AUDIT REPORT

Willow Court

Date of Visit: 16th and 17th July 2024

Private & Confidential
SRG CARE CONSULTANCY LIMITED

Contents:

Service Name: Willow Court **Provider:** Liaise (London) Limited

Address of Service: 23a Highbridge Street, Waltham Abbey, Essex, EN9 1BZ

Date of Last CQC Inspection: 8th and 16th September 2022

Ratings

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

KLoE Domain	Rating	Overall Score
Is the service safe?	Good	68 (out of 100)
Is the service Effective?	Good	66 (out of 100)
Is the service caring?	Good	75 (out of 100)
Is the service responsive?	Good	67 (out of 100)
Is the service 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:

- 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 16th and 17th July 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, staff, and two residents, a tour of the building and review of key documentation.

SUMMARY OF OUTCOME

Willow Court 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 11 residents. At the time of this audit the home had full occupancy.

Care records and 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.

The service uses Blysfull for care plans, RADAR for quality assurance and monitoring and recording events and actions and QUODA for health and safety. Staff input daily occurrences via tablets such as nutrition, personal care and support provided.

DISCLAIMER

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

RATINGS

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

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

KLOE	Applicable Regulations	Comments
Safe	**Regulation 12 (f) and (g) Safe Care and Treatment** **Regulation 13: Safeguarding users from abuse and improper treatment** **Regulation 17: Good Governance** **Regulations 18 & 19: Staffing - Fit and Proper persons employed** **Regulation 20: Duty of Candour**	**Learning culture:** Score 2 There was an operational work flow system for events, which included staff raising an event as an incident, reviews, and an action plan. Incidents were recorded at different levels, depending on the severity of the event. Where incidents were of a more serious nature, these included more detailed records of the event including duration, intensity and more detail of the actual event However, clear and accurate details were not always recorded. It was not always known or recorded details of post incident and debriefs were not always in place, although it was confirmed that this was happening. For example, an incident occurred where staff used a breakaway technique, following aggressive behaviour by one person. The incident was not escalated to a serious incident. There was no note of whether there had been a debrief session for the staff member. It was confirmed that a debrief took place following the incident, but the incident investigation recorded that there was no debrief. Care needs to be taken to ensure that documentation is completed accurately. **(SR 1)** The Registered Manager encouraged reflective learning through debriefs to further support learning from incidents, although as noted above, this was not aways recorded. Lessons learnt was shared at team meetings. **Safe systems, pathways and transitions:** Score 3 Good working relationships had been developed with internal and external professionals to promote safe pathways of care. Where incidents were reviewed and concerns were identified in relation to individual needs, both internal and external referrals were made. This included the involvement of the registered provider's practitioner development team including the speech and language therapy (SALT) and positive behavioural specialist (PBS) teams.

KLOE	Applicable Regulations	Comments
		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 People were safeguarded by staff who had been trained to identify and act on any signs of abuse or neglect. Staff spoken with understood what was meant by safeguarding. The manager recorded safeguarding concerns and reported them as appropriate to CQC and the local authority and would assist in the investigation when asked to. There was information around the service advising people how to raise concerns. People had support from outside professionals and families who could act in their best interest if required. **Involving people to manage risks:** Score 3 People were supported to manage risks. There was information on what people could manage for themselves and factors that put them at risk. Risk assessments included activities and community access, choking, autism, behaviours, communication, diabetes, diet and nutrition, finances, oral care, personal are, safeguarding, and flammable creams, for example. Risk assessments generally identified individual risks and were specific to the individual person. Risk assessments lacked some detail in places, for example, where one person was to be supported to maintains a healthy weight by offering healthy meals & snacks, but not what these were. However. Other risk assessments had been developed and contained more detail and information to guide staff in how to support people safely with their individual needs. For example, clear assessments of risks related to diabetes and epilepsy. **(SR 2)** Each person had a Positive Behaviour Support (PBS) plan. This included information about the person,

