AUDIT REPORT

Liaise (London) Supported Living (Meridian Site)

Date of Visit: **7th and 8th February 2024**

Private & Confidential
SRG CARE CONSULTANCY LIMITED

Contents:

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

Address of Service: 69 Bloomfield Road, London, SE18 7JN

Date of Last CQC Inspection: 18 January 2022

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		69 (out of 100)
Is the service Effective?	Good		71 (out of 100)
Is the service caring?	Good		75 (out of 100)
Is the service responsive?	Good		68 (out of 100)
Is the service well-led?	Good		65 (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 7th and 8th February 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, senior staff, discussions with staff, discussions with people who use the service, a tour of the building and review of key documentation.

SUMMARY OF OUTCOME

Meridian is registered with CQC and provides personal care. It's category of registration is personal care and provides supported living accommodation to adults under 65 yrs, caring for children (0 - 18yrs), Learning disabilities, Mental health conditions, Physical disabilities, and Sensory impairments. At the time of this audit the service was supporting 13 people at the time of the visit. This was split between Meridian Mews, Meridian Place and Meridian Court.

We read care plans for three people, 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 Accidents, incidents, and untoward events were recorded through the RADAR system. Operational workflows were in place which included notification of the event, review by the operations manager, an investigation, action planning, learning outcome and final review before these were signed off. A sample viewed evidenced that these were detailed and identified what had happened, and the support provided at the time. Lessons learnt were recorded into the radar system and then staff were informed at handover or in meetings. **Safe systems, pathways, and transitions:** Score 3 Referrals were made where required. Following one serious incident safeguarding had been informed. Meetings had been held with the psychologist/psychiatrist and MDT. Care plans and risk assessments were updated. There was a positive move not to use physical interventions and this had not been used in the last six months. **Safeguarding:** Score 3 There was one open safeguarding, which was being managed in line with the local authority procedures. The management team were aware of their responsibilities to report to the local authority and CQC. All staff had completed their safeguarding training, and this was refreshed yearly. In addition, staff were assessed for their knowledge of safeguarding at induction and then annually. The service had a safeguarding policy in place and staff were aware of their own roles and responsibilities in order to safeguard people from abuse. Whistleblowing policies were also in place and staff told us they were confident to use the whistleblowing process if they had concerns. Whistleblowing allowed staff to raise concerns whilst legally protecting their anonymity. People living in the service said they felt safe.

KLOE	Applicable Regulations	Comments
		Safeguarding was discussed at the service users monthly meeting and people were given advice on how to report any concerns if they felt they were at risk or thought someone was at risk of abuse. Information was available in people's flats or rooms about understanding safeguarding. People were supported with managing their finances. There were safe systems in place to support this. Monthly financial audits took place, and this checked individual finances and that processes were followed. Where people were supported with their money there was a financial transaction sheet which included the balance, the transaction detail, and the signatures of two staff. Some people had capacity to manage their own money and bank accounts and were supported to do this. **Involving people to manage risks:** Score 2 Risk assessments were in place for areas such as flammable creams, communication, diet and nutrition, behaviours, medication, finances, domestic skills, community access. Risk assessments generally identified the individual need, although there was some room for improvement. One person had been identified as at risk of absconding in the mental capacity assessment. There was some reference to this in the activity and community access risk assessment, but this lacked detail. This was also not included in the personal emergency evacuation procedures (PEEPS). **(SR 1)** There were missing person's profiles in place, but these were quite basic and although may be adequate it is suggested that the Herbert Protocol is reviewed to identify if any more information could be included in the current missing person profiles. **(SR 2)** Herbert Protocol form (met.police.uk) People, however, were kept safe as they were supported with their assessed needs in the community. For example, two staff were allocated to support.

