AUDIT REPORT

The Burrows

Date of Visit: 24th & 25th of April 2025

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Service Name: The Burrows **Provider:** Liaise (East Anglia) Limited

Address of Service: Sandy Lane, West Runton, Cromer, NR27 9LT

Date of Last CQC Inspection: Inspected under previous provider on: 22 July 2021

Ratings

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

Key Questions	Rating	Overall Score
Safe	Good 	63 (out of 100)
Effective	Good 	66 (out of 100)
Caring	Good 	75 (out of 100)
Responsive	Good 	71 (out of 100)
Well-Led	Good 	71 (out of 100)

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

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

4 = Evidence shows an exceptional standard

3 = Evidence shows a good standard

2 = Evidence shows some shortfalls

1 = Evidence shows significant shortfalls

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

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

Overall Service Commentary

INTRODUCTION

An audit based on the CQC Key Questions and Quality Statements, aligned with the Single Assessment Framework, was conducted by an SRG Consultant over two days on 24th & 25th April 2025. The purpose of this review was to highlight in a purely advisory capacity, any areas of the service operation which should or could be addressed in order to improve the provision and recording of care and increase overall efficiency and compliance with CQC Standards and Regulatory Requirements.

TYPE OF INSPECTION

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

METHODOLOGY

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

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

OUR VIEW OF THE SERVICE

The service is a residential home providing support for younger adults. The service could accommodate ten people and was fully occupied at the time of the visits.

Judgements were made considering the ‘Right support, right care, right culture’ guidance which is used to assess whether people with a learning disability and autistic people are supported with respect, equality, dignity, choices, independence and good access to local communities that most people take for granted.

There was an active and positive culture of safety grounded in openness and honesty. Incidents and safety events were generally reported as required. Nevertheless, certain improvements were necessary. Incident reports lacked detail at times, and staff did not consistently record other support provided prior to

administering Lorazepam as a PRN following incidents of challenging behaviour, despite being able to describe the support measures in place. Additionally, not all incidents involving the administration of Lorazepam were recorded as events on RADAR.

Risk assessments were reviewed and updated regularly, generally identifying individual needs, with some minor areas for improvement noted. Staff did not always ensure a safe environment for individuals. Staffing levels were safely managed, with rotas arranged based on calculations of core and one-to-one hours. Staff recruitment procedures included suitable checks. Staff training was primarily up to date, although there were delays in PEG care and Proact Scipr training. Medication management was carried out safely, with improvements made to systems and processes following reported errors. It was noted that the reasons for PRN administration were not always recorded in the MAR charts.

People were supported with their health care needs. Improvements were needed to the monitoring of outcomes and mental capacity assessments.

The service was well-led. The registered manager understood challenges and areas of improvement. Staff felt the management team led the service well and were supportive.

PEOPLE'S EXPERIENCE OF THIS SERVICE

Most people were not able to share their experiences about living in the home, although one person did say they were happy and felt safe. However, it was clear from observations people were confident and relaxed with staff and felt comfortable and safe within their environment.

Personal relationships were encouraged to help people connect with others. Observations showed a relaxed atmosphere in the home. Staff provided timely support, promoting independence and choice throughout the day. People could decide their daily activities and destinations. Staff interacted well with people, understanding their individual needs. Staff treated people with dignity and respect, and staff wellbeing was also considered.

DISCLAIMER

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

RATINGS

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

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

Outstanding – The service is performing exceptionally well.

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

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

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

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

Key Question	Applicable Regulations	Quality Statements and Comments
Safe	**Regulation 12: Safe Care and Treatment** **Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment** **Regulation 17: Good Governance** **Regulation 18: Staffing** **Regulation 19: Fit and Proper persons employed** **Regulation 20: Duty of Candour** **Regulation 15: Premises and Equipment**	**Learning culture –** Score 2 There was a proactive and positive culture of safety based on openness and honesty. Incidents and safety events were generally reported as required. These were reviewed and addressed through the RADAR system. However, some improvements were noted in relation to the recording of incidents. Some incident records varied in content and were not always detailed. For example, for one person they had been recorded as self-harming (witnessed by family members). The only detail of the actual incident was 'self-harm'. Incidents should record the actual event in more detail. Which could help to prevent or reduce future recurrence. **(SR 1)** Where PRN (as and when required medicines) were used, staff were not always recording what had been tried prior to the administration of lorazepam. Conversations with staff evidenced that they followed the PBS plans and knew actions actins to try prior to administration of PRN, but this does need to be recorded. **(SR 2)** Not all incidents where lorazepam had been administered was recorded as an event on RADAR. For example, on 2nd April and 15th April, records within the Blyssful care notes identified that PRN lorazepam had been administered, but there was no corresponding incident report. **(SR 3)**. Staff were supported with debriefs following incidents. Records showed that staff had the opportunity to reflect on the event, and review actions taken Learning was passed on to staff in the form of care staff meetings, and one-to-one supervision. This helped to embed learning into practice. However, at times information from lessons learnt were slow to be shared formally within the service. For example, following a medication error in February, a de-brief and discussion with staff was not held until 25th March, learning was not identified until mid April and not shared at a staff

