AUDIT REPORT

Middleton's Lane

Date of Visit: **14th and 15th February 2024**

Private & Confidential
SRG CARE CONSULTANCY LIMITED

Contents:

Service Name: Middleton's Lane **Provider:** Liaise (East Anglia) Limited

Address of Service: 157 Middletons Lane, Norwich, Norfolk, NR6 5SF

Date of Last CQC Inspection: 11 September 2021.

Ratings

CQC's Overall Rating for this Service:	Good (Inherited from previous provider)	
SRG Overall Rating for this Service:	Good	

KLoE Domain	Rating		Overall Score
Is the service safe?	Good		68 (out of 100)
Is the service Effective?	Good		70 (out of 100)
Is the service caring?	Good		75 (out of 100)
Is the service responsive?	Good		75 (out of 100)
Is the service well-led?	Good		75 (out of 100)

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

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

4 = Evidence shows an exceptional standard
3 = Evidence shows a good standard
2 = Evidence shows some shortfalls
1 = Evidence shows significant shortfalls

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

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

Overall Review Summary

INTRODUCTION

An audit, based on CQC KLoE, was undertaken by one SRG Consultant over two days on 14th and 15th 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, staff, discussions, and observations of people who use the service, a tour of the building and review of key documentation.

SUMMARY OF OUTCOME

Middleton's Lane was registered on 3rd April 2023 with Liaise (East Anglia) Limited. They have not been inspected yet and have inherited their rating from the previous provider.

Middleton's Lane is registered with CQC and provides accommodation for persons who require nursing or personal care. It's category of registration is a Nursing Home and has specialisms/services in; Caring for adults over 65 years, Caring for adults under 65 years and Learning disabilities. The service must not provide nursing care. The service provides accommodation for up to six people, who are supported in their own self-contained flats. At the time of this audit the home had full occupancy.

Some of the people who live at Middleton's Lane have communication difficulties and/or cognitive impairments; therefore, we observed some interactions between staff and residents to ensure they were comfortable with the support / engagement that they were having. 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.

Middleton's Lane was using paper-based care plans at the time of the visit but were transitioning over to a cloud based electronic software system (Blyssful). RADAR was used for quality assurance, event monitoring and action planning. QUOODA was used for health and safety checks and YourHippo was used for staff e-learning.

DISCLAIMER

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

RATINGS

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

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

KLOE	Applicable Regulations	Comments
Safe	**Regulation 12 (f) and (g) Safe Care and Treatment** **Regulation 13: Safeguarding users from abuse and improper treatment** **Regulation 17: Good Governance** **Regulations 18 & 19: Staffing - Fit and Proper persons employed** **Regulation 20: Duty of Candour**	**Learning culture:** Score 3 There were systems for reporting and recording any accidents and incidents. These were recorded onto the RADAR system and there was individual responsibility for the operational workflow. The manager reported that RADAR was an effective system for monitoring pathways and decisions made. A sample of incidents reviewed identified that actions were taken, however, staff were not always recording the full details of incidents, in particular in relation to behavioural incidents. For one person, where there were prolonged episodes of behaviour, the PBS (positive behaviour support) plan identified the support required. This included to administer lorazepam if no other support measure were effective. Although staff were identifying when they administered the medication, the details of the incident did not always clarify that the incident was prolonged and if other support measures were tried before administering medication. **(SR 1)** Where there was a GDPR breach this had been raised and this was investigated by the registered provider. One breach had occurred in September 2023, and it was confirmed that actions had been taken and this had resulted in a dismissal and appropriate referral was made. However, there was no information in the current incident report and no record of progress and was recorded as being 154 days overdue. **(SR 2)** Where any themes were identified, then new systems were put into place, which addressed how to improve the system. For example, it had been recognised that medication administration record (MAR) charts were not fit for purpose. The manager had addressed this with the pharmacy and worked with seniors to implement change. However, lessons learnt at a local level were not always fully formalised and were more through a verbal process which was not always recorded. Completed events were reviewed and there was some acknowledgement of lessons learnt, but this needed further development. **(SR 3)** Organisational lessons learnt were shared through manager forums and quality risk meetings. **Safe systems, pathways, and transitions:** Score 3