KLOE	Applicable Regulations	Comments
		Some risk assessments were duplicated. For example, for one person there were two risk assessments for mental capacity and DoLs. This increases the risk of information not being consistent as where one is updated, and another section may not. Some people could access the community independently, where this had been assessed as appropriate and people were not subject to legal requirements. The risk assessment for one person contradicted itself, as one section stated that the person could go out independently, but not if they were going to buy alcohol. However, another part of the risk assessment stated that they could go out when they pleased. Although it was reported that they were no longer drinking, there was a lack of clarity about the actual risk. For another person there was a pre-diabetes and a diabetes risk assessment and care plan, which contradicted each other. Care needs to be taken to ensure that risk assessments are not duplicated or contradictory **(SR 3)** One person used emollient creams, which are flammable and can soak into clothing, bedding and towels. They lived in their own flat and managed many of their daily living activities for themselves including washing and drying clothes. The risk assessment in place was quite generic and did not refer to washing and drying of fabrics. **(SR 4)** Alongside the individual risk assessments additional assessments included falls. Where people were at risk of falls, a recognised falls risk assessment tool was used which included the history, mobility, medication, and impairments which might impact. Choking risk assessments were in place and identified how to manage a choking incident. One person could make allegations, there was procedures on how to interact with the person in order to reduce the risk of this happening. Risk assessments were in place. PEEPS were in place which identified people's support needs in the event of an emergency. *(See SR 1 for recommendation).* Positive Behaviour Support (PBS) plans were in place. These included positive characteristics and the persons views. Behaviours or concern were identified and how to avoid or prevent triggers. For example,

KLOE	Applicable Regulations	Comments
		promoting relationships with family and where not to promote relationships, the use of how to redirect or divert and which reassurance techniques worked with the person. Reactive strategies were in place and what to do if specific behaviours exhibited itself. When a person was in crisis this was identified and PROACT SCIPr UK interventions recorded. People were supported with post incident management and debriefs. **Safe environments:** Score 3 People lived in their own flats or in the case of the Meridian Court, there were shared communal spaces and people had their own ensuite rooms. As this was a supported living environment, the landlord for the building was responsible for the upkeep of the building. Maintenance and repair issues were reported to the landlord. Monthly and weekly health and safety checks were completed. These included emergency lighting, fire doors, fire alarm, fire drill, fire extinguisher, call point, window restrictors and water temperatures. These were recorded onto the system known as Qooda and were seen to be up to date. Service specific risk assessments were in place to maintain the service safely. These included working at height, infection control, legionella, slips, trips and falls and flammable creams. These had been reviewed in November 2023. Fire risk assessments had been completed for each building. Recommendations had been made. It was difficult to establish whether these had been completed, but this was confirmed by the end of the visit. **Safe and effective staffing:** Score 3 Staffing was arranged in accordance with individual needs. Rotas were in place and planned about a month in advance. Samples viewed showed that there were enough staff on duty. There was a consistent and stable staff group and agency had not been used for approximately six months. Recruitment was managed by a central team from head office. They carried out all checks as required by regulation.

KLOE	Applicable Regulations	Comments
		Evidence of recruitment was kept electronically. A check was made on two new staff members recruitment records. However, it was then reported that one of the members of staff was no longer in employment, therefore the personnel file should be archived. **(SR 5)** Most of the information as required by Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was seen to be in place in the other staff member's file. This included an application form, checks made on gaps in employment history, references, a health declaration and the completion of a Disclosure and Barring Service (DBS) check to help ensure staff were safe to work with adults. The registered provider had a sponsorship licence to help with recruitment and right to work status was checked. Staff received the training and support to carry out their role. Induction was in place which included shadowing, e-learning, face-to-face training and reviewing care plans, health and safety and administration processes. One new staff member reported that they had been supported to settle into their new role and also into the country as it was a new experience for them. They said they had received good training at the start of their employment and more experienced staff had provided mentorship. The majority of training was online through a recognised training company (Your-Hippo). Training included health and safety, infection control, learning disabilities, manual handling (theory), MCA and DoLS, medication awareness, privacy and dignity and safeguarding adults, for example. As well as Autism, British sign language, diabetes, PROACT SCIPr and PBS. Training compliance was at around 100% for individual staff members. There were some gaps in PROACT SCIPr and PBS training and this should be addressed. **(SR 6)** Supervisions were scheduled in for every six weeks. This reviewed practice, staff well being, training, and any service user issues. Supervisions were at 78% and direct observations also took place, and this was at 100%. **(SR 7)** Competency assessments were also in place for Health and Safety/Fire, IPC and Food Hygiene, MCA and Safeguarding and medication. These were at 100%.

