve goals were in place and reviewed at key worker meetings. For the third person, it is acknowledged that due to their specific behaviour's this was more difficult to support the person, but one goal was for the person to live and a healthy and happy life and to develop communication and social skills, but how to support with this was not included in the support plan. **(RR 7)** **Planning for the future:** Score 3 No-one in the home was receiving end of life care at the time of the visit. People living at the service were young and had limited understanding of dying and death. This was not an area people, or their relatives wanted to discuss. It would be useful to record this. **(RR 8)** **Providing information:** Score 3 Information was provided to people in formats that they were able to access. This included easy read and pictorial. The complaints procedure was available and, in line with Liaise procedures, also available in an easy read format. information made available also included understanding safeguarding and who to report to • This service scored 64 (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**		

KLOE	Regulations	Comments
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 2 It was noted at the visit, that the service did not appear to have found its level. The aim was for supported living, but there were aspects of residential care support. This may be due to individual needs, but I suggest this is monitored to ensure that the supported living approach is fully integrated into the culture of the service. **(WR 1)** **Capable, compassionate, and inclusive leaders:** Score 2 There was a manager in post, although they had handed in their notice and were leaving in the near future. They aimed to ensure that they left the service operating effectively and safely and to hand over to a new manager. There was consistency in the remainder of the management team as the deputy manager was remaining in post. There was an area manager who provided support. **Freedom to speak up:** Score 3 There were processes that gave staff opportunities to contribute their thoughts and ideas and be heard. Staff meetings were also held on a regular basis. These were either specific to a person or issue or to discuss the service overall. These included a review of support provided and how people had been settling in. Meetings had been held in January, February, March, and May. January was an introduction to the service, and March was a review of processes. Staff spoken with felt they could have a say and were listened to. There was an open-door policy to the office. No staff surveys had been completed as staff were still new to the service, but it would be useful to implement an in-house survey to establish how staff had found settling in and working in a new service. **(WR 2)** **Workforce equality, diversity, and inclusion:** Score 3

KLOE	Regulations	Comments
		The manager reported that they felt there had been an unconscious bias in relation to the service and that a full and inclusive fair culture had not been promoted by the company. **(WR 3)** The management team worked with staff to arrange flexible working hours and individual cultural needs were considered when staff requested annual leave. Policies and procedures were in place for equality and diversity. Staff received training in equality and diversity. **Governance, management, and sustainability:** Score 2 In line with Liaise procedures audits were completed on the RADAR system. Audits included Managers support plan and risk assessment audit, managers walk around audit, Monthly health and safety and infection control, Monthly finance audit. Medication audits were also in place which included weekly medication shift leaders audit, managers monthly medication audit and area managers quarterly medication audit. A sample were viewed: Weekly medication audit: 1st April 100% Weekly medication audit: 8th April 100% Monthly Health and Safety/ Infection Control Audit 13th April 95% Medication quarterly Area Manager's Audit 18 April 67% Manager's Walk Around Audit 18 April 94% Manager's monthly Finances Audit 20 April 100% Weekly Medication Shift Leader's Audit 23 April 100% Manager's monthly Medication Audit 25 April 96% Manager's Walk Around Audit 25 April 100%

KLOE	Regulations	Comments
		Monthly Vehicle Maintenance Audit 2 May 100%. Manager's Quarterly Support Plans and Risk Assessments Audit 25 March 92%. Audits are not always identifying areas of shortfalls. For example, the Manager's Quarterly Support Plans and Risk Assessments Audit, which was completed on 25 March recorded the outcome as 92% with one action. However, this was not completely accurately. One question was for Consent documented or decision specific MCA/BI in place for each care provision. But the consent document for the care plan list for one person did not reflect the actual care plans in place, therefore was not compliant and another section was recorded as not applicable when it was. **(WR 4)** Manager meetings were happening, and information was shared with the service. Care files and information related to people who used the service was stored securely and accessible by staff when needed. This meant people's confidential information was protected appropriately in accordance with data protection guidelines. **Partnerships and communities:** Score 3 The service was promoting relationships with health and social care professionals in the community as identified within this report. **Learning, improving and innovation:** Score 2 Actions from audits were signed off before they were completed to embedded. For example, an action for a risk assessment to have more information added with detailed measures on management of risk had been signed off as being completed, but there was no detailed measure within the risk assessment. Another completed action identified that now all medication dispensed in blisters had the information leaflet, a check found this was not the case. Actions should be embedded before they are signed off. **(WR 5)** The manager also reported that they felt there was no learning culture within the organisation.