KLOE	Applicable Regulations	Comments
		Safety and continuity of care was monitored. Where there were changes in needs or concerns about individual people, referrals were made. Staff had identified that some medicines were either nor having a positive effect on the person, or a PRN (as and when medicine) had not been used for a substantial amount of time. Medication reviews had been requested and held and in line with the STOMP (stopping over medication of people with a learning disability) initiative, changes and/or reductions had been made to individual medication regimes. Where one person had exhibited ongoing behaviours, a psychiatrist referral had been made. Staff had also considered health needs and made referrals to hospital for an ultrasound. Where one person's mobility could put them at risk, the O.T. (occupational therapist) had been contacted and they had worked with staff to review safe systems to support the person. **Safeguarding:** Score 3 People were protected from the risk of abuse. Safeguarding matters were taken seriously, and any concerns were raised to the appropriate local authority. The manager described actions which had been taken following a concern and the plans which had been put into place. These had a positive outcome. Staff had received training on how to recognise and report abuse and they knew how to report any concerns and were confident that they would be acted on. Staff were also aware of whistleblowing procedures. These were made available to staff. People were given information about safeguarding and safety was discussed at regular key worker meetings. **Involving people to manage risks:** Score 2 There were individualised risk assessments in place for identified areas of risk. These were specific to the person. For one person risk assessments included use of walking frames/rollators, biting (including triggers and how to reduce), use of sprays, showering, cutting when shaving, traveling in a vehicle, and use of a sensor.

KLOE	Applicable Regulations	Comments
		For another person risk assessments included safety in the home identified with mobility, aids, falls and using the kitchen, eating, and drinking, road safety, the weather, using transport, using equipment, vehicle access, Inappropriate disposal of items, finances and visiting specific places. In support plan documentation viewed, there was a section for risk support plans which covered a range of areas and how to support safely. In addition, there was section for My Safety, which covered safety in the home, around eating and drinking, emotions and keeping safe when going out. These duplicated sections of the risk support plans. This is an area that needs to be monitored, to avoid duplication and the risk of contradiction. It may be that this will be addressed when care plans and risk assessments are fully transitioned over to the new cloud based electronic software system (Blyssful). A good practice recommendation is made in relation to this. **(SR 4)** For one person there was information in one part of their support plan which identified that they did not like loud noises and crowded environments. There was no further information on how to manage this risk and what the consequences were. **(SR 5)** Where one person was diagnosed with Autism, there was an assessment in place which identified the individual traits and how to support. However, this referred to OCD rituals, but not what these were and how staff should support. **(SR 6)** One person wanted to have private time to themselves. More detail was required in the support plan to ensure that this was clearly identified, and any potential risks included. It is acknowledged that this needs to be recorded sensitively to respect individual privacy and dignity. **(SR 7)** Some people had behaviours that could challenge or be of concern. There were PBS plans in place, and these were supported by risk assessments. Risk assessments associated with behaviours included self-injury, self-neglect, behaviour distress in the community and behaviours towards others. These identified how to support and manage the risk. One person did not like animals or birds, and they could cause them distress. Staff had thought creatively and placed a plastic hawk on a high pole outside of their flat. This meant that birds did not land in the garden and upset them. One person had a history of making unfounded allegations, this was acknowledged with the risks identified and there was a robust intervention plan, with how to manage such any situations. Staff were

KLOE	Applicable Regulations	Comments
		aware of the risks of allegations, and these were always acknowledged with the person. Support was given in each situation and the manager worked with them in the event of such an occurrence. There were no physical restrictive interventions in use. Staff had NAPPI (Non-Abusive Psychological and Physical Intervention) training but were being integrated and transitioned over into the PROACT SCIPr UK training, which was the preferred training programme used by the registered provider. **Safe environments:** Score 2 Environmental and generic risk assessments were in place. These included emergency procedures, gas safety, slips, trips and falls, legionella, food preparation, electrical, lone working, and infection control. All had been reviewed and were up to date. Staff had not signed to say that they were aware of these and knew where to locate them. **(SR 8)**. There was a lift in place which was in daily use. There was no reference in the business continuity plan and the risk assessments as to what would happen in the event of a lift failure. Although people living in flats on the first floor both could use the steps with support, I would suggest including this in either the business continuity plan or implement a separate risk assessment. **(SR 9)**. There was a fire grab bag located near the front door. This contained Hi-Viz jackets, a flashlight, foil blankets and an up-to-date personal emergency evacuation plan (PEEP) for each person, along with plans for the building and emergency numbers. There was a lack of clarity in relation to night time evacuations for people. The allocation of staff did not meet with the number of staff who would be on duty. One person had one-to-one support, but other people shared hours during the night. The PEEPs stated that once evacuated, two people would need one-to-one support, which meant that there were not enough staff for the remaining three people. There were two exit routes and there was no information on which route people should take if the alarm was activated during the night. **(SR 10)** The fire evacuation was due, and this was planned to take place imminently. Health and safety checks took place around the environment. It was confirmed that each individual flat was checked and if there were any issues in any of the flats this was highlighted in the system. Once all safety checks were confirmed, then this would be confirmed on the system.

