AUDIT REPORT

Totteridge House

Date of Visit: 9th and 10th December 2024

Private & Confidential
SRG CARE CONSULTANCY LIMITED

Contents:

Service Name: Totteridge House **Provider:** Liaise (London) Limited

Address of Service: 310 Totteridge Road High Wycombe Buckinghamshire HP13 7LW

Date of Last CQC Inspection: 20th September 2022

Ratings

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

KLoE Domain	Rating		Overall Score
Is the service safe?	Good		71 (out of 100)
Is the service Effective?	Good		75 (out of 100)
Is the service caring?	Good		75 (out of 100)
Is the service responsive?	Outstanding		89 (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 9th and 10th December 2024. The purpose of this review was to highlight in a purely advisory capacity, any areas of the service operation which should or could be addressed in order to improve the provision and recording of care and increase overall efficiency and compliance with CQC Standards and Regulatory Requirements.

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

METHODOLOGY

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

SUMMARY OF OUTCOME

Totteridge House is registered with CQC and provides accommodation for persons who require nursing or personal care It's category of registration is a care home in; Caring for adults under 65 years with learning disabilities. The service provides accommodation for up to 6 residents. At the time of this audit the home had full occupancy.

Some of the residents at Totteridge House have communication difficulties and/or cognitive impairments; therefore, observations of some interactions between staff and residents were made to ensure they were comfortable with the support/engagement that they were having. The care plans for three residents and three staff files were reviewed. 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 were reviewed.

Totteridge House uses the Blyssful electronic platform, for service user information. The Radar electronic platform for all incident recording, staff support and quality compliance information. The QUOODA electronic platform for Health & Safety and fire.

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 Staff recorded incidents on the RADAR system. Where there were incidents of behaviour staff recorded who was involved, whether anyone else was affected or involved, the activity that the person was engaged in at time of incident, when the incident happened, a factual account of the incident, possible triggers, behaviours of concern and staff actions. A sample of these were reviewed, those sampled evidenced that staff were recording detailed information within the records, which identified what had happened and actions taken at the time. Following incidents of behaviours that could challenge, a debrief took place. These gave staff the opportunity to reflect on the incident and look at what had gone well and what could have been done better, along with a wellbeing check on the person and staff involved. The positive behaviour support team were complimentary of the detail of the reporting from the staff team. They advised that the level of detail was good and helped them to review incidents and build on PBS plans. Learning from safety events was used to support staff to continually improve their practice and provide safe, high-quality care to people. Lessons were reviewed following each incident to identify if anything could have either prevented the incident or could have been done better at the time. For example, where one person could become obsessive with items that may not belong to them, there was a reminder for staff to stay consistent when providing support, for another it was around using additional staff, if required and communication. Where incidents had escalated, actions were reviewed by the operations manager and escalated to the regional general manager if needed, to help maintain oversight. **Safe systems, pathways and transitions:** Score 3 There were processes in place to ensure that people's monies were safely managed. Monthly audits took place to ensure that systems were working, and receipts were kept.

KLOE	Applicable Regulations	Comments
		Money was kept in security coded envelopes in a safe in the office. There were individual records kept of what money had been spent and where, which was checked on a daily basis and balanced at the end of each month. The PBS team were fully involved in reviews of incidents related to behaviours of concern, to identify any patterns or trends and supported the service is implementing changes to support people appropriately. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and the service had regard for this and took this into account with the support provided. **Safeguarding:** Score 3 There were processes in place to safeguard people from abuse and harm. A safeguarding policy was in place that detailed the types of abuse and how to escalate concerns if staff suspected or saw abuse to ensure people were protected. Staff had been trained in safeguarding adults and understood how to protect people from harm and who to report to when required. Staff were aware of their responsibilities to keep people safe and knew what represented a safeguarding concern and who they would report their concerns to. Staff knew how to access outside agencies, such as CQC, if they felt their concerns were not being acted on. However, staff spoken with felt that safeguarding was taken seriously and if they raised any concerns, these would be dealt with. There were no current safeguarding matters open in relation to the service. However, they had a raised a safeguarding in relation to another service, when one the people using the service had been admitted to hospital. Where needed, the service worked with the local safeguarding team and investigations undertaken were in line with safeguarding procedures. **Involving people to manage risks:** Score 3