KLOE	Applicable Regulations	Comments
		with proactive, active and reactive strategies. Triggers were in place and PBS plans clearly identified how to support people. PROACT SCIPrUK Interventions were only used when necessary and as a last resort. These were identified in the PBS plan. **Safe environments:** Score 3 Systems were in place to monitor health and safety within the environment. An electronic system known as QUOODA was used to monitor the health and safety of the service. There were a range of checks in place which were completed on a daily, weekly and monthly basis. Evidence was seen that these were up to date. These included: Monthly fire alarm door release, weekly fire alarm test, monthly fire extinguisher check, monthly emergency light check, monthly fire door check, weekly carbon monoxide and monthly fire drill. Internal and external lighting, call points, weekly water flush, monthly ladder check, weekly window restrictors, monthly lift check, monthly grab bag, weekly fire doors, monthly carbon monoxide and weekly plug checks. Water temperatures were tested on a monthly basis. Quarterly checks on the extract fan, garden equipment, ladders and pathways. Bi-annual and Annual risk assessments included: ➢ Health and safety: Due September 2024 ➢ Fire: Due September 2024 ➢ Water: Due October 2024 Bi-annual and Annual Servicing included: ➢ Fire extinguisher maintenance. Due September 2024 ➢ Emergency Lighting: Due September 2024

KLOE	Applicable Regulations	Comments
		➢ Fire door inspection: Due September 2024 ➢ Passenger lifts: Due September 2024 ➢ PAT testing: Due September 2024 ➢ Gas safety: Due May 2025 Maintenance issues were in place on the action plan. These included the replacement of cracked tiles in the hallway, plans to clean the carpets, redecoration of communal areas and new furniture. **Safe and effective staffing:** Score 2 People were supported on either a one-to-one basis or two-to-one either in the home or in the community and at other times, people shared hours. There were enough staff available to meet individual needs and staffing levels were considered appropriate and reflective of the assessed support needs of each person. Recruitment continued to be managed by a central team from head office. They carried out all checks as required by regulation. Evidence of recruitment was kept electronically. Recruitment procedures were checked to assess compliance with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were gaps in employment histories on the files viewed. For one person, attempts had been made to obtain an account of the gaps, but not all had been explained in the response from the staff member. For another person, there was only an employment history for nine years, rather that a full employment history. **(SR 3)** As people tended to provide a C.V., they did not always record why they had left other employment. Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states: 'Where a person (P) has been previously employed in a position whose duties involved work with children or vulnerable adults, satisfactory verification, so far as reasonably practicable, of the reason why P's employment in that position ended'. This should be obtained from staff. **(SR 4)**

KLOE	Applicable Regulations	Comments
		Staff records viewed contained other necessary documentation, such as interview questions, references, a medical questionnaire and disclosure and barring checks (DBS). Right to work checks were in place along with proof of ID and address. New staff were issued with a handbook which included information about key working conditions, conduct, holidays and policies and procedures which affected the employee. Staff were issued with a contract when they started work, as required by employment law. Although, it was noted that two viewed had not been signed by the employees. **(SR 5)** New staff were supported with an induction. This included a welcome and orientation to the service with an overview of staff processes, rotas and shift patterns, mission and values, health and safety, policies and procedures, health and safety, responsibilities, people supported and their care plan and systems. Evidence was seen that new staff completed the induction. There was a much-improved induction in place, which would further support staff in their role. Staff competencies were assessed through induction as well as on an annual basis, following this. The medication competency stated that staff should have a competency assessment on three different occasions. However, on the majority of the files viewed there was only evidence of one medication competency assessment. **(SR 6)** Staff were supported with training. This was primarily online through the training provider Your-Hippo. Mandatory training included safeguarding, medication awareness, Mental Capacity and Deprivation of Liberty Safeguards, health and safety, food safety, autism, equality and diversity, privacy and dignity, fire safety, GDPR, infection control, manual handling and learning disability. Required training included British sign language COSHH, diabetes, Duty of Candour. Duty of Care, Epilepsy, Epilepsy and Buccal Midazolam, Mental Health, Nutrition, Oral Health, and person-centred care, for example. Staff training records showed that staff had completed their training and were at 100 % compliance at the visit.