KLOE	Applicable Regulations	Comments
		Health and safety checks included fire safety, water safety, lighting, window restrictors and checks on the environment. These were all up to date. A CoSHH (control of substances hazardous to health) register was in place with data safety sheets and risk assessments for hazardous products. Kitchen checks were in place and food temperatures were taken. There were a number of maintenance and repair issues which needed addressing. These were ongoing and there was maintenance support in place. Some of the decoration in the communal areas needed renovation. This was ongoing. Liability insurance was in place. **Safe and effective staffing –** Score 3 Everyone living at the service were supported with a range of one-to-one support hours. These varied from 28 hours a week for one person, 12 hours a day for four people and 24 hours one-to-one support for one person. In addition, to the one-to-one support staff, there was a team leader floating, and the manager and deputy manager were on duty during the week. There were three staff on duty at night, one for the one-to-one support and one waking and one sleep in staff member. Appropriate staffing levels were consistently maintained, so that people's needs were met. One person could choose when they wanted to use their hours and worked with staff to arrange these. There was some use of agency, but it was confirmed that consistency was maintained to promote continuity of care. Two staff files were reviewed for information relating to recruitment in line with the Health and Social Care Act (Regulated Activity) Regulations. Employment history was not robust. The employment history for one person was recorded on the 'Welcome Pack' as self employed between 2016 and 2022. The gap in employment check recorded had

KLOE	Applicable Regulations	Comments
		own grocery store between 2017 and 2022, which meant dates differed from the 'Welcome Pack'. There were other dates referencing July and December 2023. There was a reference to gaps in employment, but this was disjointed and not clear and this had not been further explored or clarified and there was no clear list of full employment history. This all meant it was difficult to establish a full and robust employment history. It should be noted that this seems to be a theme when visiting locations for this registered provider. **(SR 11)** References were in place, although it was noted some of these recorded, 'to whom it may concern,' which is generally not considered good practice. Although, these were date stamped with a letter head and signed, so as these are verified, then it is considered that these may be acceptable. **(SR 12)** A sample of other files found that not everyone's personnel records had been sorted into compliance and contract documents which meant it was difficult to establish if all the information was available. All new staff received an induction. A sample of one viewed evidenced that staff were supported with an initial two-day induction which consisted of a tour of the service, health and safety, policies and procedures and introduction into service user support and care planning. Staff said that they felt well supported during induction. Staff training was in place. Training was mainly online through Your-Hippo. Mandatory training included safeguarding, medication awareness, Mental Capacity and Deprivation of Liberty Safeguards, health and safety, food safety, autism, equality and diversity, privacy and dignity, fire safety, GDPR, infection control, manual handling and learning disability. Required training included British sign language, CoSHH, diabetes, duty of candour, mental health, oral health, and PBS. All staff except three of the newer staff were up to date with their training. Two of the staff still needed to complete PBS training. Staff were supported with supervision and competency assessments in Health and Safety/Fire, IPC and Food Hygiene, MCA and Safeguarding and medication. Some of the competency assessments were outstanding, which the manager was aware of.