KLOE	Regulations	Comments
		Environmental sustainability – sustainable development: Score 2 There had been an aim to promote less paper, but policies and procedures had been printed off for staff to sign, which the manager felt was not necessary. **(WR 6)** It was reported that recycling was promoted where possible. • This service scored 59 (out of 100) for this area.

Outcome: Improvement is required to ensure that 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: **Requires Improvement**

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 incidents are recorded*						
SR2	*Further develop lessons learnt*						
SR3	*There should be clear guidance on how to support people with risk associated with constipation*						
SR4	*Care plans to be in place for where people have identified risks*						
SR5	*Ensure there is clearer guidance in place as to how individual risks are managed*						
SR6	*Identify what action to take in the event someone refuses to leave the building in an emergency, such as a fire.*						
SR7	*Ensure that the fire alarm is tested on schedule.*						
SR8	*Review and confirm when the fire alarm service was completed and update the system or arrange to take place.*						

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SR9	*Review how shift breaks are managed*						
SR10	*Ensure that proof of address had the name of prospective staff on the evidence*						
SR11	*Ensure that there are detailed records of employment history in one place, which makes it easier for the regulator to assess*						
SR12	*Ensure there is evidence available of induction*						
SR13	*Additional training to be evidenced*						
SR14	*Actions need to be taken to ensure that staff are supported with supervision and direct observations*						
SR15	*The opening date of boxes to be recorded*						
SR16	*Ensure that information leaflets are available for all medicines*						
SR17	*Ensure that events are updated with actions taken following medicines refusals*						

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SR18	*Follow up and action should be taken to address how to ensure that medicines are delivered in a timely manner.*						
SR19	*Ensure there is clear information about which medicines are PRN*						
SR20	*PRN should identify when to use which medicines if there is more than one medicine for a specific condition*						
SR21	*Include what pain to look for when administering PRN*						
SR22	*Administration of homely remedies to be recorded*						
SR23	*Ensure that temperatures are recorded daily*						

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	*Ensure that full assessments are completed in relation to individual health care needs.*						
ER2	*Include more information in support plans in relation to individual conditions*						
ER3	*Keep the MCA assessments under review to ensure that this is in keeping with the Mental Capacity Act*						
ER4	*Ensure that people's consent is obtained before providing care and support*						

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 people's care records are individualised to their needs*						

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	*Further develop and personalise support plans, especially in relation to people who cannot communicate or be actively involved*						
RR2	*Consider a short survey to get feedback on people's experiences of moving in and settling into the service.*						
RR3	*Include information on how staff can recognise when people who have limited communication are in pain.*						
RR4	*Ensure that all complaints are acknowledged*						
RR5	*Ensure that any progress with complaints is recorded.*						
RR6	*Consider how people can be supported on an equal basis to have equity in access, where this is not possible support plans and risk assessments should clearly identify this*						
RR7	*Ensure that any goals are supported with a plan on how to achieve*						

RR8	*Record where people do not want to discuss end of life matters.*						

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	*Monitor the culture to ensure that a full supported living service is promoted, and lines are not blurred with residential care*						
WR2	*Consider carrying out a staff survey to establish how staff had found settling in and working in a new service*						
WR3	*It may be worth discussing the sense of unconscious bias in relation to the service and that a full and inclusive fair culture had not been promoted by the company at exit interview*						
WR4	*Ensure that audits accurately reflect findings*						
WR5	*Actions should be embedded before they are signed off.*						
WR6	*Try to reduce the use of paper*						