Key Question	Applicable Regulations	Quality Statements and Comments
		meeting until 23 April 2025, which was a delay of two months following the incident. Although actions may already have been taken, the formal process needs to be managed in a timelier manner. **(SR 4)** **Safe systems, pathways and transitions –** Score 3 Notifications made to CQC as required. The Registered Manager was aware of their responsibilities. There was a business continuity plan (BCP) in place to help promote the smooth running of the service, in the event on an emergency. The service worked with people and healthcare partners to establish and maintain safe systems of care. Actions were taken to ensure people received timely and appropriate care. It was seen that people had been referred to appropriate professionals when required to ensure individual needs were met. **Safeguarding –** Score 3 Safeguarding was taken seriously. Potential concerns were raised to the local authority when they were identified and the service was responsive, when safeguarding concerns were raised by other professionals. Staff knew how to keep people safe. All staff spoken with knew how to report any concerns and who to report them to. Staff were aware of external agencies which could be contacted if they felt actions were not taken appropriately. Staff, however, were confident that any concerns raised were acted on. Staff received training is safeguarding and additional competency assessments had been introduced to help embed knowledge. People were seen to be comfortable and relaxed with staff and one person said they felt safe living in the home. **Involving people to manage risks –** Score 2 There were risk assessments and support plans in place to ensure people were safe when being supported. These included support with decision making, personal care support, health care needs, activities, PBS

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		(Positive Behaviour Support), support with end of life, communication and additional identified risks, such as those associated with health care needs. Risk assessments and support plans were in the process of being reviewed and updated in order to reflect individual needs with more clarity for staff. It was reported that these were on target and there were three more support plans to be updated. Although, it was noted that some people whose care records had been updated had support plans or risk assessments which were now due for review again, including end-of-life, and a PBS support plan. **(SR 5)** Risk assessments varied in detail, with some containing clear guidance on how to support people and reduce the risks. For example, where one person was at risk of falls there was clear guidance on how to support with this along with their mobility needs and the support required to help them stand, with step-by-step instructions for staff to follow. Some other information lacked detail though. For one person there was a risk assessment in relation to over-eating, but this was not linked to the medical and health support care plan. there was information in the care plan which stated; *'Recommendations have been put in place around my food and fluid intake by the CLDN to reduce the amount of high calorie items available to me and advice around a healthy balanced diet. offering me fruit and vegetable items as snacks.'* But the recommendations were not in Blyssful, and the overeating risk assessment stated, *'Staff should follow the portion sized meals that was assessed by the LD team to provide to X', b*ut not what these were. **(SR 6)** Risk assessments were in place for people who were at risk of constipation, with some information not always being included in the support plan. PBS plans were in place, but information from elsewhere was not always transferred through to these in detail. For example, where staff may need to use restrictive interventions, this was not detailed in the PBS plan, although there was some reference in the Blyssful support plan . **(SR 7)**

Key Question	Applicable Regulations	Quality Statements and Comments
		Safe environments – Score 2 The environment was not always maintained safely. Some CoSHH (Control of Substances Hazardous to Health) products were stored in a cupboard in the kitchen. Although there was signage identifying that chemicals were stored in this cupboard, the door was difficult to secure, which resulted in staff leaving it unlocked. This meant people living in the home could access the potentially hazardous substances. **(SR 8)** Staff has returned from shopping and picked up a prescription for one person. When they returned the bag containing the prescription was placed on the counter in the kitchen, and then left unattended, until it was brought to their attention. As people using the service were free to go in and out of the kitchen without support, this meant that they had access to a prescribed medication. **(SR 9)** PPM checks, which consisted of the regular health and safety checks had been moved over to RADAR, from the QUOODA system. These checks included daily fire patrols, weekly and monthly fire checks, laundry equipment, lighting, emergency lighting, window restrictors and water temperatures, for example. There had been some slippage as not all of required checks had been identified as requiring completion n the system. For example, daily fire patrols had not been recorded since 11th April, water temperature checks were recorded as being overdue for 16th and 23rd April, and plug checks were overdue on 14th and 21st April. The Registered Manager started to address these at the time of the visit, but care needs to be taken to ensure that health and safety checks are completed. **(SR 10)** Appliances and utilities were checked and/or serviced in line with health and safety schedules. Documentation had been uploaded to RADAR. There was a grab bag in place which contained safety equipment which could be needed in the event of an emergency, such as torches, first aid kit, Hi-Viz jackets, foil blankets, emergency information and individual PEEPs (personal emergency evacuation plans). A review of the PEEPs identified that there as still reference