KLOE	Applicable Regulations	Comments
		Staff said that they received good training opportunities and felt well supervised. **Infection prevention and control:** Score 3 People lived in their own flats, but as the service was registered as a care home, staff followed national colour-coding guidance for all cleaning materials and equipment and food safety to maintain infection control procedures. People had their own cleaning materials in their individual flats. There were cleaning schedules in place for each flat, although it was noted that this were not always completed. **(SR 13)** Staff were appropriately trained to maintain good standards in cleanliness and mitigate the spread of infection. **Medicines optimisation:** Score 3 People received support in relation to their medication. Medicines were stored in locked medication cabinets in people's flats. Temperatures were checked on a daily basis. There were no controlled drugs or medicines requiring fridge storage in use. Staff knew arrangements to make should storage for these be needed. Each person had a medication profile which included the individual diagnosis and any allergies. The profile also included any specific communication needs, the preferred way of taking medicines and actions to take if medicines were refused. There was an easy read medication guide, which was a pictorial guide for individual medicines. This included a picture of the medicine, what it looked like, why it was needed, any side effects and when to take it. The pictorial guide for one person had not been updated appropriately in line with changes in medicines, but this was addressed at the time of the visit. A sample of MAR charts were viewed. These were seen to be completed appropriately with signatures and correct codes used. Countdown sheets were in place to monitor the number of medicines in place. The countdown sheets tallied with the number of tablets recorded as administered.

KLOE	Applicable Regulations	Comments
		Two members of staff signed Handwritten MAR charts to check for accuracy. PRN protocols were in place and these included information about the directions, reasons for use, signs and symptoms, things to try before the use of the PRN, what the effect should be, side effects and when to seek further help. When PRN was used, the reasons why were recorded. **Add a bit more to conclude this section** • This service scored 68 (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 One person had recently moved into the service, and the assessment process was reviewed. This had been an emergency admission, but a full assessment had been completed. Staff had visited the person prior to them moving in and assessed in relation to personal care, health, mental health, eating and drinking, communication, behaviours of concern, any forensic history, PBS plan, sleeping, activities, cultural needs, finances, and any training needed. Support plans and risk assessments had then been implemented. **Delivering evidence-based care and treatment:** Score 3 The staff team worked with people and health/social care professionals to ensure that people received the care and treatment that they needed. It was reported that the local authority preferred their own specialist teams such as the SALT, O.T. and community learning disability nurse. Staff worked with external processionals to deliver care and support in line with good practice standards. People had a section for their health in the support plans. This included an overview of how to maintain good health in relation to allergies, skin care, hair, eye care, ears/hearing, dental care, nail care, foot care and continence. In addition, mobility, diet, pain, and health appointments were considered. Health support plans were in place for individual conditions, such as autism. There were some areas which were not included, such as Parkinson's for one person, or spinal fusion, for another and how this affected their daily lives. It would be good practice to include this. **(ER 1)** Risk assessments were in place for individual needs, such as choking, eating, and drinking, skin care, oral care, diabetes, and continence. People's nutritional needs were assessed, and SALT were involved, where needed. One person had been assessed as being pre-diabetic and staff were working with the dietician. **How staff, teams and services work together: Score 3** The staff team worked proactively and effectively with health and social care professionals. They made appropriate referrals, where needed.

KLOE	Regulations	Comments
		The CHC (Continuing Healthcare Team) funded one person and they had been contacted to carry out a review. The Homecare team clinical pharmacist had visited and supported with the medication reviews which had resulted in positive changes with reductions and stoppages of medication, and where needed changes to a more suitable medication. The SALT (Speech and Language Therapy) team supported one person. They had provided the service with a plan on how to support the person. When the person needed teeth to be removed, SALT were contacted for a review. The community learning disability nurse and the O.T. were involved through reviews and assessments. The O.T. was working with the service and one person to help them gain independence and develop their skills. Staff had worked with external MDT's (multi-disciplinary teams) to assess in relation to specific health care needs and appointments, such as dental and removal of teeth. There were hospital passports in place which were used to support people when they were admitted to hospital. In addition, where people went to hospital other information such as MAR charts to ensure that the hospital had the information they needed. Staff also accompanied so they could share information. **Supporting people to live healthier lives:** Score 3 People were supported with annual reviews. This was an Annual Health Check which was to ensure that the person with learning disabilities has aspects of their health checked and recorded by their GP Practice. It also allowed people to identify anything that was worrying them. The G.P. was carrying out the annual reviews on the day of the visit. People had been made aware that the G.P. was visiting and why. After their review, one person told the manager that everything was ok, and they were happy because they had their blood pressure taken but did not need any injections. There was easy read guidance available for annual health checks and it would be useful to share with people so that have the information to hand, should they need it. **(ER 2)** Annual_health_checks_Easy_Read_1.pdf (mencap.org.uk)