KLOE	Applicable Regulations	Comments
		Infection prevention and control: Score 3 Staff completed training in infection control, both during induction and on annual basis. Records showed that staff training in infection control was up to date. There was a CoSHH register in place with a risk assessment for individual products. **Medicines optimisation:** Score 2 People had an individual medication file which included their profile, temperature records, changes to medicines, medication administration record (MAR) charts, a pain profile, easy read medication guide, as and when needed medicine (PRN) protocols, body maps, medication stock monitoring, consent forms and home leave records. PRN medicines were not always recorded as such on the MAR charts and when PRN was offered but not required, appropriate codes were not always used. For example, for one person there as a line drawn through the signature box rather than a code used. **(SR 8)** Systems for signing medicines in and out of the service were not always robust or accurate. One person was admitted to hospital for a routine operation. Staff signed twelve days of medicines out of the service, to ensure they had enough. However, the person returned after three days and when the medicines were brought back, the amount was not signed back in. This meant there wasn't an accurate record of the amount of these medicines within the service. **(SR 9)** A check against medicines administered found that these had been administered accurately. Apart from incorrect coding in relation to PRN, all other entries viewed were seen to be correct. Some medicines, such as creams, were kept in lockable cabinets in individual flats or rooms. All other medicines were kept in individual plastic boxes in lockable cabinets in the main office. When staff administered medicines, they collected the plastic box and took this through to the individual and once administered, returned the box to the lockable cabinets. It was reported that it was not always safe to keep medicines in individual flats or rooms. ***(See Consent to Care and Treatment – Effective)*** • This service scored 69 (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 Discussions were held in relation to assessing needs prior to people moving in. The deputy manager explained the processes. When a person was referred to the service, information was reviewed, including current assessments and any behavioural assessments. A full assessment was carried out which included an assessment of mental, health and physical care needs. Before people moved in, there was a transition period where staff were allocated to the person. Through the transition people have opportunities to visit. Care plans and risk assessments were developed based on current information and the multi-disciplinary team were included, to start to develop any positive behavioural support plans. **Delivering evidence-based care and treatment:** Score 3 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). They supported with various aspects including assessments and involvement in care planning. The SALT team supported people that had any risks associated with dysphagia or choking. Yellow box (IDSSI) guidelines were in place. These gave staff information on the level of food and fluid modification, positioning, and any particular risks. Although the information was not always transferred through to the care plans, it was available in flats or kitchen areas. **(ER 1)** The PBS practitioner implemented PBS plans, as referred to in the Safe section of this report. Care plans and risk assessments were in place for individual physical and mental health needs. Individual conditions such as autism and bi-polar were clearly detailed in the care plans and there was guidance about how to support in the event of an episode. For bi-polar there was guidance on how to stay calm and to support the person to focus and placing themselves in the person's shoes and taking an empathetic view.

KLOE	Regulations	Comments
		Where people had epilepsy, information within risk assessments or care plans was place which identified the risks and how to support. One person had severe allergies, and this was included in the care plan there was information on how to use adrenaline auto-injector. Risks around constipation were in place. One person had coeliac disease. Although staff supported with cooking or heating meals, Mum was the main provider in relation to the management of their diet. They bought all the food and ingredients for cooking. However, there was no risk assessment or information in the care plan for a 'back-up' plan should Mum not be available for any unforeseen event or emergency. **(ER 2)** **How staff, teams and services work together:** Score 3 The service collaborated with other professionals, both internally and externally. There was an internal specialist team who provided support including the PBS, SALT, and OT therapists. Referrals were made, and staff collaborated with these professionals to implement recommendations and changes to how people were supported. Hospital passports were seen in place. This is a document which goes with the service user when they attend the hospital. Information included within this passport supports the hospital staff to be aware of the most pertinent things they needed to know about the person. **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.