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		to the main house (Squirrel Lodge) for support. This service was now closed; therefore, the PEEPs need reviewing and updating. **(SR 11)** Daily opening and closing checks were in place in the kitchen. These were signed to say had been completed and where an issue was identified, this was seen to be rectified. Fridge and freezer temperatures were in place, and temperatures ere taken of food items. A bottle of sauce did not have a label on to identify when it had been opened. **(SR 12)** Environmental and generic risk assessments were in place and maintained on RADAR. **Safe and effective staffing –** Score 2 Staffing levels were safely managed, with rotas arranged based on a calculation of core and one-to-one hours. There were ten staff on duty in the morning, nine in the afternoon and four at night. Staff were allocated to provide one-to-one or two-to-one support, dependent on individual assessed needs, alongside the core hour allocations. Core teams had been created to provide continuity of care and enabled staff to focus on a smaller service user base to embed their understanding of individual needs. Having said that, staff were aware of the different needs of everyone using the service and were able to move between teams, if required. Team leaders led each shift and allocated support workers their daily duties to promote a consistent approach. There had been a significant reduction in the use of agency staff, with 7.6% of hours being provided by agency staff in the week before the visit, and this was provided by consistent agency to promote stability. Recruitment procedures were checked to assess compliance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Key Question	Applicable Regulations	Quality Statements and Comments
		Staff were requested to supply a full employment history. Checks were made where staff had not completed a full employment history and staff were requested to clarify and record any gaps. The registered manager supplemented checks made by the HR department and double-checked employment histories and ensured that there was an appropriate record of any gaps. Checks were made with the Disclosure and Barring Service (DBS) to ensure that new staff were safe to work with vulnerable people. Either a new DBS was applied for, or appropriate checks were made against the update service. References were in place and checks were made to verify the source. Proof of identity and address, right to work status, and medical health declarations were all in place. Staff were provided with a contract at the start of their employment. There was a fairly new staff team, with most staff having been employed for under a year. In order to embed staff learning, all staff had re-completed the initial two-week induction programme, which gave an overview of the service's systems and processes. In addition, all staff were in the process of completing the Liaise provider wide induction workbook. The workbook was linked to the care certificate, training programme and the Academy framework and included evidence-based assessments. The induction program acquainted staff with its content, emphasising the recognition of equality and diversity, Liaise models of work, and the organisation's visions and values. The induction covered all aspects of service user support, including an awareness of the conditions affecting those using the service and pertinent health and safety matters. Practical and theoretical activities were completed to evidence competency, along with observations of practice. Staff were being encouraged to complete this within six months of the start date of the induction, with staff progress to be checked through the supervision process. A sample of supervisions reviewed, did not identify progress with the induction programme. In order to monitor such progress and better evidence to external

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		regulators, it is suggested that there is a more robust process for monitoring progress with induction or the is a specific section added to the supervision document to identify this. **(SR 13)** All staff had received regular training in subjects identified as mandatory and required. Training was provided through face-to-face sessions and the YourHippo E-learning system. Mandatory training consisted of autism, equality and diversity, fire safety, food safety, GDPR & Data Protection, health & safety, infection control, Learning Disability, MCA & DoLS, manual handling, medication awareness, privacy & dignity, and safeguarding. Staff were primarily up to date with mandatory training. Required training consisted of British sign language theory and practical, CoSHH, Duty of Candour, Duty of Care, End of Life, key word signing, key working, medication administration, mental health, nutrition, oral health, person-centred care, your role, and personal development. Additional required training included areas specific to the needs of people using the service, and comprised of diabetes management, PEG care, epilepsy awareness, IDDSI (International Dysphagia Diet Standardisation Initiative), proact scipr, and positive behaviour support. It was noted that there was some slippage in PEG care training with eight out of the twenty-seven staff on the training matrix either not having completed the training or required an update. However, it was confirmed that only trained staff supported the person with their PEG care. A review of the MAR charts and daily care notes confirmed this. I suggest that this is monitored, and that staff are supported to complete this training, or it is recorded as being not applicable to their role. **(SR 14)** Seven members of staff were not up to date with their training in relation to proact scipr, and as there were people who could display behaviours that challenge, this needed addressing. **(SR 15)** The provider did not provide Oliver McGowan training in relation to people with a learning disability or autistic people, which is the Government's preferred and recommended training for staff working with

Key Question	Applicable Regulations	Quality Statements and Comments
		people with a learning disability. However, staff completed appropriate training in relation to people with a learning disability or autistic people on a regular basis. Additional staff competencies had been introduced. These included health, safety, and fire, infection control and food hygiene, safeguarding, MCA and DoLS. These have been put into place to support staff to upskill and improve their knowledge and understanding. As yet they have not been reviewed and signed off. Staff were being supported with monthly supervision. Historically a sample of supervisions did not evidence that actions were identified or reviewed and moving forward this needed addressing. One person had started in August 2024 and had received two supervisions. The first supervision had identified objectives of completing e-learning, but this was not followed up at the second supervision, although it was reflected that they had completed their hippo training. Checks and follow ups on actions was not apparent. **(SR 16)** **Infection prevention and control –** Score 3 The home was clean and hygienic. Systems were established to manage risks associated with infection control. Monthly infection control audits were conducted. Cleaning schedules were implemented. National colour-coding guidance for cleaning materials, equipment, and food safety was followed to uphold infection control procedures. Personal protective equipment (PPE) was provided as required. **Medicines optimisation –** Score 3 Medication profiles were in place and included any allergies and key medical information and contacts, with a list of current medication. Easy read medicine protocols were in place. These described what the medicines were, what it looked like, why the person took it, any side effects and when to take it.