KLOE	Applicable Regulations	Comments
		There were risk assessments and support plans in place to ensure people were safe when being supported, such as positive behaviour support plans, which included triggers and measures to support people when they were anxious. PBS (Positive behaviour support) plans were in place. Staff were supported by the PBS practitioners, who were involved in reviews and updates of people's PBS plans. PBS plans identified individual behaviours, along with triggers and strategies of how people were to be supported. Individual risk assessments were in place for people using the service. These included diet and nutrition, sensory needs, flammable creams, safeguarding, oral health, finances, behaviours, personal care and mobility, medication, shaving and daily living for example. Risk assessments identified the individual need and how to reduce the risks. Where people were at risk of possible choking, dysphagia guidelines were in place to help guide staff. Paraffin cream risk assessments were in place. Staff supported people to stay safe. They supported them to access the community and maintained one-to-one support where needed. **Safe environments:** Score 3 Checks and servicing took place on utilities and appliances. This included: ➢ Health and Safety risk assessment: Due October 2025 ➢ Fire risk assessment: Due October 2025 ➢ Fire alarm servicing: Due June 2025 ➢ Fire extinguisher maintenance: Due April 2025 ➢ Emergency Lighting: Due May 2025 ➢ Fire door inspection: Due April 2025

KLOE	Applicable Regulations	Comments
		➢ Water TMV servicing: Due August 2025 ➢ Five year hard wiring check: Due September 2025 ➢ Gas safety: Due July 2025 ➢ Call bell system: Due August 2025 ➢ Legionella risk assessment: Completed on 26th November 2024 ➢ Fire panel service and detectors were checked on 6th December 2024 ➢ PAT testing was completed on 2nd December 2024 The daily weekly and monthly checks on the environment included: Fire safety checks included a daily fire patrol, weekly fire alarm test, emergency lighting, and fire door check, monthly fire alarm door release, and fire door check, monthly fire extinguisher, emergency drill, emergency lighting, and the grab bag checks also took place. These had all been completed and were up to date. The carbon monoxide detector was checked on a weekly basis, along with weekly water flushes, checks on window restrictors, plug sockets and laundry equipment, again, all of which was up to date. The water temperatures were checked monthly, and shower heads descaled quarterly. Environmental and generic risk assessments were in place and maintained on RADAR There was a grab bag in place, and this included a first aid kit, equipment such as torches, foil blankets and Hi-Viz jackets, and useful information in the event of a fire such as the service continuity plan, the fire safety policy and emergency response plan and the PEEPs. Food temperatures were taken for each individual meal. Opening and closing checks were in place in the kitchen. These checked whether appliances were working properly, handwashing and cleaning materials were in a place and that opened food was dated. Fridge and freezer temperatures were taken, and calibration checks were completed. Along with safety checks for sharps and individual cutlery count.

KLOE	Applicable Regulations	Comments
		Safe and effective staffing: Score 2 There were appropriate numbers of staff on duty to support people safely. We saw staff were available when people wanted them, and they responded to people's requests quickly. Staff rotas confirmed there were enough staff to support people safely. A check was made to assess whether staff were being recruited in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Two staff recruitment records were reviewed. Information as required by regulations was mainly in place. This included: ➢ Full employment histories. ➢ Satisfactory references which had been verified as having been obtained from a reputable source, such as company emails or headed paper. ➢ Proof of identity and address and right to work. ➢ Medical health declarations. ➢ Disclosure and Barring Service (DBS) checks were carried out, and this also included checks on the update service. However, for one person, the check had been made, but the check had returned as being 'no longer current' and to apply for a new DBS. The check had been signed off, without applying for a new DBS. This meant that the person had been working at the service without a current DBS. **(SR 1)** Staff were issued with contracts as required by employment law. New or returning staff completed the new induction workbook, which was issued at the start of employment. The workbook was linked to the training programme and the Academy framework and included evidence-based assessments. The induction introduced staff to the content of the induction, recognition of equality and diversity, Liaise models of work, visions and values. Staff were supported to understand their role along with their duty