KLOE	Applicable Regulations	Comments
		Proact Scipr training, which taught staff positive and proactive strategies for supporting people in crisis was in place and used effectively when needed. Staff were supported with supervisions though both one-to-one and observational. Supervisions gave staff the opportunity to review performance, training needs, and any support needed. Actions would be set to be reviewed at the next supervision, although these were not always detailed nor were they reviewed at the next supervision. For example, one action was for some specific training to be completed, but this was not identified on the next supervision as to whether this had been completed or not. Actions were often ongoing, but with no goals. **(SR 7)** Assessments of individual knowledge and understanding of staff competencies in relation to Health and Safety/Fire, IPC and Food Hygiene, MCA and Safeguarding and medication were in place. These started at induction and then were renewed on an annual basis. These were all recorded at 96.4% on the day of the visit. Appraisals were in place. **Infection prevention and control:** Score 3 People were protected from the risk of infection. Staff had received training in food hygiene and infection control. There were cleaning schedules that ensured cleaning tasks were completed either on a daily, weekly, or monthly basis. The managers monthly environmental audit monitored infection control and cleaning procedures. Appropriate PPE was available for staff to use if they needed it. **Medicines optimisation:** Score 3 Medication was managed safely. Systems for managing medicines were appropriate. Medicines were either kept in a clinical room in a locked cabinet or people's own rooms in locked cabinets. Temperatures were taken on a daily basis. There were systems for people to take their medicines out with them when they went out for the day or to visit family.

KLOE	Applicable Regulations	Comments
		There were systems for ordering medicines and any returns. A sample of medication administration records (MAR) charts were reviewed, those seen had been completed accurately. Medication countdown records were maintained to ensure that the correct number of medicines were kept for each person. PRN (as and when medicines) protocols were seen and these included the medication details, reasons for use, signs, and symptoms to be managed, alternative suggestions, conditions to administer, when medical advice should be sought any side effects and actions taken after. Easy read daily medication profiles were in place. • This service scored 68 (out of 100) for this area.

Outcome: The service is considered safe
'Safe' is defined by the CQC as meaning "**people are protected from abuse and avoidable harm".**

Characteristics of services the CQC would rate as 'Good' in this area are those displaying evidence through systems, processes and practice which reflect: People are protected from avoidable harm and abuse.

SRG RATING: Good

KLOE	Regulations	Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: The need for Consent** **Regulation 12: Providing Safe Care and Treatment** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 15: Premises and Equipment.** **Regulation 17: Good Governance** **Regulation 19: Staffing**	**Assessing needs:** Score 3 People had lived at the service for a while and there had been no one new move into the home since the last SRG visit in 2023. Observations gave assurance that staff knew and understood the people living in the home. Regular reviews were in place to ensure people's current needs were being met. **Delivering evidence-based care and treatment:** Score 3 STOMP (Stopping over medication of people with a learning disability and autistic people) is a national NHS England initiative aimed at preventing inappropriate prescribing of psychotropic medications. In line with this initiative, people were supported with individual medication reviews, with the most recent being carried out in June. These were carried out by the clinical pharmacist to ensure that people were being supported appropriately with their medicines. People with learning disabilities are at risk of experiencing poorer health outcomes. To help monitor individual health care needs, people over the age of 14, which have a learning disability have a right to an annual health check. People were supported with making appointments for these reviews and to attend them. Where one person suffered with reduced mobility and balance, staff had supported them to visit the chiropodist and complete a fitting for specialist shoes to help their balance and mobility. Assessments and support plans contained information about how to support people in relation to any health care conditions, such as epilepsy or diabetes. Where people were at a potential choking risk, there was detailed information on how to manage this risk in line with first aid guidance. Where people had allergies, these were identified. **How staff, teams and services work together:** Score 3

KLOE	Regulations	Comments
		information was shared with other health care professionals. There was good evidence that referrals were made, and staff collaborated with these professionals to implement recommendations and changes to how people were supported. People were supported with reviews of care from the local authority. Each person had a hospital passport. This was documentation which contained key information about the person so people could take this with them when they went into hospital. This helped to promote consistency of care. Internal multi-disciplinary teams worked effectively with staff at the service to ensure that people's needs were kept under review and adjustment made where needed. **Supporting people to live healthier lives:** Score 3 Incident records showed that staff reacted appropriately when people suffered with a seizure and took actions to safeguard the person and monitor whilst the seizure was occurring. During the visit, there was good evidence seen as to how an incident was managed when one person suffered from a seizure and staff managed well and monitored the person in accordance with their care plan. Pain profiles were in place for people using the service which identified potentially when someone may be in pain, what they took and how to support. There was also a reference to someone who knew the person well, but for one person the staff member had left the service, and this had not been updated. **(ER 1)** Where one person needed to attend regular hospital appointments in relation to a health condition, they were supported to do this, with robust records of treatment provided. People's nutritional needs were met, and where people had specialist diets, these were catered for. **Monitoring and improving outcomes:** Score 2 Systems were in place to monitor people to ensure that they were safe and not at risk from any health care conditions which may affect their wellbeing.