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		It was noted that medicines recorded on these two documents did not always correspond with the current MAR charts. For example, one person used creams, an inhaler and was prescribed lactulose, but these were not included on the profiles. **(SR 17)** There were two types of MAR charts in use. One provided by Boots, as the prescribing chemist and the other generated by the home from QCS documentation. This resulted in different codes on the two different formats and although there were only three of the in-house generated mar charts, it is good practice to keep the codes the same to promote consistency. This was addressed at the visit. PRN (as and when medicine) protocols were in place. Reasons for the administration of PRN was to be recorded on the back of the MAR charts or on a separate recording sheet. However, this was not routinely happening, and staff were not always recording the reasons for the administration of PRN. For example, for one person paracetamol recorded on the MAR chart as being administered twice on 6 April and once on 7 April, but this was not recorded on the additional medication note sheet or on the back of the MAR charts. **(SR 18)** Medicines were stored in individual bedrooms, with temperatures checked on a daily basis. MAR charts viewed had been completed appropriately. One person was fed by a tube (peg) and had medicines administered through the peg. There was a feeding regime, the most recent being 2/4/25 from the Norfolk Community Health and Care trust dietician team. The MAR chart/records for peg feed showed that these were being administered in line with the guidance from the dietician. There was a commitment at the service to STOMP, which is national best practice guidance on stopping the over-medication of people with a learning disability and or autistic people when distressed.

Key Question	Applicable Regulations	Quality Statements and Comments
		Medicine audits were carried out to detect any errors and if any were found they were addressed. Following a number of medication errors, new systems and processes had been put in place to address this, which had resulted in a considerable reduction in medication errors. • This service scored 63 (out of 100) for this area.

SRG RATING: **Good**

This service maximised the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

"Characteristics of services the CQC would rate as 'Good' Safety is a priority for everyone and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation".

Key Question	Regulations	Quality Statements and Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: Need for Consent** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 18: Staffing**	**Assessing needs –** Score 3 People's needs were assessed and reviewed. Staff understood people's individual needs and assessments were in the process of being reviewed and updated as part of the improvement plan. As noted elsewhere within this report, this was in progress. **Delivering evidence-based care and treatment –** Score 3 Current evidence-based good practice and standards were used to support people with their individual needs. One person needed support with nutrition, hydration and medication partially through a PEG feed. A review of the risk assessment and support plan identified that there was detailed information on the support required which had bee developed in line with appropriate professional specialists. Staff understood information and guidance provided by the SALT team. One person was only permitted 15 spoonsful of pureed food and thickened liquids per day, as identified by the SALT team assessment and guidance. What was positive to see, as well, was that every member of staff spoken with, were aware of this. Staff were able to explain how they supported the person, and, in addition, staff were seen to blend food appropriately and blended individual foods separately. Where people had been diagnosed with epilepsy there was information within the support plans in relation to the support needed. The STOMP initiative was in place. **How staff, teams and services work together –** Score 3 Staff at the service worked positively with health and social care partners. People were supported to access social and health care support as needed.

Key Question	Regulations	Quality Statements and Comments
		Evidence was seen of people attending appoints for blood tests, chiropody, dental treatment and G.P. appointments as needed. People were referred to appropriate services such as the SALT team, dietician, wheelchair clinic, and the learning disability team, for example. People were supported with annual reviews and reviews of medication, as needed. Staff were working with the intensive support team to review individual behaviours in relation to one person. A review had been held to discuss progress and assess how current interventions were supporting the person, which was seen to be positive. 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 People were supported to attend external appointments to support their physical and mental wellbeing. This meant people were supported to help maintain their healthcare needs. There was some inconsistency within the support plans in relation to food consistencies. For one person there was reference to both level 7 and level 5, but it was not clear which foods could be consumed at level 7. In addition, the SALT assessment was not available in the kitchen folder or on Blyssful. **(ER 1)** For another person the keyworker reviews identified that they had been losing weight, but a review of the weight records identified that they although there was some fluctuation, they had been putting on weight. Care needs to be taken to ensure that there is a consistent and correct approach to reviews. **(ER 2)** Pain profiles were included in the medication folders, but none of those reviewed had been completed, which is particularly important for people who are unable to communicate when they have pain. Although