KLOE	Applicable Regulations	Comments
		of care. The induction included all aspects of service user support along with an awareness of the conditions of people using the service and health and safety matters. Practical and theoretical activities were completed to evidence competency, along with observations of practice. Staff completed PROACT-SCIPr-UK training which was a recognised model of support for people with learning disabilities and autism. New staff completed a three-day foundation course, which was refreshed annually, by way of a one-day workshop. Training was online through a recognised training company (Your-Hippo). Training was generally up to date, with most staff at 100%, although there was one bank staff who was at 61%, at the time of the visit. Training included Required: BLS, CoSHH, Diabetes, Duty of Candour, Duty of Care, Epilepsy and Buccal Midazolam, Medication Administration, Mental Health, Nutrition, Oral Health, PEG Care, PBS. Mandatory: autism awareness, equality and diversity, fire safety, food safety, GDPR and data protection, health and safety, infection control, learning disabilities, manual handling (theory), MCA and DoLS, medication awareness, privacy and dignity and safeguarding adults. **Infection prevention and control:** Score 3 There was a cleaning schedule in place. There were some gaps where items should be cleaned daily, such as the fridge, floors and bins. **(SR 2)** There were systems in place to prevent and control infection. Regular infection control audits took place. PPE was available as required. There was a CoSHH register in place, along with all the relevant safety sheets and risk assessments. **Medicines optimisation:** Score 3 People were supported with their medication.

KLOE	Applicable Regulations	Comments
		Each person had a medication folder which included their profiles, medication administration record (MAR) charts, PRN protocols and medication support needs. Medication profiles were in place, although these only gave a brief overview of when the person took their medicines, and whether it was covert. These would really benefit from including more detail about how they took their medicines, whether they were compliant, and what their preferences were. **(SR 3)** There was a lack of information about how covert medication was to be administered. for example, for one medicine (Brivarcetam), this was to be given covertly but could not be crushed or chewed, there was no information on how to give this. It was discussed that this had been agreed with the prescriber and the person was aware of the tablets being given whole on a spoon, and the risk of not taking at all outweighed the risk of chewing. This should be included in the care plan. **(SR 4)** Each person had an easy read medication profile, which included what the medication was, what it was for, what it looked like, any side effects and when they took it. The Disdat tool was used for identifying distress. PRN protocols were in place. Temperatures were taken of medicines and there was a signature record which staff had completed. MAR charts viewed were seen to be completed, with no gaps or appropriate codes completed. Although the brought forward amount had not been included on the MAR charts. However, countdown sheets identified that the correct number of tablets were in stock. Staff had also entered the wrong number of tablets administered for paracetamol. They had recorded one, when they had been administered two. Both of these issues were addressed at the time of the visit. • This service scored 71 (out of 100) for this area.