KLOE	Regulations	Comments
		Care plans included information about individual health care needs. People had individual health and medical care plans. These included information about individual needs and the support people needed. **Monitoring and improving outcomes:** Score 3 Monthly meetings and health checks were carried out with people using the service. The key workers led this meeting. These gave people the opportunity to discuss any events, any health care needs and review the care and support provided. An action had been previously made to ensure that these meetings happened on the 18th of each month. A selection sampled, evidenced that this was happening. Care plans and risk assessments were reviewed on a six-monthly basis, or if needs changed. Monitoring charts were not routinely used in order to promote individual independence. However, where concerns were identified, then charts for food, fluids or other areas would be implemented. Nutritional needs were monitored through regular weight checks, where needed. For one person, a risk assessment for epilepsy stated to check every 15 mins when in room alone. A review of care records saw that this was not happening. It was reported that this was the information given to the service when the person moved in, although there had been no episodes. However, outcomes should be monitored in line with risk assessments or reviewed appropriately. **(ER 3)** **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 were MCA assessments in place for some people, and these were decision specific. There were a number of MCA assessments which were outstanding, and this had been identified on the action plan on RADAR. **(ER 4)** A sample viewed contained information as to how staff had discussed the decision with the person which included showing of videos, use of gestures and pictures and were detailed. Some of the assessments were seen to detailed, but some which had been completed recently, in line with action plan

KLOE	Regulations	Comments
		recommendations did not all contain the level of information or detail included in MCA assessments which had been completed for other people at earlier assessments. **(ER 5)** Consent agreements or MCAs were in place for medication but there were no other consent agreements in place. It was reported that photographs were never taken, no matter what the reason, therefore consent for this was not needed and that information was not shared unless there were medical reasons or with external auditors/CQC. It would be good practice to implement appropriate consent agreements. **(ER 6)** Risk assessments and care plans were in place, where people had variable capacity, and this was reflected in care plans. For example, one person had capacity to understand when they were in pain but did not have capacity to book appointments. There was a tendency to keep everyone's medicines (apart from creams) and individual finances in the office. However, there were no assessments either risk or mental capacity on the individual records viewed as to why it was not appropriate or safe for people to have medication cabinets or safes. One assessment did record that it was not appropriate to keep medicines in a cabinet in their flat, but this was because there was no medication cabinet in the flat. This may be the most appropriate and safest process and there may be a number of reasons why safes or medicine cabinets were not in use, apart from storing creams. However, it is suggested that individual assessments are carried out in relation to risk and capacity to assess individually as to where is the most appropriate location. **(ER 7)** 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, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Authorisations had been applied for but were outstanding for six people. There was evidence that the service continued to follow these up by contacting the DoLS team for updates to progress. But these continued to be outstanding. Where people were not subject to a DoLS authorisation and had capacity, they knew the code to the main gate and could come and go as they pleased.

KLOE	Regulations	Comments
		• This service scored 71 (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 People were able to make choices and daily living preferences were listened to. There were positive interactions between people who were being supported and staff. All people who were being supported appeared to be comfortable in the presence of staff. Observations showed that staff spoke to people in a respectful manner. Dignity was included in care plans. Relationships with families and friends was promoted. A family member complimented staff because they thought staff treated their relative well. **Treating people as individuals:** Score 3 Each person had an 'About Me.' This included an overview of the person; however some areas would benefit from more detail. For example, for two people the family background or current and past interests and places I have lived sections stated N/A and for another person it just stated, 'lived in family home.' However, for other people there was more information. It would be useful to include some information in relation to this, where there is limited detail. **(CR 1)** Cultural needs were included within the care plans. Where people followed a particular faith or cultural diet this was recorded in the care plans. 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 People were supported to choose how they wanted to spend their day and staff listened to their preferences and choices.