KLOE	Regulations	Comments
		Pain assessments and profiles were in place which included how people let staff know that they were in pain and how they took their tablet. There was a pictorial pain chart that the people could use to help identify where they were in pain. 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. People were supported with planning weekly menus. Eat well plates had been introduced to help people eat a balanced diet. One person had been supported to purchase an air-fryer, so meals could be cooked in a healthier way. For another person, staff had supported them to improve taking exercise, by encouraging to go for walks, in which the length had gradually increased. **Monitoring and improving outcomes:** Score 3 There were a several monitoring records in place. These included the bowel charts, one-to-one, general observations, behaviour monitoring charts, PRN monitoring charts, fluid charts, mattress audit, physio exercise logs, skin integrity charts, oral health check, weight and MUST review and Waterlow, for example. These were largely routinely completed for most people. However, there was not always a reason as to why particular charts were completed for everyone. One person had a high threshold of pain and would be severely impacted before they told staff that were constipated, however, this was not recorded in the support plan. Other people were independent with their needs, but again there was no reason recorded why they needed monitoring in individual areas. There may be good reasons in place, but these should be identified. **(ER 3)** Key workers reviewed care records on a monthly basis. Care plan reviews were in place. As identified, elsewhere in this report, staff collaborated with health and social care professionals to monitor and review outcomes for people. **Consent to care and treatment:** Score 2

KLOE	Regulations	Comments
		People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, this is usually through MCA application procedures known as DoLS (Deprivation of Liberty Safeguards). Applications had been made where people were subject to limitations on their freedoms. Staff worked with assessors to review individual needs. Paid representatives were in place. They provided independent support and acted in the best interests of the person. Paid representatives had visited to review the current care needs. This included mobility, family involvement, any restrictions, well-being, and personal care needs. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Mental capacity assessments were in place for medical appointments, finances, medication, and opening letters that come through the post. Some areas of capacity had not been recorded. For example, most people's kitchen doors were locked, due to reasons of safety. This was not always recorded in the DoLS, and MCA assessments were not in place. **(ER 4)** One person had a sensor mat, but there was no MCA assessment for this. **(ER 5)** Where people needed more support to make an informed decision, external professionals were included such as major dental treatment and maintaining a personal relationship. People were included in any decision making, where people could make their own decision's, they were supported with this. Consent agreements were in place for the use of photographs. • This service scored 70 (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 Staff were kind, considerate and very understanding towards people. There was an easy friendly atmosphere which was encouraged with high levels of interaction. People were comfortable with staff who they knew well. Consideration was given to important individuals in people's life. This included family, friends and people who were attached to important places where they visited. Relationships were promoted and encouraged, and people were supported to see family and friends. People's privacy, dignity and independence was respected and promoted. When staff discussed or identified sensitive issues, this was done in a manner that respected individual dignity. **Treating people as individuals:** Score 3 Relationships for key workers were developed and consideration was given to likes, dislikes, age, culture, and personalities. This helped people to develop positive relationships. Each person had a one-page profile. In addition, there were life histories for each person which gave some detail about their background and family life. Support plans identified particular things people liked such as activities, pastimes, and foods. One person liked to attend Mass but found that Sundays were too busy. Staff had made arrangements for them to visit at other times when it was less busy. Staff worked individually with people to support them in choosing how they spent their day. Staff listened to people and respected their daily living choices, whilst maintaining individual safety. **Independence, choice, and control:** Score 3 In each support plan there was a section for making important decisions. This were personalised to the person and identified an important decision to the person, how they should be involved and supported to understand and who made the final decision. These showed that staff worked with people to support them to make decisions.