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

KLOE	Regulations	Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: The need for Consent** **Regulation 12: Providing Safe Care and Treatment** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 15: Premises and Equipment.** **Regulation 17: Good Governance** **Regulation 19: Staffing**	**Assessing needs:** Score 3 Discussions were held around assessments for people moving into the service. There was an understanding and recognition of the importance of assessment and transition. Assessment included personal care, continence care, health, nutrition, communication, mobility, and behaviours. As part of the assessment, staffing levels were considered, to ensure that there were enough staff to meet people's needs. Regular reviews took place to ensure that people's needs were monitored. **Delivering evidence-based care and treatment:** Score 3 Where some people had specific conditions, there was information in the support plan to guide staff as to how this presented itself and affected the person in relation to their daily living. Where people suffered with a condition, such as epilepsy, there was information available in relation to this. There was an epilepsy support plan and risk assessment in the Blyssful system which was supplemented by a seizure management plan. This included information about the type of seizure, and the description of how it could potentially manifest, management and intervention, and when to give medication. There was clear guidance about how to support the individual with their needs in relation to this condition. Regular reviews of individual needs in relation to epilepsy were completed with the epilepsy nurse. The STOMP initiative was in place, with a self-assessment and action planning tool in place. The Disdat (disability distress assessment) tool was in use. This identified indicators of when people were content or distressed. **How staff, teams and services work together:** Score 3 Staff at the service worked positively with health and social care partners, both internally and externally.

KLOE	Regulations	Comments
		People were supported to access community psychiatry, the learning disability team, the mental health team, with a delegated community mental health nurse, social workers, G.P., district nurses, and the epilepsy nurses. Where people would not attend hospital or healthcare appointments, staff arranged for video calls to take place, to help them have access to support, or supported visits to take place in the home, such as visits by the domiciliary community teams for dentists and opticians. **Supporting people to live healthier lives:** Score 3 Support staff were not directly involved in providing health care support. However, staff supported people to access healthcare services. It was confirmed that people were supported with contacting the G.P. or district nurse for example. Support staff monitored and reviewed people, in line with their health care needs and supported them to access appropriate health care support. Staff supported people to manage their health and wellbeing to maximise their independence, choice and control. Changes in people's presentation, emotional state or distress which may show a deterioration in their health or wellbeing, were recognised by staff. Staff acted in a timely manner when they identified changes and escalated them to relevant professionals. 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. 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. Allergies were recorded in individual files and on the MAR charts viewed. **Monitoring and improving outcomes:** Score 3 Monthly health checks were carried out. The key worker sat down with the person and reviewed their health care needs. These checks included a review of people's feet, hands, skin condition, ears, hair

KLOE	Regulations	Comments
		and scalp, dental care and oral health, weight and BMI, bowel management, and any other health monitoring processes such as seizures. People were supported to maintain a healthy weight. These were taken on a monthly basis. There was a monitoring system in place for one person who had epilepsy and suffered with frequent seizures. Staff recorded the type of seizure, how long it lasted for, if there were any warning signs, observations of the seizure, and whether any PRN or buccal midazolam was used. Records viewed showed that staff were recording the information appropriately. One person was at risk of constipation, and this was potentially linked to their seizures. The bowel charts were not completed in detail, with often gaps in place, where they were should have either been a record of having or having not been to use the toilet. There was also a paper record of the bowel charts maintained, which were completed on a more regular basis, but the use of two sets of records can cause some discontinuity and lack of clarity, especially when the electronic records are not as robust. **(ER 1)** Where one person was reluctant to be supported with oral care, there was information in the support plan and risk assessments to identify this, and oral care was monitored through the monthly health checks. **Consent to care and treatment:** Score 3 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. Individual capacity was considered and assessed. Areas assessed included sharing of information, personal care, support with diet and nutrition, positive behaviour support, and finances, for example. A selection for two different service users were reviewed. MCA assessments recorded how staff had made to attempts to assess capacity through the use of communication aids and there was information on best interest decisions.

KLOE	Regulations	Comments
		Restrictive practices were minimised. Areas of the home were only locked where there was a health and safety risks, such as CoSHH and medicine safety. 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. This is known as Deprivation of Liberty Safeguards (DOLs). Applications were made as needed. • This service scored 75 (out of 100) for this area.