KLOE	Regulations	Comments
		Key worker meetings were happening on a monthly basis. These gave people the opportunity to discuss their goals, health issues, what had gone well, anything they felt they had achieved and anything there were proud of. These also have people the opportunity to raise any concerns. People had activity planners which was specific to their individual needs and preferences, which could be changed as and when people wanted to do something different. **Responding to people's immediate needs:** Score 3 Behaviours of concern records showed how staff responded and supported people during such incidents. Communication tools were used to help people identify to staff support needs. **Workforce wellbeing and enablement:** Score 3 Staff were supported with debriefs following any incidents. Through supervision, staff well-being was monitored. Wages had been reviewed and staff had been supported with an increase. Staff had been provided with a blue light card, which entitled them to discounts. Annual leave was considered and where people wanted to take extended leave as they wanted to visit family abroad, this was accommodated as far as possible. Steps were taken to reduce isolation, as staff often worked alone with people in the individual flats. • 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."**		

KLOE	Regulations	Comments
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 Care plans included social relationships and networking, personal care, personal relationships, sensor needs, activities and community access, culture, religion and end of life, family, medical and health care, diet and nutrition, communication and goals and outcomes. It was noted that some of the terminology within the risk assessments was on occasions not as person centred as it could be. For example, a risk stated, 'maintain frequent checks on patient and ensure resident knows how to get help.' **(RR 1)** Communication passports were in place. These included information about the person, what they did and did not like, how they communicated and how to communicate with them and tools to use. There was evidence that people were supported to maintain their independence and carry out daily living tasks such as house keeping or domestic duties and managing care independently. Sometimes information did not cross reference for example in the cultural and religious care plan for one person there was reference to using a native language, but this was not included in the care plan for communication. Included in people's care records was information about activities they enjoyed such as dancing, artwork, cinema, swimming, bowling, shopping. Goals and outcome were considered. Goals and outcomes were person centred and agreed with the person. Each person had an individual plan for this. However, some of these lacked detail. One person wanted to become more independent in terms of cooking and managing personal care and living independently. The support measures were to 'Support to become more independent with daily living skills.' There was no information on how this would be achieved and if there was any progress since the plan has been developed in October 2023. Key worker meetings identified that the goals were reviewed, but not what progress had been achieved. In order to support people with their goals and review progress and outcomes, there needs to be more detail on how to achieve individual goals update with progress. **(RR 2)**

KLOE	Regulations	Comments
		Care provision, integration, and continuity: Score 3 Staff worked with health and social care professionals to promote outcomes for people. Reviews of care was undertaken. Staff had access to policies and procedures through the RADAR system. Each member of staff had a log-in and they could access these with through the computer or the app on the tablet. **Listening to and involving people:** Score 3 Service user meetings were held on a monthly basis. The last meeting being held in January 2024. People had the opportunity to discuss health and safety, redecoration, personal safety, activities, and menus. Service user meetings had recently been re-developed into a more user-friendly format. A Service User survey was completed in June 2023. This also gave people the opportunity to feedback about how they spent their time and if they had opportunities to speak with staff or friends and family. It was recorded that all 13 people living in the service had contributed to the survey. However, it was noted that out of 18 questions, only responses for 7 questions were recorded. The remaining questions recorded that all 13 respondents 'skipped' the same questions. These were key questions such as do staff listen to you, do staff support you well and feedback on making own choices had no responses. **(RR 3)** However, it was noted that there were no relatives or professional surveys, and it would be useful to consider this. **(RR4)** There were five recorded complaints in the Radar system since the beginning of 2023. A check on these found that these had been reviewed and responded to. The complaints procedures were available in an easy read format. **Equity in access:** Score 3 People could access care, treatment, and support when they needed to and in a way that worked for them. Staff made referrals to other professionals to support people.