Key Question	Regulations	Quality Statements and Comments
		there were references within support plans in relation to pain, these were not always identifying how staff could recognise when someone was in pain. **(ER 3)** **Monitoring and improving outcomes –** Score 2 Staff used the Blyssful system to monitor and record care and support provided. There was some inconsistency in relation to the recording of how people were monitored. There was some nice person-centred approaches with staff recording people's wellbeing and consent. *(See Consent to care and treatment and Person-centred Care sections).* However, some of the monitoring records were not being maintained robustly. • Where marks or bruises were identified, staff were recording this within the Blyssful system. Staff created a body-map, which were often accompanied by a photograph, a note of the type of mark, and the location. Although review dates were identified, the body map records were more often than not, closed down without any review or update of progress or deterioration. For example, on 2 April, a body map had been created for one person who had developed some small blisters with a treatment plan to observe and monitor, and contact G.P., if worsens. This was archived with no update. For another person, a body map was opened on 13th April with a review date of 14th April. This remained open and had not been reviewed at the date of the visit. Not reviewing or updating progress or deterioration on body maps, meant that there was no consistent approach to monitoring the outcomes of any marks or bruises. **(ER 4)** In addition, body-map records often did not record any possible causes, although these may not always be known; it is good practice to identify if the cause is not known, and where possible causes are known, this would help to monitor for any patterns or trends. **(ER 5)**

Key Question	Regulations	Quality Statements and Comments
		• Some people were at risk of constipation and the support plans identified the support and monitoring needs. Staff were not consistently recording bowel records in line with individual care plans. For example, one person had no records of bowel movements between the 4 and 8 April 2025. **(SR 6)** **Consent to care and treatment –** Score 2 Staff understood people's capacity to make decisions about their care and support using their preferred method of communication including non-verbal communication. For example, one person could understand what staff said, but was unable to verbalise and used some signage, which staff were able to explain what different gestures meant. Care records showed that staff obtained consent from people before providing care and support. For example, staff recorded that they had gained consent from people when supporting with medication or personal care. 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 MCA 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. Where people lacked capacity to make certain decisions, MCA assessments were in place. These were decision specific and there was an appropriate record of conversations held with people to evidence how individual capacity was assessed. Where people were subject to restrictive practices, such as restrictions on smoking, individual MCA assessments were primarily in place. Although for one person there were references to food intake restrictions but there was no evidence of an MCA for this. **(ER 7)** Not all assessments were supported with a best interest decision record, such as the use of window restrictors, for one person. **(ER 8)**

Key Question	Regulations	Quality Statements and Comments
		Blyssful identified that the majority of the MCA assessments needed review and updating, with 35 of the assessments being overdue. This was in progress at the time of the visit but does need addressing. **(ER 9)** 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Applications had been made as required, where people were subject to limitations on their freedoms. • This service scored 66 (out of 100) for this area.

SRG RATING: Good

This service maximised the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

"Characteristics of services the CQC would rate as' Good' People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work".

Key Question	Regulations	Quality Statements and Comments
Caring	**Regulation 9: Person-centred Care** **Regulation 10: Dignity and Respect**	**Kindness, compassion and dignity –** Score 3 Individual support workers demonstrated positive attitudes and compassionate care to the people they were supporting. Time was spent observing how staff interacted with people living in the home. Observations showed that people were supported by staff who took time to talk to people and listen to what they said. Staff checked people were happy and had everything they needed. Staff understood the importance or treating people with dignity and respect. One staff member said, *'You have to step into people's shoes to be able to understand their needs'*. Systems were in place to protect people's privacy and confidential information. All service user care records were stored electronically with all personal information managed and stored securely. **Treating people as individuals –** Score 3 Information had been developed in the support plans about individual preferences, likes and dislikes. This was recorded within the care records as 'My Support Plan', which was an overview of the person and included known life history, individual preferences, interests, routines and what was important to the person, for example. Those viewed were detailed and gave a good overview of the person, which would help staff to get to know the person. Staff know people well. They were aware of their different preferences and individual support needs. Staff were able to describe how they gave people daily living choices to ensure they were supported in a manner that suited their individual needs. **Independence, choice and control –** Score 3 People were supported to manage as much for themselves as they could and maintain their independence with regard to personal care and eating and drinking, for example. Staff said they encouraged people to do as much as they could for themselves.

Key Question	Regulations	Quality Statements and Comments
		Staff were observed offering people choices of meals, drinks, activities, and people made their own decisions with support from staff when needed. **Responding to people's immediate needs –** Score 3 Team meetings were held to discuss issues relevant to the service, people using the service or staff experience. Discussions about how to make improvements were included. Support staff identified when people were not feeling well or were becoming agitated, and observations showed that they responded appropriately and in a timely manner. For example, one person needed the G.P., staff identified the concern, contacted the G.P. and requested a home visit. Staff were key workers for people which meant they took responsibility for making sure they knew and understood people. Staff spoken with were able to describe individual support needs. **Workforce wellbeing and enablement –** Score 3 Staff reported that they felt well supported. They said the manager was approachable and supportive. Staff reported that there was an open and inclusive atmosphere within the service. There was an employee assistance programme in place with a free confidential helpline which staff could access for mental wellbeing and additional support, should they feel they needed it. Staff had been provided with access to the blue light card, which is a scheme that allows staff to benefit from discounts from a range of retailers and organisations. Above and beyond nominations were in place for staff who have gone the extra mile to support people to help recognise where staff had achieved good outcomes for people. • This service scored 75 (out of 100) for this area.