Outcome: The service is considered effective

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

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

SRG RATING: **Good**

KLOE	Regulations	Comments
Caring	**Regulation 9: Person-centred care** **Regulation 10: Dignity and respect**	**Kindness, compassion and dignity:** Score 3 Staff treated people with kindness, compassion, and respected people's dignity. Observations showed that people were supported with kindness and compassion by staff members. People had a positive relationship with staff and their dignity was respected. 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. Relationships were promoted and encouraged, and people were supported to see family and friends. **Treating people as individuals:** Score 3 Staff and the management team knew people well and were able to describe people's preferences on how they liked to be supported and activities to ensure they were treated as individuals and care was personalised according to their preferences. Support plans were individualised to the person. They were clearly broken down into sections and were specific to the person and their needs in different areas. Support plans clearly described what each person could and could not manage. Regular key worker meetings were held with staff to ensure people's preferences were captured and this was monitored to ensure people received personalised care and were treated as individuals. **Independence, choice and control:** Score 3 People were involved in decisions about their care and how they would like to be supported where possible, and independence was promoted. Observations showed that people were encouraged to maintain their independence as do as much for themselves as they could manage. Support plans and quality of life plans identified what people could manage for themselves and where they wanted to maintain their independence. For example, where one person preferred to stay in their room, but liked to make their own breakfast, staff had arranged for the person to have a fridge, so they

KLOE	Regulations	Comments
		could keep things like milk and butter. Staff would bring them a tray with toast and cereal, and they could then add milk and butter their toast as they wished. Evidence was seen of people taking part in small household tasks including domestic, cooking, shopping and watering plants. **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. These were embedded within the culture of the service. Staff were vigilant and responsive to people's needs. They knew and understood when people were becoming restless or bored and made arrangements for different activities to happen, including going out or taking part in an activity in the home. Behaviours of concern records showed how staff responded and supported people during such incidents. Referrals were made to external health or social care professionals if concerns about their welfare were identified. **Workforce wellbeing and enablement:** Score 3 Information was made available to staff in relation to the staff support mechanisms within Liaise. This included the twenty-four-hour counselling and advice support service, which was displayed on the office wall with a reminder for staff of the log-in details of the website and the direct line phone number. Staff financial wellbeing was considered with the financial wellbeing app, Wage stream, which allowed staff to access their wages as and when they earnt it, to help staff manage in the current economy. Staff could access a fully funded blue light card, which gave them access to discounts in many shops. Staff were provided with life assurance of two times their salary, in the event of their death.

KLOE	Regulations	Comments
		There was a refer a friend scheme. There was a colleague recognition scheme, whereby staff cold nominate other staff who they thought had gone above and beyond. The management team worked flexibly with people to help them create a rota that worked for them and balanced home and working life. There was an open-door policy to the management team, and they actively worked with staff during the day. A staff Christmas party had been arranged for December. Following incidents of concern, the management team supported staff with debriefs. • This service scored 75 (out of 100) for this area.

Outcome: The service is considered as Caring.

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

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

SRG RATING: **Good**

KLOE	Regulations	Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 12: Providing Safe Care and Treatment** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred care:** Score 3 Staff at the service supported people in line with the quality-of-life strategy. This gave staff guidance on supporting people to make choices, learning new things, relationships, health, doing interesting things in the community, individual rights, managing money, and feeling well. Alongside the support plans in Blyssful each person also had a quality-of-life support plan. These were in a user-friendly format with pictorial and easy read versions in place. It was note that two had not been reviewed for over a year, and it would be useful to do this. **(RR 1)** Alongside the support plans and quality-of-life plans, there was additional support records such as PBS plans and communication passports. At times there was some duplication of documentation, as people had both a support plan on the electronic system and the quality-of-life easy read care plan. sometimes the information to support the person was not always as detailed in one as it was in the other. For example, where one person used electronic systems to communicate with staff on occasions, this was more detailed in one document had not so apparent in the other. It would be worth reviewing the individual plans to ensure that they contain the same detail of information. **(RR 2)** People received person centred care and were supported well by staff. Observations showed that staff knew people well and understood their individual needs. Staff were able to describe how people liked to be supported and gave examples of people's preferences. **Care provision, integration, and continuity:** Score 3 Systems were in place to ensure people had access to care provisions, integration and continuity. The registered manager said that systems were in place that included people had access to local communities and they worked jointly with other agencies to ensure continuity of care. People were supported to access community resources. Links had been built with the learning disability liaison for the adult learning centre at the community college. They provided bespoke classes and people attended to learn digital and cooking skills.