KLOE	Regulations	Comments
		The O.T. had supported on person with assessments and adaptations to their flat to support them with unrestricted access in their own home. **Equity in experiences and outcomes:** Score 3 Meridian was located in residential suburb but has easy access to shops and transport systems. Taxis were accessed as needed. People were supported to go out and about in the community. Where people needed the support of two staff to access the community, staffing was arranged to support with this. People were also encouraged to go out independently where they had capacity and were not restricted by DoLS authorisations. Staff had supported people to enrol in college to ensure there were given access opportunities to learn and be part of the community. People had been supported to apply for and obtain Motability allowance so they could use this to 'purchase' a vehicle which removed a number of barriers in accessing the community. **Planning for the future:** Score 2 End of life had been identified as an area of improvement in the action plan, which had now been signed off as being completed. However, in the end-of-life care plans viewed there were various levels of information some of which lacked detail and reference as to whether the person wanted to talk about this. **(RR 5)** Where people had discussed end of life, there was information available in an easy read format and one person wanted to leave their belongings to Lady GaGa. **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

KLOE	Regulations	Comments
		they need in relation to communication. There was information available in a format suitable to individual needs. There was information available in different formats for people including alternative formats such as easy read guidance. This included individual guidance for any specific health care needs, such as managing constipation, complaints procedures, activity planners and safeguarding information. • This service scored 68 (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 There was a shared direction. There was a focus on people and promoting positive outcomes. Staff aimed to support people to grow and develop and maximise their skills. The registered providers values were or Personal – Progressive – Positive, which staff knew about. The Right support, right care, right culture guidance was in place and the service worked within the principles of this. This meant that people were supported with maintaining choice, control, independence, and people's human rights were promoted. Sharing the easy read version with people living in the service was discussed at the visit and the deputy manager accessed this. However, the link has been included for future reference if required. Right support, right care, right culture easy read (cqc.org.uk) There was a positive and open culture at the service. The staff were positive about working at Meridian and spoke positively about how they supported people. Staff felt listened to and involved in the service. Discussions were held with the service and deputy manager about Duty of Candour, although they were fully aware of an open and honest culture, there was some lack of clarity abut how to implement the Duty of Candour. **(WR 1)** **Capable, compassionate, and inclusive leaders:** Score 3 There was a clear management structure that monitored the quality of care to drive improvements in service delivery. There was a registered manager in post who oversaw the service. They were supported by a service manager and a deputy manager. Senior staff also led individual shifts, both during the day and overnight. The in-house team were supported by operations and quality management teams. The management team were visible in the service. The registered manager met with one person who had concerns and the service manager actively supported people with their care and support. There was an open-door policy which encouraged staff to seek management support if needed. **Freedom to speak up:** Score 2

KLOE	Regulations	Comments
		There were processes that gave staff opportunities to contribute their thoughts and ideas and be heard. Staff meetings were also held on a monthly basis. Topics included service user experience, CQC compliance, feedback from incidents with themes and learning, medication, training, quality and safety and updates to guidance. Actions were identified and reviewed at the following meeting. The most recent being checking MAR charts, training and health and safety in the environment. Staff surveys were undertaken which gave staff the opportunity to feedback about their well-being and working at Meridian. The one in May had some negative responses around the culture, the outcomes were discussed at team meetings. However, actions from the survey could not be located and these should be available for any future reference. **(WR 2)** Another survey had been carried out in November 2023, this was more positive, but again there were a one or two negative comments around the culture. This was in the process of being reviewed with actions being planned. **(WR 3)** **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. Policies and procedures were in place for equality and diversity. Staff received training in equality and diversity. **Governance, management, and sustainability:** Score 3 In line with Liaise procedures audits were completed on the RADAR system. Audits included Managers monthly support plan and risk assessment audit (which had been introduced more recently). Managers walk around audit, Monthly health and safety and infection control, Monthly finance audit and Night time audit. Medication audits were also in place which included weekly medication shift leaders audit, managers monthly medication audit and area managers quarterly medication audit. Audits were completed within the schedules. It was noted that apart from the quarterly audits, all other audits had been mainly recorded as being 100% compliant with one or two exceptions. From those actions were generated. It was noted that this