Key Question	Regulations	Quality Statements and Comments

SRG RATING: Good

This service maximised the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

"Characteristics of services the CQC would rate as 'Good' People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible."

Key Question	Regulations	Quality Statements and Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 17: Good Governance** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred Care –** Score 3 Staff spoken with knew and understood individual needs. However, they were not very good at demonstrating this, which was disappointing at times. Observations showed that when staff thought they were not being observed, they were different to when they did not know they were being observed. More subtle observations showed that staff interacted well and were comfortable with people. Care notes identified the support staff provided in line with their support plans. There was evidence that people's opinions were considered, and staff took into consideration individual preferences. There was some inconsistency in relation to how the person was identified within the support plans, on occasions they were written in the third person, but at other times used I or my, far example. **(RR 1)**. Communication needs were included in the support plans and staff knew and understood how to communicate with individual people. **Care provision, integration, and continuity –** Score 3 Continuity of care and treatment was maintained as staff collaborated with other professionals to deliver flexible and integrated services. People were able to access care, treatment, and support as needed and, in a manner, tailored to their preferences. A proactive approach was taken to ensure that individuals were assisted in utilising available resources, including attending appointments or assessments. Staff coordinated with other professionals to facilitate this support. **Providing information –** Score 3

Key Question	Regulations	Quality Statements and Comments
		Not all people using the service could communicate with ease and interacted through nonverbal methods, such as facial expressions and body language, along with verbal communication. Communication support plans were in place, which helped to guide staff. Easy read and pictorial information was available for people. **Listening to and involving people –** Score 3 People were supported with monthly key-worker meetings, where staff met and discussed a range of topics including health, activities, meals and food, if there was anything troubling the person and a review of goals, for example. This gave people opportunities to be involved in their care and support. People living in the home were not involved in house or group meetings. This was something that people living in the home tended not to be interested in, and staff reported that this was due to individual physical or mental health conditions. Although, other steps had been taken to try and involve people, there was a lack of evidence to support this. For example, discussions with a team leader identified that menus had been reviewed and adapted, and as a result the menus had been reviewed and updated. They were able to explain how they sat with people and used people's preferred methods of communication such as pictures, objects of reference or examples to meals to help people develop menus, but there was no evidence available. **(RR 2)** It was reported that there had been no complaints. The complaints procedure was available. Staff had reached out to families to facilitate improved involvement and communication. Evidence was seen that relatives were being encouraged to be more involved, and positive feedback was seen from one family who said they found this useful and helpful. **Equity in access –** Score 3

Key Question	Regulations	Quality Statements and Comments
		Staff worked with health care professionals and community mental health services to ensure people had access to external support as and when they needed it. Staff supported people to access the community and appointments as required. **Equity in experiences and outcomes –** Score 3 People did not like to get involved in activities within the home. Staff reported that people did not enjoy organised activities and preferred to spend their days going to and about. People enjoyed going for walks or to local shops and cafés. Some people regularly attended a local centre where they could participate in sensory activities, aromatherapy and swimming. During the visit, observations showed that people constantly supported to go out and about. New activity planners had been implemented with people's preferred choices to help guide and support staff. Support plans for activities and had been developed and included some nice person-centred information about how people liked to spend their time and their preferred activities. Although it was noted that care records contained limited information about the activities people were involved in. **(RR 3)** Goals were being developed with people, but as yet were not embedded. Goals were not being reviewed, and keyworker meetings were not evidencing how people were supported to achieve these. **(RR 4)** **Planning for the future –** Score 2 Effective end of life considerations was not consistently in place. Where people were diagnosed with epilepsy, there was reference to the risk of SUDEP (sudden unexpected death in epilepsy). Although this was not included in the end-of-life plan for one person. For another person, there was no reference to end-

Key Question	Regulations	Quality Statements and Comments
		of-life matters. Where end-of-life information was included, there was no information or detail about how the person could be supported. Although people were younger, I do suggest that this is an area which is reviewed. **(RR 5)** • **This service scored 71 (out of 100) for this area.**

SRG RATING: Good

This service maximised the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

"Characteristics of services the CQC would rate as 'Good' People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood, and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics".