KLOE	Regulations	Comments
		These varied in detail and robustness. For example. where one person was at risk of falls, hourly checks had been put into place, and these were seen to be happening. However, one person had been identified as being at risk of constipation and the care plan stated that bowel movements should be recorded. The person was generally independent for using the toilet and bowel charts were not in use. **(ER 2)** One person was to have their blood sugars monitored twice a day. This was not routinely being recorded in the Blysfull system. There were no records for the 7th, 8th, 11th, 12th, and 13th of July of the level of the blood sugar. **(ER 3)** The support plan for this person indicated that there was a risk of the blood sugar levels reached above 8.5mmol, but approximately half of the blood sugar levels recorded identified that the levels were above this, reaching as high as 14.3 and 15.1 for two entries. Staff only recorded what the blood sugar level was and not what actions, were taken or if there were any needed, or the person's wellbeing. **(ER 4)** **Consent to care and treatment:** Score 2 The Mental Capacity Act (MCA) 2005 requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. There were MCA assessments in place for different areas, where people did not have a capacity to make a decision. These were decision specific. These were being reviewed and updated as the current MCAs had been transferred from the previous electronic care planning system. An updated MCA was reviewed; however, this lacked detail and did not describe the actual conversation, any communication tools used and whether the person could retain the information. The Registered Manager was aware that updated MCA assessments needed more information. **(ER 5)**. Consent forms were in place for care, medication, care and support and use of pictures. These were in the process of being updated. **(ER 6)**

KLOE	Regulations	Comments
		People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, this is usually through MCA application procedures known as DoLS (Deprivation of Liberty Safeguards). People at the service were subject to deprivation of liberty safeguards (DoLs) and these had all been applied for, some of which had so far been granted. Monitoring was in place to check progress of authorisation by the local authority. It was confirmed that some people had representatives who had legal rights such as through Lasting Power of Attorney. However, there were no processes to monitor this and not all legal representatives had provided proof of their legal rights in relation to the people living in the home. Proof should be obtained, and proof can also be accessed through the Office of Public Guardian website. **(ER 7)** Find out if someone has a registered attorney or deputy - GOV.UK (www.gov.uk) • This service scored 66 (out of 100) for this area.

Outcome: The service is considered effective

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

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

SRG RATING: **Good**

KLOE	Regulations	Comments
Caring	**Regulation 9: Person-centred care** **Regulation 10: Dignity and respect**	**Kindness, compassion and dignity:** Score 3 People spoken with all said they thought staff were kind and caring and listened to them. Feedback from a recent service user survey evidenced that people thought staff respected and listened to them. During a tour of the service and general observations noted during the course of the visit there was good evidence of positive support provided to people. It was also observed that there was a relaxed atmosphere. All people who were being supported appeared to be comfortable in the presence of staff. We observed staff speaking to people in a respectful manner. Support plans were written sensitively, with promoting dignity identified. **Treating people as individuals:** Score 3 Not everyone using the service had additional detailed information included in their care records about their life history and likes and dislikes, for example and this would benefit from being expanded on for some people. **(CR 1)** Care plans included what people could manage for themselves. One person enjoyed their role as being part of the staff and helped out with communal duties such as cleaning and organisation of the lounge. People were supported to attend church, where they wanted to. **Independence, choice and control:** Score 3 Staff encouraged people to express their views and make choices about their care. Throughout the visit staff were seen to involve people in making decisions, such as asking how they wanted to spend their time and what they would like to eat. People were seen to be able to make choices about where they wanted to spend their time.

