AUDIT REPORT

Meridan Place – Liaise (London) Supported Living

Date of Visit: 9th & 10th April 2025

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Service Name: Meridian Place **Provider:** Liaise (London) Supported Living

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

Date of Last CQC Inspection: 27th April 2022

Ratings

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

Key Questions	Rating	Overall Score
Safe	Requires Improvement 	44 (out of 100)
Effective	Inadequate 	33 (out of 100)
Caring	Good 	65 (out of 100)
Responsive	Requires Improvement 	39 (out of 100)
Well-led	Good 	68 (out of 100)

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

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

4 = Evidence shows an exceptional standard

3 = Evidence shows a good standard

2 = Evidence shows some shortfalls

1 = Evidence shows significant shortfalls

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

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

Overall Service Commentary

INTRODUCTION

An audit based on the CQC Key Questions and Quality Statements, aligned with the Single Assessment Framework, was conducted by an SRG Consultant over two days on the 9th and 10th of April 2025. The purpose of this review was to highlight in a purely advisory capacity, any areas of the service operation which should or could be addressed to improve the provision and recording of care and increase overall efficiency and compliance with CQC Standards and Regulatory Requirements.

TYPE OF INSPECTION

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

METHODOLOGY

To gain an understanding of the experiences of people using the service, a variety of methods were employed. These included observing interactions between people and staff, speaking with the Peripatetic Manager, Deputy Manager, and holding discussions with staff and people. A tour of the building was conducted, kindly facilitated by a person who uses the service along with a review of key documentation. For people with communication difficulties and/or cognitive impairments, observations were made to ensure they appeared comfortable and content with the support they were receiving. Additionally, three care plans were reviewed, three staff recruitment files were checked, and records were examined to confirm that staff training and supervision had been conducted appropriately. Medication records and operational documents, such as quality assurance audits, staff meeting minutes, and health and safety and fire-related documentation, were also assessed.

OUR VIEW OF THE SERVICE

At the time of the visit, the service was supporting 13 individuals, all of whom are regulated under CQC. The service is registered to provide personal care for up to 16 people and supports adults aged 18 and over with mental health needs, learning disabilities, and autism, in a supported accommodation setting. Each person has a separate tenancy agreement with a housing association, with a 28-day notice clause in place.

The home had appropriate staffing levels, and staff received regular training and supervision. However, medicines were not being managed safely. This issue had already been identified by the provider, who was in the process of implementing safer systems for managing medication.

People were supported with food and drink in line with their contracted support hours. Health monitoring was taking place, though this was inconsistent. Staff worked with a multi-agency approach and were engaged with external professionals in supporting people's wider health needs.

Consent was being sought from individuals, including those who lacked capacity. However, there were concerns about the team's overall understanding of the Mental Capacity Act 2005. While safeguarding was understood in principle, there were gaps in some staff members' safeguarding training.

People were treated with kindness and compassion. Staff respected individuals' privacy and dignity, and people were supported to make choices about their care. Staff were attentive to people's needs and responded promptly. However, opportunities for meaningful activities were limited, and documentation required significant improvement to accurately reflect the care and support being provided.

Families were aware of how to provide feedback or raise concerns, and there was clear evidence that complaints were handled appropriately and in a timely manner. People's preferences around end-of-life care had been explored in some cases, but this area was still under development and remained on the service's improvement agenda.

Governance systems were in place, and actions identified through internal reviews were followed up. However, some audits failed to pick up on recurring themes, and there were gaps in oversight. The management team was visible and approachable. Staff reported enjoying their roles and said they felt supported to give feedback. They spoke positively about the recent changes in leadership and felt encouraged about the future, highlighting that the service now feels more stable and supportive of their personal and professional development

PEOPLE'S EXPERIENCE OF THIS SERVICE

People and their relatives gave mixed reviews about the quality of care provided.

Both people and their relatives noted that the staff were kind, respectful, and upheld their dignity. One person shared, *"The staff are lovely, friendly, and very nice."* While some activities were available, participation varied and again there was mixed feedback, with one individual stating, *"They have put the activities on for you"*.

There have been management changes which has caused the staff to become more cohesive. Staff stated that they felt like the change was positive and they were now looking forward to the future of working with the service.

One service user was happy because he felt his preferences of activities were always met.

DISCLAIMER

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

RATINGS

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

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

Outstanding – The service is performing exceptionally well.