KLOE	Regulations	Comments
		People were made aware about hospital or G.P. appointments so they could agree and consent. If they were not able to consent, MCA assessments were in place. Each person had a support plan section which identified things they could do for themselves this included daily living skills around personal care such as dressing and undressing, housekeeping, and domestic duties and out in the community. The O.T. was actively involved with one person and was supporting them to learn and develop their daily living skills. They had worked with the person to implement guidance and advice on cooking. They were also being supported to visit a local animal sanctuary and would be volunteering there. There was a plan that they visited with the same member of staff, to promote consistency. Eventually there was a plan for them to attend this on their own. The person said that they enjoyed being more independent and liked living in their own flat. They said there were being supported to achieve things. **Responding to people's immediate needs:** Score 3 People's needs, views, wishes and comfort were a priority. Staff were proactive when supporting people and identified when they needed support. Communication tools were used to help people identify to staff support needs. **Workforce wellbeing and enablement:** Score 3 Staff well-being was considered. There was an employee assistant programme, which included occupational health, to support staff. Staff were supported to take regular breaks and consideration was given to annual leave. Staff were supported with supervision and there was an open-door policy to the managers office. • This service scored 75 (out of 100) for this area.
Outcome: The service is considered as Caring.		

KLOE	Regulations	Comments
'Caring' is defined by the CQC as meaning **"that the service involves and treats people with compassion, kindness, dignity and respect"** **"Characteristics of services the CQC would rate as 'Good' in this area are those displaying evidence that people are supported and treated with dignity and respect and are involved as partners in their care."** **SRG RATING: Good**		

KLOE	Regulations	Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 12: Providing Safe Care and Treatment** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred care:** Score 3 Care plans included people's routines as to how they liked to spend their day and what a good or bad day looked liked, this was split into morning, afternoons, and evening and how the person would be if it was a good or bad day. People were supported with activity sessions planning, a reason they liked doing the activity and why it was important to them. These were individualised to each specific activity session and identified how people liked to be supported to carry out the activity. Activities included pamper days, going for walks, card making, swimming, going to the airport, clay modelling, picnic, eating out, baking, church, and shopping. These were individualised for the person and demonstrated that there was a person-centred approach. Each person had a communication section in their care plan. This included how people communicated and how staff could communicate with them. In addition, there was information about how people would indicate that they did not understand what staff were saying to them. There were specific communication pathways for specific times, and this described what they will do, what staff think it means and what should be done about it. People were supported with achieving goals. These were individualised to the person. A range of goals, for one person, was to lose weight, go swimming and attend sensory classes. Staff were able to explain how they had supported the person through small bite steps at a time, which had improved their confidence and willingness to participate, and now they looked forward to the different activities. For another person, their goal of more independence was clearly defined and there were plans to support one person to visit a fire station. Another person wanted to visit horses although the plan for this, was for staff to 'sort it out,' which lacked clarity about how to support. **(RR 1)** **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.

KLOE	Regulations	Comments
		People were support to access health care professionals as needed and as identified throughout this report. **Listening to and involving people:** Score 4 There was good evidence that people were listened to by staff and the manager. Throughout the visit, people popped into the office to talk with the manager and either ask for advice or share an experience. There were plans to develop a staff office into a sensory room. The manager had sourced a range of colours and shared a colour board with people so they could choose their preferred shade. The manager was disappointed that people had chosen a different colour to her preference but acknowledged their choice. This helped to demonstrate that people were listened to. There were monthly service users' meetings. Everyone liked to join except for one person who preferred to have one-to-one meetings, and staff accommodated this. Where one person had wanted to change their key worker, they had been listened to, and the person said they were happy with this. People had opportunities to report what they had been doing, things they were happy or unhappy with, anywhere they would like to visit, any purchases they wanted, feeling safe, and had anything special happened. Subjects were changed on a monthly basis to gain more varied feedback. It would be useful to add in at the end of the meeting, what had been/will be done about any requests and how these were accommodated and how any negative responses were addressed. **(RR 2)** People chose a monthly take-away, and where everyone wanted something different, staff arranged this for them. There were key workers in place, and they carried out monthly meetings with people. Discussions included medication, health, nutrition, working towards dietary aims, contact with families and friends, any incidents, events that may affect and any concerns. In addition, care plans were reviewed as were activity sessions to assess whether they were working and needed any changes. The service user survey has just been sent out and was currently in progress.