KLOE	Regulations	Comments
		People were supported to develop their independence through maintaining and developing life skills, such as getting involved in cooking, or preparing snacks laundry and general household duties. Where redecoration was taking place, people had been involved in choosing the colour schemes. **Responding to people's immediate needs:** Score 3 Communication tools were used to help people identify to staff support needs. Referrals were made to internal or external health or social care professionals if concerns about people's welfare were identified. **Workforce wellbeing and enablement:** Score 3 The provider had processes in place to support staff wellbeing. There was a free counselling and advice service, which staff could contact on a confidential basis. There was also a care workforce app, which staff could access if they felt worried or overwhelmed. There was an above and beyond scheme, which staff were nominated for, with a reward of a voucher and a CQC bonus for when a home achieved a good or outstanding rating from CQC. The company was part of the blue light scheme, which gave staff access to discounts and benefits. Staff said they felt well supported. Staff were supported by the registered manager and the deputy. There was an open-door policy and staff were seen to pop in and out of the office as they needed to. • 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**		

KLOE	Regulations	Comments
with dignity and respect and are involved as partners in their care". SRG RATING: Good		

KLOE	Regulations	Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 12: Providing Safe Care and Treatment** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred care:** Score 2 Appropriate staffing enabled people to be supported in the way they wanted to be supported. Routines were flexible so people were supported with personal care, meal preparation and assistance with daily living at times that met with their needs. One person who needed to attend dialysis three times a week, consistency was promoted which meant they were supported by the same two staff, who knew and understood their needs. On occasions, some of the support plans were repetitive and duplicated. For example, the Medical and Health support, incl. medication, diagnoses, wellbeing, sensory needs, mobility, diet and nutrition for one person was repetitive, with the same information repeated on multiple occasions throughout the plan, which made it difficult to follow. There was information about the diabetes, the support plan then referred to mental health needs and then again to blood sugar levels. The care plan then referred to a food allergy, then back to the diabetes, choice of meals, covid and then diabetes again. I suggest that the support plans are placed in sections so all details referring to one subject are kept together. **(RR 1)** Daily care records did not always evidence that people were supported to take part in pastimes and activities of their choice, as there was limited evidence in relation to activities that people took part in. **(RR 2)** Discussions with staff evidenced that they knew what the keyworker role involved, but as yet, this had not been embedded. For example, key worker meetings were in place. These were used to review goals, check health care needs, what had gone well, was there anything people were proud of, where there any barriers to achieving outcomes, whether there were any new activities and if there were actions identified or actions incomplete from the last review that need to be completed in the next month. A review of records confirmed that these were happening on a monthly basis, however some areas of these lacked substance with no reflection on progress of any goals, with responses stating that goals had been achieved, but not what these were and little person-centred reference to any future plans. **(RR 3)**

KLOE	Regulations	Comments
		Care provision, integration, and continuity: Score 3 Staff maintained regular contact with families to keep them up to date with progress or updates about their relatives. Staff worked with health and social care professionals to promote outcomes for people. Reviews of care was undertaken. **Listening to and involving people:** Score 2 The complaints procedure was in an easy read format and made available for people. There had been no recent complaints, with the last recorded complaint made in June 2023 from a neighbour in relation to noise at night. Learning from this had been recorded and there had been no repeat of the complaint. Although it was advised that people were asked about menus and shopping, there were no house meetings in place to give people opportunities to have a say about the home and be involved. **(RR 4)** As identified above key worker meetings needed further development to fully evidence how people were involved. Surveys had taken place for people using the service, with responses seen to be positive. Family meetings had happened, although none had taken place recently. **Equity in access:** Score 3 Staffing levels ensured that people were not disadvantaged when accessing the community. People could access care, treatment, and support when they needed to and in a way that worked for them. One person had a health condition and staff were advocating on their behalf with health care professionals to review future treatment to ensure they were given the same opportunities to live an ordinary life as any other citizen. **Equity in experiences and outcomes:** Score 3 Although, these were not always recorded, people were supported with a range of activities.

KLOE	Regulations	Comments
		People enjoyed going out to the cinema, bowling, cycling, and going out for meals. They also enjoyed going out on trips and rides into the country. People had also visited an airfield and a local petting zoo. Games and cinema afternoons and evening were arranged, along with coffee mornings, quizzes and music and dance sessions. Feedback indicated people enjoyed the activities. **Planning for the future:** Score 3 There was no one living in the home with life limiting conditions and there was no one receiving end of life care at the time of the visit. Some consideration had been given to end of life matters and future planning. The family for one person had worked with staff to discuss and plan end of life matters. Contact had been made with other families to further develop this area. Where people had any particular religious or cultural preferences, this was reflected in the end-of-life plans. **Providing information:** Score 3 The internal support team provided support and guidance for people in relation to communication needs. For example, one person was non-verbal, and the SALT team had implemented guidance on the introduction of burst-pause activities, which allowed for a short activity and then a break with communication to see if the person wanted the activity to continue. Now and next boards were in use to help people structure their day, and to support them to move onto the next activity once they had completed one part of their living activities. Consideration was given to pictures, symbols and some Makaton signs to aid communication. The SALT team had produced communication passports for some people. These were a guide to help staff get to know the individual person's communication style. Not all the information around communication in relation to SALT guidance was included in the support plans. **(RR 5)**