KLOE	Regulations	Comments
		Listening to and involving people: Score 4 Staff used a range of communication tools, such as pictures, photographs, easy read documentation and Makaton to promote effective communication between people and staff. Key worker meetings were happening on a monthly basis. These were not recorded on the Blyssful but completed on an easy read format. Each month staff checked with people if they were getting the support they needed with personal care, family, friends and relationships, their home, health care needs, finances, community access and activities. Where people were making plans for the following month, the key worker sessions did not review these to see if these had been achieved. There was evidence in the daily notes that an activity had been completed, but no review as part of the key worker session. **(RR 3)** The reviews looked at goals and if there had been any progress. Goals were dependent on individual needs and preferences of the person. For example, for one person this was to go swimming, for another person this was to purchase a fridge for their room, which they had done. They had also wanted to visit the garden with the therapy dog, but this was currently still in progress. Monthly house meetings were held which people could join in as they wished. People had opportunities to plan and discuss upcoming events and celebrations, such as Halloween and Christmas, any achievements, activities, updates for the house and any general news updates. There were systems in place for people and their families to raise any concerns or complaints. There had been no complaints from families or people using the service. Influencers had been introduced into Liaise, which was a group of people who lived in the services that were helping the organisation to find out what people might need, and whether they were living in the right home. As yet they had not visited Totteridge House. **Equity in access:** Score 4 The Registered Manager ensured that people were treated equally and as an individual. They supported people to access care and treatment and advocated on their behalf.

KLOE	Regulations	Comments
		Following a high-level incident, one person had been admitted to a mental health unit. The Registered Manager had advocated for them and sought additional support and managed to get them discharged back to the home. They explained how the team had worked collaboratively with external professionals to achieve this. Staff were alert to discrimination and inequality. Training was provided on equality and diversity. This helped to raise awareness of people's rights. People were supported with appropriate adaptations to suit their needs. For example, one person preferred a bath, and had a bath rather than a shower. Another person had needed adaptations such as a walk-in wet room and added ramps before they moved in, and these had been accommodated. **Equity in experiences and outcomes:** Score 4 Care plans were personalised based on people's preferences and choices. Staff had a good understanding of the ethos of the service and were clear about their responsibilities. They understood their roles and said they were supported by the management team. Where people had any cultural or religious needs, these were recorded to ensure staff were aware of them. People were supported with a range of activities they preferred to take part in. consideration was given to what people preferred to do. Some people liked going for walks, drives, swimming, eating out, bowling, trampolining, going to the cinema, and exercising. In house people liked electronic toys and gadgets, sensory aids, listening to music, using an iPad, watching old films or wrestling. Where one person would very seldom leave their room, staff took the activities to them. For example, when helping with baking, staff took the ingredients and mixer to the person and set them up in the room so they could take part. People were supported with a range of experiences and events. National days were celebrated these included, a swallowing awareness day where people had made mocktails to promote awareness of dysphagia.

KLOE	Regulations	Comments
		Some people went to college for cooking and IT skills along with daily living skills. There was a Wishing Tree which was used to help people achieve goals and aspirations. The evidence of the caterpillar that progressed through to the butterfly meant that people had achieved a goal or aspiration. This was a visual and active part of people's daily lives. Goals which had been achieved included: ➢ Starting college ➢ Purchasing a headset ➢ Visit the theatre ➢ Have a weekend in London ➢ Going swimming ➢ Going to watch wrestling **Planning for the future:** Score 3 There was no one living in the home who had a DNACPR. People were young and had limited understanding of death and dying. Family input had been sought in relation to end-of-life planning. Where families had felt able to participate, this information was included in the support plan. There was an emergency plan in place in case of a sudden death. **Providing information:** Score 4 People were supplied with different information about the service, should they want it. There was a home information pack that was available to relatives, visitors and commissioners. This was also available in an easy read format for people using the service. Support plans were available on the Blyssful system, but staff at the service had continued to provide people with a quality-of-life care plan which focussed on the support need and how the person was involved through pictures and how staff ensured they received the support they needed.