KLOE	Regulations	Comments
		The registered provider had carried out a survey of relatives for the whole of Liaise. The results had been broken down into regions and actions had been sent out. The senior management team from Liaise had held a meeting in September to introduce the service to the Norfolk area, as they had taken over another group. Families had been invited so they could learn about Liaise. The manager reported that this had been positive. There had been one complaint since Liaise took over registration. This had been an anonymous whistleblowing to CQC. This had been investigated and responded to and closed down. There had been no complaints from anyone using the service, their families or care professionals. There was an easy read complaints procedure in place. **Equity in access:** Score 3 People were supported to access care and treatment when they needed it. Staff worked with the district nurses visiting people at home, as this was people's preferred choices. One person was supported to purchase a wheelchair to help access the community. They had visited the shop to be assessed for an appropriate wheelchair. Another person needed a new knee brace and a referral had been made for this. Paid representatives visited to ensure that people's rights were being monitored. **Equity in experiences and outcomes:** Score 3 People were supported with accessing community resources. Staffing levels ensured that people were not disadvantaged when accessing the community. People were supported with their preferences and staff listened to what people wanted to do. People were at the centre of Middleton's Lane and encouraged to feedback and put forward their thoughts and ideas. **Planning for the future:** Score 2

KLOE	Regulations	Comments
		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. There was no information around end of life, although there was consideration being given to this through easy read information and guidance. It would be good practice to review this. **(RR 3)** **Providing information:** Score 3 Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication. There was information available in a format suitable to individual needs. People had folders in their flats with a range of information. This included the complaints procedure, menus, and activity planners. Where people had SALT plans in place, this information was available for them. Where needed, information was also made available in larger print or pictures to help people see them. Safeguarding and whistleblowing information was on display in communal areas. Some people needed supported to communicate their feelings and a traffic light system had been developed to help them identify their feelings when they could not their feeling into words. One person said this helped them most of the time and they understood why and when it was needed. Staff used a now and next board, for one person, if they needed it. Social stories were not in use. These are short descriptions of a particular situation, event, or activity, which include specific information about what to expect in that situation and why and can help people to manage the event of activity. This may be worth thinking about. **(RR 4)** • This service scored 75 (out of 100) for this area.
Outcome: The service is considered as Responsive.		

KLOE	Regulations	Comments
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 an aim for everyone using the service to feel included and valued with a focus on people and promoting positive outcomes. People were at the centre of service and staff supported people to make decisions in relation to the control of their care and support. Staff were proactive in providing ways for people to be involved. Staff reported that positive changes had been made since the manager was in post and there was a more inclusive culture. There was a listening approach, which meant staff took time to hear what people had to say and supported them in accordance with their needs. **Capable, compassionate, and inclusive leaders:** Score 3 Since becoming the registered provider of Middleton's Lane, the senior Liaise management team had made themselves available to relatives of people using the service. A meeting had been arranged which had been positive. Support was on a rolling programme. The manager felt well supported by the registered provider and regional managers and staff felt well supported by the manager and the culture of inclusion they were promoting. The area and operations manager had been involved with the service and had supported the manager to settle into their role. Staff reported that the manager was supportive, was visible in the service and actively involved in supporting people. **Freedom to speak up:** Score 3 Staff meetings, supervisions and surveys gave staff the opportunity to be involved and have a say.

KLOE	Regulations	Comments
		Staff meetings were held on a quarterly basis. Since the manager had started in post, they had held one staff meeting in November and the next meeting was due shortly after this visit. This was so the report and feedback could be shared with staff. Staff meetings included discussions around service user needs, compliance and audits, incidents and debriefing, multi-disciplinary team feedback, feedback from operational meetings and quality and safety actions, promoting right support, right care and right culture and staff well-being. It was noted that there were some historical meetings, from prior to the manager and the registered provider being in place. I would suggest that a divider is put in to differentiate between the current provider and record these as archived meetings, so they are accessible to demonstrate a historical record. **(WLR 1)** There were robust handovers carried out on a daily basis which supported communication processes. Staff surveys took place. **Workforce equality, diversity, and inclusion:** Score 3 HR policies and procedures were in place, including for equality and diversity. Staff received training in equality and diversity. Staff were supported with their cultural needs and arrangements were made to offer alternative meals and prayer breaks if needed. The management team worked alongside staff to make reasonable adaptations such as spilt shifts to allow for childcare or personal caring responsibilities. **Governance, management, and sustainability:** Score 3 In line with Liaise procedures, audits were completed on the RADAR system. There were a range of audits which were being completed on a regular basis. These included ➢ Night time Audit ➢ Monthly Data Protection Manager's audit