KLOE	Regulations	Comments
		Some information was provided in large print or pictorial. Activity information was nicely displayed for people. However, some could be further developed with more information for people being available, such as staff on duty and menus. **(RR 6)** • This service scored 67 (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 2 Staff had not fully embraced some of the direction of the home. For example, where they had received keyworker training and been provided with a keyworker role description, they were to sign to say they had read and understood this, but this had not happened. As identified elsewhere within this report, key-working had not been embedded, although they could explain what the role entailed. Staff do not always sign to say they have read the communication book, which should be happening. Further scrutiny is needed in relation to how some of the senior roles are managed. A sample of completed supervisions were viewed, these did not evidence that staff were being appropriately supported in their role, as there were often no formal actions for staff and no follow up reviews. One supervision was evidently copied and pasted as it had someone else's name in the supervision. However, where staff performance was not meeting expectations, actions were taken to performance manage staff with clear lines of accountabilities and expected actions. **Capable, compassionate and inclusive leaders:** Score 3 The Registered Manager was visible in the service and monitored the level of care and support being provided to people. The area manager was also visible within the service and worked alongside the Registered Manager, they provided support and guidance in line with Liaise procedures. It was reported that they were additional positive support from the senior management team. There was an open and transparent culture which acted on concerns raised and protected people in line with safeguarding and whistleblowing procedures. There was an aim to promote more independence for people using the service. Since the last visit people were being supported to do more for themselves and make more independent choices. **Freedom to speak up:** Score 3

KLOE	Regulations	Comments
		There was an open-door policy to the office and the registered manager and deputy were visible on site and available to chat to staff, when needed. Staff were supported with regular meetings. There was a set format which included a review of previous meeting outcomes, experiences of people using the service, compliance, debriefs along with learning and actions, medication, health and safety, staff wellbeing and promoting a positive culture through the right support guidance. Minutes from the meeting in May 2023 and identified a number of areas which needed addressing in relation to staff performance including cleaning, activities, breaks and bedrooms, for example. Actions were made, but these were not formalised and or formally monitored, which would be useful to implement. **(WR 1)** Staff surveys were in the process of being sent out and returned. **Workforce equality, diversity and inclusion:** Score 3 Policies and procedures were in place for equality and diversity. Staff were supported with reasonable adjustments so they could balance their working and home life. Staff reported that they felt well supported by the larger organisation. **Governance, management and sustainability:** Score 3 Systems were in place to support the smooth running of the service through a schedule of checks and roles to be carried out on a daily, weekly, monthly and less frequent basis. These included, for example: Daily: Shift planning, handovers, health and safety checks, monitoring of daily notes and monitoring of staff duties. Weekly: QUOODA and RADAR audits, weekly walk around and medication checks. Monthly: Supervision, team meetings, key worker meetings, quality of life meetings, health checks, QUOODA and RADAR audits and house meetings.

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's Walk Around Audit (Weekly): The last two had been completed on 9 and 16 July, with an improved rating from 86% to 91%, with actions taken to improve outcomes. ➢ Medication Audit (Weekly): The most recent audit on 10 July 2024, identifying that the service was 100% compliant. ➢ Medication Audit (Monthly): This was completed on 14 July 2024, and identified improvements in training, which had now been booked in. ➢ Manager's monthly Finances Audit (Monthly) This was completed on 24 June 2024 and was 100% compliant, although it was noted that it was recorded that there were no bank statements in place, although they had been requested. However, this was recorded as compliant rather than as an action needed. ➢ Monthly Health and Safety/ Infection Control Audit: Completed on 10 June 2024, with a 100% rate of compliance. This did not include the actions required to replace the flooring, which was still waiting to be completed. ➢ Manager's Quarterly Support Plans and Risk Assessments Audit Completed 21 June 2024, with a 97% compliance rate and an action to compile care plans into the new system, which was in progress. ➢ Monthly Vehicle Maintenance Audit: Completed on 17 June 2024 and was 100% compliance with no actions required.