KLOE	Regulations	Comments
		There was easy read information in the form of the complaint's procedures. Guidance was available through leaflets advising or safeguarding and whistleblowing, which was available for anyone visiting the service. People using the service were provided with planners and easy read wall planners which identified the plan for the day, who was supporting them and what the weather was like. Some people living in the home could not always or preferred not to communicate directly with staff and others. There was information within the support plans in place in relation to individual communication support needs. These were supported by communication passports which gave detailed information about how the individual person communicated with staff or other people. For example, one person did not like to speak to staff but would leave messages through electronic gadgets, and another person used a communication booklet to connect with staff. Staff understood about communication and explained different ways of communicating, and observations showed that they communicated effectively with people throughout the visit. • This service scored 89 (out of 100) for this area.

Outcome: The service is considered as Responsive.

Responsive is defined by the CQC as meaning "that the service meets people's needs".

"Characteristics of services the CQC would rate as 'Good', are those that people's needs are met through the way services are organised and delivered".

SRG RATING: **Good**

KLOE	Regulations	Comments
Well led	**Regulation 12: Providing Safe Care and Treatment** **Regulation 17: Good governance / Record Keeping** **Regulation 19 - Fit and Proper persons employed**	**Shared direction and culture:** Score 3 There was an open and transparent culture which acted on concerns raised and protected people in line with safeguarding and whistleblowing procedures. Staff were made aware of changes and updates. There was a read and sign folder, which contained key information for staff, including reports from external inspections, team meeting minutes, updates to the business continuity plan and policies, results of the survey, and the yearly report. This helped to ensure that staff knew what was happening in the company. There was a commitment to ensuring that people using the service were supported to access a regular. The registered manager had purchased the Skills for Care good and outstanding guide and was using this to help guide the service. There were shift planners in place to help staff organise the day and ensure that all tasks and roles were completed. This included completing allocated tasks and supporting people with activities and appointments. Staff understood their role and responsibilities. They said they were kept up to date with changes in people's needs and their wellbeing by the management team this was done during handover and meetings. **Capable, compassionate and inclusive leaders:** Score 3 The registered manager and deputy manager had been in post for some years, and therefore knew the home, people, and staff well. Staff were positive about the management of the home and said they that they always had time for them. Staff said the Registered Manager and the Deputy Manager were actively involved in supporting people, and did not expect staff to carry out any support that they themselves were not prepared to support with. Staff were actively involved in carrying out audits and checks, this was to help ensure that everyone knew what the expectations were.

KLOE	Regulations	Comments
		Following high level incidents, staff at the service felt supported by the senior management team. However, in the longer term, there were times when the management team felt isolated and remote from the provider. **Freedom to speak up:** Score 3 Staff had opportunities to speak up through staff meetings. These were primarily held on a monthly basis. Staff were given opportunities to discuss experiences of people supported, compliance and audits, internal and external, incident, safeguarding and lessons learnt, MDT feedback and training. Staff said they felt listened to by the management team and supported. Surveys had been completed and where responses were needed, these had been made available to staff with actions which were to be taken. There was a staff champion who spoke up on behalf of staff at the service. **Workforce equality, diversity and inclusion:** Score 3 Staff told us they were valued by the management team and enjoyed working at the service. A staff member told us, “I like working here, we are a good team.” An equality and diversity policy was in place and staff had been trained in this area. Systems were in place for flexible working arrangements as shift plans showed staff were able to work flexibly. Systems were in place to record incidents towards staff and action taken to ensure staff were safe. All staff had opportunities to develop their skills and knowledge. The home gave staff opportunity to progress their careers. **Governance, management and sustainability:** Score 3 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.