Key Question	Regulations	Quality Statements and Comments
Well-Led	**Regulation 17: Good Governance** **Regulation 5: Fit and Proper Persons Employed - Directors** **Regulation 7: Requirements Relating to Registered Managers** **Regulation 18: Staffing** **Regulation 20A: Requirement as to Display of Performance Assessments**	**Shared direction and culture –** Score 3 There was a positive approach to the direction of the service. The management team had a focus on the people using the service with a commitment to promoting a person-centred approach. Staff reported that felt the culture of the service had improved. One staff member said, *'Things started to change as soon as the manager came back from the other service. It was all over the place before and now it is much better.'* Another staff member said, *'It is more like a home now.'* The Registered Manager was implementing changes to help share the direction of the service. The supervision format has been reviewed and developed into a different format. This now included a review of performance, allowing staff opportunities to discuss experience or concerns, relationships with colleagues, learning and development requirements, and any other issues. As yet this format had not been fully implemented and was in the process of being rolled out. A review of a sample of supervisions completed with the new format noted that it was difficult to establish what actions had been discussed and agreed. I do suggest that there is a more formalised approach to recording and identifying any actions with a formalised review at the start of the next supervision. **(WR 1)** An area manager visited on a regular basis, as did the quality team. Feedback was that the senior team was supportive. **Capable, compassionate and inclusive leaders –** Score 3 Staff demonstrated a positive attitude to the leadership of the service. Staff felt the Registered Manager led by example, was approachable and fair. The senior team in the service were caring and supportive towards staff and the people that used the service. Staff felt they were listened to and were supported in their roles by an approachable management team. Staff said they felt valued by the senior team.

Key Question	Regulations	Quality Statements and Comments
		It was reported that communication was good, and this helped to support the organisation of the service. **Freedom to speak up –** Score 3 There was a positive culture where staff felt they could speak up and their voice would be heard. Staff said they would be comfortable to speak up about any concerns. They reported that they felt well supported by the management team, and were confident any concerns they raised would be reviewed fairly. Staff had access to regular supervision and team meetings where they could share their views and had opportunities to discuss any areas of concern. The Registered Manager operated an open-door policy and was available for support, when needed. There was a staff champion who represented staff at provider level meetings. **Workforce equality, diversity and inclusion –** Score 3 There was a policy and procedures in place for equality, diversity and inclusion. Staff received training in equality and diversity. Flexible working arrangements were in place with reasonable adjustments were made to support staff with any health care, cultural or caring responsibilities. Staff reported that they felt part of a team, and that consideration was given to individual cultures and diversity. **Governance, management and sustainability –** Score 2 Quality assurance systems were in place. Audits had been carried out on the running of the home to ensure people received safe care such as on medicines, health and safety and support plans. Audits and checks were carried out in line with the providers procedures. A series of enhanced audits were in place which included:

Key Question	Regulations	Quality Statements and Comments

		• Manager Walk Around Audit: 22/4/25: 95%
		  ○ Audits have been completed weekly since the beginning of the year. Scoring has been consistently at 90% or above.
		• Weekly Medication Shift Leader Audit: 23/4/25: 100%
		  ○ These were generally completed weekly, although one had been missed on 16 April, but resumed on 23 April. Scoring was consistently around 100%
		• Managers Monthly Medication: 14/4/25: 100%
		• Operations manager quarterly medication audit: 10/3/25: 67%.
		  ○ A number of issues were identified, and actions were identified.
		• Health and Safety Monthly: 18/4/25: 100%
		  ○ There were routinely being identified at 100%
		• Out of Hours: 16/4/25:100 %
		  ○ Completed monthly and routinely being identified at 100%
		• Finance Audit: 10/4/25: 100%
		  ○ Completed monthly and routinely being identified at 100%
		• Manager's Quarterly Support Plans and Risk Assessments: 19/3/25: 100%
		  ○ This identified that some areas were still in the process of being addressed but had been recorded as compliant. I suggest that where actions are still in progress, this should be identified on the audit. **(WR 2)**.

Key Question	Regulations	Quality Statements and Comments
		Where audits were being identified as bin 100% compliant, there was a lack of evidence of why the service had achieved this and I recommend that more evidence is provided to demonstrate compliance. **(WR 3)** Some of the audits were identified as being overdue, although they had been completed. This was because they had not been signed off. This needs to be monitored. **(WR 4)** Some documentation could not be located at the time of the visit, for example, the SALT guidance for one person was not available in the kitchen or on the computerised system, and evidence of menu reviews with people were not available. **(WR 5)** Some areas of improvement as noted at this visit had not been identified through the actions plans and governance systems, and as identified within the Safe domain of this report, PPM health and safety checks had not all been completed within schedules. Therefore, some improvements are needed in relation Governance, management and sustainability. The provider used a system known as the TaMI (Trends and Monitoring Information), to help maintain oversight. This reviewed data generated from RADAR, Blyssful, the training department and the quality team, for example. **Partnerships and communities –** Score 3 The Registered Manager understood their duty to collaborate and work in partnership, so services worked seamlessly for people. Evidence was seen of reviews held and working partnerships with other services. **Learning, improving and innovation –** Score 3 The service promoted a learning culture and had implemented changes which had come about following an external inspection from the local authority. An action plan had been developed from the recommendations and evidence was seen that this was actively being worked on and implemented.