KLOE	Regulations	Comments
		Care does need to be taken to ensure that actions are recorded and not signed off before they are completed. **(WR 2)** A monthly operations manager visit audit had been introduced which would be starting in the near future and included a review of documentation, healthcare checks, health and safety, Medication, first impressions and engagement. A quarterly operations manager medication audit was also booked in for August. The QAF monitoring system has been replaced by a new monitoring system known as ARC, to further promote oversight. A HR audit had not been completed for Willow Court and as there were shortfalls in staff files, it is recommended that this is completed. **(WR 3)** Not all competency documents were in place on staff files, although the matrix recorded that these had happened. **(WR 4)** **Partnerships and communities:** Score 3 There were positive partnerships with the internal specialist teams, which included SALT (Speech and Language Therapy), O.T. (Occupational Therapist) and PBS (Positive Behaviour Specialists). This ensured that individual care needs were reviewed. The Registered Manager promoted the sharing of information and working with external services to improve outcomes for people. There was evidence of appointments and support provided to people to access other health services and promote access to the community. **Learning, improving and innovation:** Score 3 Actions were developed from accidents, incidents, safeguarding and audits. These were maintained on the RADAR system with a record of the action, who was responsible, when the action was due for completion and whether it had been completed. The actions promoted a learning culture, where improvements were identified through the provider processes.

KLOE	Regulations	Comments
		Completed actions were seen to include improvements to medication matters, maintenance issues, training and risk assessments, for example. When new systems are put into place, such as the ARC, for example, the senior team received training. This was being rolled out at the time of the visit. There was an action plan in place, which sat outside RADAR. This identified overarching actions to improve the service including staff performance, staff involvement and staff boundaries. This action plan did lack detail on the progress or how actions had been achieved and the current status and I suggest more detail is included in this. **(WR 5)** **Environmental sustainability – sustainable development:** Score 3 There was a positive move to promote recycling and reduce the use of paper. • This service scored 71 (out of 100) for this area.

Outcome: The service is well led.

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

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

SRG RATING: Good

ACTION PLAN:

CQC KLoE SAFE By safe, we mean people are protected from abuse and avoidable harm.							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
SR1	*Ensure that incident reports are completed accurately and in detail.*						
SR2	*Continue to develop risk assessments to the same standard to include more level of detail.*						
SR3	*Ensure there is a full recorded employment history for all staff, with any gaps explained.*						
SR4	*Ensure that there is an explanation of why staff have left a previous position, whose duties involved work with children or vulnerable adults.*						
SR5	*Ensure there is evidence that staff have signed contracts in place.*						
SR6	*Ensure there is evidence of all medication competencies in place in line with provider procedures.*						
SR7	*Ensure that supervisions identify any actions and if they have been completed.*						

CQC KLoE EFFECTIVE

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
ER1	*Ensure that pain profiles are updated when staff leave the service.*						
ER2	*Ensure that if records indicate, then appropriate charts are maintained.*						
ER3	*Ensure that where blood sugar levels are recorded in line with support plans.*						
ER4	*Ensure that where blood sugar levels are not within the individual assessed safe levels, there is a record of actions taken by staff.*						
ER5	*When reviewing MCA assessments ensure more detail is included to evidence the conversation, communication tools and whether the information can be retained.*						
ER6	*Continue to update consent forms in line with procedures.*						
ER7	*Implement systems to obtain and monitor proof of legal representation.*						

CQC KLoE CARING By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
CR1	*Further develop information about individual preferences where these lack detail.*						

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	*Continue to review support plans to ensure the information provided to staff is clear and easily accessible.*						
RR2	*Ensure that daily records identify activities that people take part in, with more detail.*						
RR3	*Continue to embed the key worker role.*						
RR4	*Consider developing house meetings for people to be involved in*.						
RR5	*Reflect guidance from support professionals within the support plans to help ease of access for staff.*						
RR6	*Further develop some of the information available for people using the service.*						

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	*Following staff meetings, formalise any actions so they can be monitored.*						
WR2	*Care needs to be taken to ensure that actions are recorded and not signed off before they are completed.*						
WR3	*Complete an audit of staff files to ensure that all the information as required by regulation are in place.*						
WR4	*Ensure that staff records of competencies are maintained and available.*						
WR5	*Include more detail of how actions are achieved on the overarching action plan.*						