KLOE	Regulations	Comments
		Audits and checks were carried out in line with the providers procedures. A series of enhanced audits were in place which included: ➢ Manager Walk Around Audit: 10th December: 100 % ➢ Weekly Medication Shift Leader Audit: 4th December: 100 % ➢ Health and Safety Monthly: 18th November: 100 % ➢ Out of Hours: 14th November: 100 % ➢ Managers Monthly Medication: 14th November: 100 % ➢ Vehicle Maintenance Audit: 13th November : 94 % ➢ Finance Audit: 10th November: 100% ➢ Manager's Quarterly Support Plans and Risk Assessments: 19th September: 100 % ➢ Operation Managers Quarterly medication audit: 28th October 96 % Evidence was seen of actions taken following any recommendations. The provider maintained oversite through the TaMI (Trends and Monitoring Information). This reviewed data generated from RADAR, Blyssful, the training department and the quality team, for example. Overall, the service was at 98%. **Partnerships and communities:** Score 3 Systems were in place to ensure people had support from health and social professionals when required. The registered manager and staff said they worked in partnership with health and social professionals to ensure people's needs were consistently met. Records showed the home working in partnership with social and health professionals to ensure people received safe and effective support. There was evidence that reviews took place to ensure people's support needs were met. **Learning, improving and innovation:** Score 3

KLOE	Regulations	Comments
		Where recommendations were made from external checks, such as independent mock inspections or local authority visits and internal checks such as an internal mock inspection and audits, an action plan was developed for any shortfalls identified. Evidence was seen that the actions raised were addressed. There was information in the action as to what had been done to address the action. For example, where a recommendation was that the single assessment framework should be discussed with staff, the manager had accessed the information from Skills for Care and discussed this at a staff meeting. Learning was shared from other services within the group and safety incidents in the community. For example, additional carbon-monoxide detectors had been purchased. Staff confirmed that the management shared learning with them so they could be involved in the improvement of the service. Information and records such as staff and service user meetings were not being saved to the RADAR system as per Liaise procedures. **(WR 1)** **Environmental sustainability – sustainable development:** Score 3 There was a sustainability champion who promoted greener practices. The use of paper was reduced and there was a reminder for staff around recycling in order for everyone to do their bit, with a guide to recycling. LED lighting was used, and lights were turned off when not in use. Energy efficient appliances were purchased. A box had been put in place for used batteries, so these could be recycled at local collection points. • 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**		

KLOE	Regulations	Comments
high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture". Characteristics of services the CQC would rate as Good, are those where **"the service is consistently well- managed and led. The leadership, governance and culture promote the delivery of high-quality, person-centered care, and the service has clear, consistent and effective governance, management and accountability arrangements"** **SRG RATING: Good**		

ACTION PLAN:

CQC KLoE SAFE By safe, we mean people are protected from abuse and avoidable harm.							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
SR1	*Ensure that proper checks are made on DBS update service to ensure that the certificate is current.*						
SR2	*Remind staff to complete cleaning schedules.*						
SR3	*Include more in the medication profiles.*						
SR4	*Include more information on how to administer covert medicines.*						

CQC KLoE EFFECTIVE **By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence**							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
ER1	*Consider the use of two sets of monitoring records. If these are used ensure both are completed in detail.*						

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	*Review the quality-of-life support plans, which have not been recorded as being updated for over a year to ensure they are still current.*						
RR2	*Review the separate individual plans to ensure that they contain the same detail of information.*						
RR3	*During the key worker meetings any planned outings, be reviewed to ensure that they were completed and were a success.*						

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	*Save records to RADAR as per provider procedures.*						