KLOE	Regulations	Comments
		➢ Manager's monthly Support Plans and Risk Assessments Audit ➢ Manager's monthly Medication Audit ➢ Monthly Health and Safety/Infection Control Audit ➢ Manager's monthly Finances Audit ➢ Manager's Walk Around Audit The history and compliance for audits had improved, work had been completed to improve the findings through identified actions. The area manager had supported with some of the monthly audits, but it was noted that there were no quarterly audits in place, which were part of Liaises to ensure there was a second layer of audits to help maintain oversight. **(WLR 2)** A matrix was in place which monitored training and systems were in place for maintaining oversight of supervisions and competency. The Quality Assurance Framework (QAF) monitored governance and overall compliance. **Partnerships and communities:** Score 3 The service worked in partnership with health and social care professionals in the community as identified within this report. This included SALT, O.T., community learning disability teams and local authorities. Staff engaged with people to help them make decisions about their health care needs. **Learning, improving and innovation:** Score 3 Ongoing learning was in place through untoward events and reviews of care plans. Actions from audits was implemented and it was seen that these were being addressed. Learning took place through reviews and observations when supporting people. For example, where one person had been afraid of needles, staff had worked with them to address this.

KLOE	Regulations	Comments
		Environmental sustainability – sustainable development: Score 3 There is an environmental policy in place, which was aimed at supporting service to commit to demonstrable environmental management. At the time of the visit, care plans and care records were paper based, but there were plans to transition over to a new electronic system, which would significantly reduce the use of paper. Electronic rotas had been introduced, which had already decreased use of paper. There were plans to set up a vegetable garden and people were supported and encouraged to use their washing machines on lower temperatures. • This service scored 75 (out of 100) for this area.

Outcome: The service is well led.

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

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

SRG RATING: **Good**

ACTION PLAN:

CQC KLoE SAFE By safe, we mean people are protected from abuse and avoidable harm.							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
SR1	*Incident reports to include full details and support measures used before administering medication.*						
SR2	*Update incident reports with the most up to date information.*						
SR3	*Further develop how lessons learnt are demonstrated to fully evidence to regulators the systems in place.*						
SR4	*Ensure that risk assessments are not duplicated to assist to avoid the potential of contradiction.*						
SR5	*Include information on how to manage potential risks in environments, such as not liking loud noises or crowded environments.*						
SR6	*Include information about OCD rituals to help guide staff.*						
SR7	*Identify the preference for private time and categorise any potential risks and how to manage.*						

CQC KLoE SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR8	*Staff to sign to say they are aware of the environmental risk assessments and know where to find them or have read and understood them.*						
SR9	*Implement a risk assessment or include information in the business continuity plan of what should happen in the event of lift failure.*						
SR10	*Review night time evacuation procedures in the individual PEEPs to ensure there is further clarity how staff will be allocated, and which exit should potentially be used.*						
SR11	*Systems are put in place to evidence full employment histories.*						
SR12	*When 'to whom it may concern references are accepted – ensure that they relate to employment history and are verified.*						
SR13	*Cleaning schedules should be completed in line with procedures.*						

CQC KLoE EFFECTIVE **By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence**							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
ER1	*Review support plans and ensure that individual conditions are included, such as Parkinson's or a spinal fusion and identify any effect this may have on their daily lives.*						
ER2	*Supply people with easy read information about the annual health checks, so they can refer to this, should they need it.*						
ER3	*Include why and when people need monitoring charts in place.*						
ER4	*Identity through MCA assessments and/or risk assessments as to why kitchen doors are locked.*						
ER5	*Implement an MCA assessment for the use of a sensor mat.*						

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	No recommendations						

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	*Include more information on how to support people to achieve any individual goals to promote a consistent approach.*						
RR2	*Add in a section into the monthly meetings for service users about any actions which had been taken as a result of the feedback.*						
RR3	*Continue to review end of life through easy read for people.*						
RR4	*Consider the use of social stories, if appropriate.*						

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	*Archive older staff meeting records, to maintain history.*						
WR2	*Review and ensure quarterly audits are carried out, where needed*						