KLOE	Regulations	Comments
		had been identified and there was an action to ensure that audits were completed more robustly, which was positive. Where quarterly audits had identified improvements needed, this was being reviewed with the quality team to ensure that the findings were accurate. The Quality Assurance Framework (QAF) monitored governance and overall compliance was currently at 94%. **Partnerships and communities:** Score 3 The service worked proactively with health and social care professionals in the community as identified within this report. Families were fully involved with the service. **Learning, improving and innovation:** Score 2 Fortnightly there were manager meetings and once a month there was a quality and safety meeting with the senior management team. In addition, once a month there was a manager meeting for the London area. These meetings were used to discuss and disseminate learning and areas of improvement. There was also a drive to learn lessons as a company rather than at a local level. As highlighted within this report where actions had been identified, there were occasions where these had been signed off prematurely and potentially had not been fully embedded. In addition, it was also noted for example it had been identified that oral care plans were missing for two people, and it had been recorded as being completed. The action was created on 18th January and been recorded as completed. However, a review of the care plans for the two people identified that the oral care plan had not been put into place and although it was referred to in the personal care plan it was not detailed, and the personal care plans had not been updated since 27th October 2023 This had been identified by the service, which again is positive. However, this is an area that needs monitoring. **(WR 4)** When actions were in progress this was not always updated into the action, which would be useful to do such as this would help to monitor progress. **(WR 5)**

KLOE	Regulations	Comments
		Environmental sustainability – sustainable development: Score 2 There were some challenges in relation to recycling as the service was classed as a business and as such waste was collected by a contractor, who did not support recycling and the local authority would not support by providing appropriate recycling bins. However, there was a repair programme in place to reduce the waste. Efforts were made to reduce the use of paper through reducing the use of printing as much as possible. Electronic programmes also helped to reduce paper. • This service scored 65 (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 there is a specific risk assessment for the risk of absconding and include information in the PEEPS.*						
SR2	*Review the Herbert Protocol and assess whether any information can be used to update the current missing person protocols*						
SR3	*Duplicated or contradictory risk assessments / care plans are reviewed, and information removed as applicable*						
SR4	*Review the risk assessment for flammable creams and personalise to the individual. Include risks of folding hot laundry when it has been removed from the tumble dryer*						
SR5	*Archive staff files when the staff member is no longer in employment.*						
SR6	*Staff who have not completed appropriate behaviour training to complete this*						
SR7	*Catch up on face-to-face supervisions*						

CQC KLoE SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR8	*Ensure that PRN medicines are clearly identified on the MAR charts and that correct codes are used for PRN medicines.*						
SR9	*Review the current systems for signing medicines in and out of the service and implement more robust procedures. This may involve amending the documentation used.*						

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 there is clear reference to where any yellow box guidelines are, if the information is not included in the care plans*						
ER2	*Include information on a 'back-up' plan, should Mum not be available to shop for the person with coeliac disease*						
ER3	*Ensure that outcomes are monitored in line with risk assessments or reviewed appropriately*						
ER4	*Continue with the implementation of the MCA assessments in line with the action plan*						
ER5	*Maintain a consistent approach when completing MCA assessments*						
ER6	*Review as to whether consent forms will be required for sharing information*						
ER7	*Individual assessments are carried out in relation to risk and capacity to assess individually as to where is the most appropriate location for the storage of individual people's medicines or money,*						

	such as in their own flats or rooms or a central location						

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	*Further develop 'About Me' or similar information to help staff get to know people*						

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	*Review some of the terminology and replace with a more person-centred approach*						
RR2	*Include more detail on how to achieve individual goals and progress which has been made.*						
RR3	*Review future surveys for service uses and consider the questions to help prompt people to want to contribute*						
RR4	*Consider relative and professional surveys*						
RR5	*Continue to develop end of life or clearly record this is an area that the person does not want to discuss*						

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	*Review and update knowledge in relation to Duty of Candour*						
WR2	*Locate the results of actions from the May 2023 survey and make available.*						
WR3	*Continue to review the results of the most recent survey and ensure any actions are shared with staff*						
WR4	*Ensure that actions are completed before they are closed*						
WR5	*Record updates in actions whilst they are in progress*						