Key Question	Regulations	Quality Statements and Comments
		An action plan was maintained on RADAR for any actions identified through audits and checks. At service level, lessons had been learnt following medication errors. It had been identified that when providing one-to-one care, the allocated staff member was administering medication to the individual service user, which meant that there was no consistency. In addition, staff were being disturbed, which meant that this had resulted in them losing concentration and making errors. The manager had changed the routine and allocated a team leader in each area of the home to take the lead on administering medicines. All staff had then been subject to re-training and competency re-assessment, and lead staff were to wear medication tabards. Although as identified elsewhere within this report, the formalised process of sharing the learning had not been completed in a timely manner. Monthly manager meetings were conducted, these were used to share learning between different services. **Environmental sustainability – sustainable development –** Score 3 Consideration had been given to environmental sustainability. Where possible recycling was implemented and staff followed local authority procedures. There was an aim to reduce the use of paper through electronic systems. • This service scored 71 (out of 100) for this area.

SRG RATING: Good

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

ACTION PLAN:

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
SR1	*Ensure staff include more detail in incident records to ensure that there is a clear record of the event which could help to reduce or prevent future recurrence*						
SR2	*Ensure that when PRN lorazepam is administered following any incidents of challenging behaviour, that there is a clear record of any actions tried prior to administration.*						
SR3	*Ensure that where lorazepam is used during any incidents of challenging behaviour, that a corresponding incident report is completed*						
SR4	*Ensure that learning from events is shared formally in a timelier manner.*						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR5	*Monitor risk assessments and support plans to ensure these are reviewed within timescales*						
SR6	*Ensure that there is more detail associated with risks of over-eating – in that the dietician advice is available*						
SR7	*Ensure that where restrictive interventions are to be used, there is detail in the PBS plans*						
SR8	*Ensure that cupboards containing chemicals or other hazardous items are kept locked at all times.*						
SR9	*Prescribed medication is not to be left unattended and should be put away appropriately once brought into the service.*						
SR10	*Ensure that health and safety checks are completed appropriately.*						
SR11	*Review the PEEPS and ensure that references to the main house (Squirrel Lodge) are removed.*						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR12	*Ensure that food items are dated when opening.*						
SR13	*Implement a more robust way of evidencing progress with the Liaise induction workbook, either through a specific section in the supervision records*						
SR14	*Support staff to complete the PEG care training or identify as not applicable to their role*						
SR15	*Ensure staff have completed training in proact scipr*						
SR16	*Ensure that checks on actions set at supervisions are followed up to assess progress*						
SR17	*Ensure that profiles and easy read protocols contain an up-to-date list of current medication as per MAR chart.*						
SR18	*Ensure that reasons for administering PRN is recorded.*						

CQC Key Question - EFFECTIVE

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
ER1	*Ensure there is more clarity in relation to different levels of food modification and which foods can be served at which levels.*						
ER2	*Ensure that there is a consistent approach to reviews and information is checked to ensure that it is correct*						
ER3	*Complete pain profiles with medication folders or remove if not required and ensure support plans include more detail of how to identify individual pain.*						
ER4	*When body-maps for marks, bruises or wounds are created, ensure they are reviewed appropriately and when they are closed down, a final outcome or resolution is recorded.*						
ER5	*Include any known causes when completing body maps for marks or wounds to help monitor for any patterns and trends or identify as not known*						

ER6	*Ensure that where people are identified as being at risk of constipation, that bowel records are recorded appropriately*						
ER7	*Ensure that where people are subject to restrictions that an MCA is in place.*						
ER8	*Complete individual best interest record decisions as part of the MCA assessment.*						
ER9	*Ensure that MCA assessments are reviewed and updated appropriately.*						

CQC Key Question - CARING

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
CR1	NO RECCOMENDATIONS MADE						

CQC Key Question - RESPONSIVE

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
RR1	*Maintain consistency when writing support plans and ensure that the same terms of reference are used consistently*						
RR2	*Ensure that when people are involved in making decisions about matters in the home, there is evidence available to support this.*						
RR3	*Ensure that staff record activities people are involved in, in more detail.*						
RR4	*Further develop goals and how people are supported to achieve these.*						
RR5	*Give more consideration to end of life matters.*						

CQC Key Question - 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	*Include a more formalised structure to the supervisions to identify any actions set, which includes a review at the next supervision.*						
WR2	*Ensure that where actions are still in progress they are not identified as compliant within the audit*						
WR3	*Ensure there is more evidence included in audits to demonstrate compliance.*						
WR4	*Ensure that audits are signed off, when completed in a timely manner*						
WR5	*Review where documentation is located in the service and ensure that this is available.*						