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

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

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

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

Key Question	Applicable Regulations	Quality Statements and Comments
Safe	**Regulation 12: Safe Care and Treatment** **Regulation 13: Safeguarding Service Users from Abuse and Improper Treatment** **Regulation 17: Good Governance** **Regulation 18: Staffing** **Regulation 19: Fit and Proper persons employed** **Regulation 20: Duty of Candour** **Regulation 15: Premises and Equipment**	**Learning culture** – Score 2 Staff reported that they complete care notes and incident forms using staff devices. These are then submitted to management for review, sign-off, and to ensure that any necessary corrective actions are taken. Debriefs for staff were included. Incident forms were available and completed. However, it was noted that some were not fully aligned with the risk assessments in place to manage or contain the identified risks. Given the complexity of the individuals supported, and the frequency of behaviours of concern, a high volume of incident reports had been completed. There is a dedicated specialist Positive Behaviour Support (PBS) worker in place who oversees behavioural plans and incorporates incident form data into their ongoing assessments. Managers reviewed trends and patterns, which were then discussed in team meetings. However, learning could be further enhanced. There is an opportunity to strengthen the learning culture by embedding regular reflective practice, offering bespoke training based on emerging themes, and moving beyond a purely system-led analysis of data. Adapting the way patterns are interpreted and used to inform practice could further improve outcomes and staff confidence. **(SR1)** Staff had completed up to date first aid training. One complaint was reviewed during the visit. The evidence provided demonstrated that the complaint had been thoroughly investigated, with a proportionate response. Learning outcomes were clearly documented and used to inform service improvements, showing a commitment to continuous learning and accountability. There was clear evidence that both medical and mental health advice were sought from external professionals when required, reflecting a proactive and person-centred approach. At the time of the visit, the Deputy Managers were new in post, and there was no Registered Manager in place. However, recruitment for the role was actively underway. The newly appointed overseeing manager presented as strengths-based, knowledgeable, person-centred, and caring. Observations indicated she is well-placed to support the development of a reflective and learning-focused team culture. Managers are implementing workshops which are addressing short falls for staff knowledge.

Key Question	Applicable Regulations	Quality Statements and Comments
		Safe systems, pathways and transitions – Score 1 A recent referral and admission pathway was reviewed and discussed during the visit. Concerns were identified in both the referral and assessment processes, with notable gaps that could increase the risk of placement breakdown for the individual being admitted. The referral form noted that the person had experienced several previous placement breakdowns. However, the causes or triggers for these were not explored or recorded. This omission limits the service's ability to plan appropriately and put preventative measures in place to reduce the likelihood of further breakdowns. Additionally, no matching or pre-admission risk assessment had been completed prior to the individual joining the service. This presents a significant risk, not only to the new individual but also to existing residents and staff. Risk assessments are a vital component of safe admission practice, and the absence of a robust matching process undermines the safety and stability of the service. There was also no evidence that the assessor had requested key supporting documentation—such as mental health risk assessments, GP summaries, or previous care plans—that would be essential in developing a person-centred, safe support plan. The lack of this information further reduces the ability of staff to manage known risks effectively from the outset. The service is advised to strengthen its referral and admission systems to ensure comprehensive information is gathered and analysed prior to accepting a new placement. This should include clear matching assessments, documented risk evaluations, and all relevant health and care documentation. Doing so will support safer transitions and help maintain the stability and safety of the overall service. **(SR2)** **Safeguarding** – Score 2 There were several concerns noted regarding the safeguarding and incident reporting systems in place. While medication errors were appropriately escalated to the local authority (LA) and a CQC notification was submitted, another incident that occurred on the 6th of March was only reported to the LA, with no corresponding notification sent to CQC. It was unclear whether there had been any follow-up with the local authority or internal review following this incident. There is no log in place for managers to chase

Key Question	Applicable Regulations	Quality Statements and Comments
		the safeguarding's with the local authority. Although all incidents were clearly recorded within the service, there was a lack of clarity around how these translated into formal notifications, including those that may fall under RIDDOR. At present, these issues appear to be logged internally, such as on RADAR, but are not always aligned with statutory notification requirements. One safeguarding concern had been raised with the support of a manager and appeared to be managed in a supportive and appropriate manner. **(SR3)** The safeguarding policy itself was comprehensive, containing a clear flowchart and all necessary procedural information. However, the policy lacked personalisation to the specific service context. **(SR4)** Moving forward, there is a need for the service to ensure safeguarding and incident reporting systems are robust, consistently linked to external reporting requirements, and that follow-up actions are clearly documented and aligned with CQC expectations. Managers were responsive and took appropriate action to manage safeguarding concerns as they arose. This was evident from the way recent incidents were handled, demonstrating timely intervention and a commitment to safeguarding individuals in their care. It was noted that some staff had out-of-date safeguarding training, and there appeared to be no evidence of cross-referencing training compliance during staff supervisions. In particular, a supervision record from October 2023 did not reflect any discussion or review of safeguarding training status, raising concerns about how staff competence in safeguarding is being monitored and addressed through the supervision process or in any other formal process. **(SR5)** It was clear from discussions with staff and general observations that staff understood how to safeguard individuals and were confident in raising concerns. They demonstrated knowledge of the appropriate steps to take in order to immediately protect people when issues arise. There was mixed feedback as to whether people felt safe at the service. Lessons learnt were feedback into staff meetings.

Key Question	Applicable Regulations	Quality Statements and Comments
		Involving people to manage risks – Score 1 Assessments, support plans, and risk assessments were not person-centred and lacked the necessary detail to reflect individual needs, preferences, and lived experiences. The documentation reviewed was inconsistent and of poor quality, which poses a risk to individuals as it may lead to unmet needs or inappropriate support. The service was aware of these issues, and action plans had been put in place to drive improvement. However, at the time of the visit, these changes had not yet been fully embedded. **(SR6)** PEEPs were in place and adequate. Risk assessments were frequently generalised and lacked a personalised approach. This limits the service's ability to effectively manage and reduce individual risks and does not reflect best practice or CQC expectations around person-centred risk management. **(SR7)** Individual concerns were discussed at the time of the inspection. While staff were completing key working sessions, these were largely audit-driven and prescriptive. The current format does not fully support meaningful engagement or reflect the voice of the person. There is an opportunity to improve how keywork sessions are delivered and documented, for example by involving advocates or family members in planning or reviewing goals and progress. **(SR8)** Resident meetings had not taken place in over six months, with poor attendance cited as the reason. However, this presents a missed opportunity to engage people in the running of the service. Meetings could be adapted into less formal formats such as regular morning chats or creative group sessions where feedback and ideas are captured in more inclusive ways. Staff need to demonstrate professional curiosity and use imaginative approaches to gain input from those they support. **(SR9)** There were limited opportunities for both people and families to provide feedback on the service. This restricts the ability of the service to learn, adapt, and improve based on the views of those involved in people's care and support. **(SR10)** **Safe environments** – Score 3 Environmental risk assessments were in place and up to date. Any identified issues appeared to have been addressed in a timely manner, ensuring the immediate environment was safe for the people supported.

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		There was a trampoline on-site, which had a suitable risk assessment in place. Given that most individuals were in receipt of 1:1 support at all times, this risk was well managed, with appropriate supervision procedures embedded in day-to-day practice. During the walk-around, no trip hazards or environmental concerns were observed in the communal areas or hallways. Personal Emergency Evacuation Plans (PEEPs) were in place for all individuals. There was also an emergency grab bag located on-site. However, it was noted during discussion that some essential items for the grab bag had only recently arrived, and a number were still missing. This presents a gap in emergency readiness that needs to be addressed. **(SR11)** A fire risk assessment and evacuation plan were available and appeared to be suitable. Regular fire drills were taking place monthly, and tests of fire alarms and systems were recorded. The staff training matrix showed that staff had completed fire safety training. Fire safety audits and checks were being completed; however, there were some gaps within the system. Management were aware of these and were in the process of addressing them. While this demonstrates accountability, it highlights the importance of consistent recording and oversight of safety checks. **(SR12)** One flat was viewed during the visit. A call bell system was in place in the person's room with a poster indicating its use. However, during discussions with management, it was confirmed that this system was not currently in operation. This inconsistency could lead to confusion or missed opportunities for individuals to request help and should be addressed promptly to ensure people receive accurate and reliable information. **(SR13)** Chemicals were securely stored in a locked cupboard. Up-to-date COSHH (Control of Substances Hazardous to Health) risk assessments and data sheets were available for staff reference and were clearly accessible. While the environment was generally clean and well maintained—including the laundry area and shared hallways—the staff kitchen required attention. Specifically, the area around the skirting boards was visibly unclean, suggesting a need for more robust cleaning standards and monitoring in staff-only spaces. **(SR14)**

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		CQC recognises the challenge of maintaining a homely environment when supporting people with behaviours of concern that may result in damage. However, services are still expected to provide accommodation that reflects dignity, comfort, and personalisation. Although repairs were acknowledged during the visit, the use of wooden boards in place of windows significantly detracted from the homely feel of the accommodation. There is a need for more creative and person-centred solutions that maintain safety without compromising the right to live in a warm, welcoming home. **(SR15)** Infection control audits are in place and being carried out routinely. However, the service could further strengthen its infection prevention measures by implementing regular spot checks for staff practice. This would align with CQC's expectation that spot checks and observational audits be embedded across the service to ensure consistent adherence to infection control protocols in real time. **(SR16)** **Safe and effective staffing** – Score 2 There is currently no Registered Manager in post, which is a breach of Regulation 7. While there is a senior manager providing overall oversight, advice, and support, this does not substitute for the statutory requirement of a Registered Manager for this specific location. However, there were effective interim leadership arrangements in place, including strong day-to-day oversight, clear roles, and accountability while recruitment is ongoing. **(SR17)** Two newly appointed Deputy Managers are now in post, contributing to leadership stability and operational management. The service employs over 60 staff members, with no use of agency or bank staff, which supports continuity of care and stability for the people supported. A clear induction process is in place, including the use of structured workbooks. There was evidence of probation periods being reviewed and completed. Staff files were reviewed and found to be well-maintained, complete, and audit ready. These are managed centrally by HR, and there were no gaps noted, reflecting a strong auditing and compliance system. Staff supervisions are recorded on the HIPPO platform, and an increase in the frequency of supervision for new starters was evident. This demonstrates a proactive approach to staff support and performance monitoring.

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		The rota system was robust and linked to the service's Home Office sponsorship license, meaning shifts are managed in accordance with visa conditions. Rotas were prepared six weeks in advance, and it was reported that there were no issues with shift cover, even at short notice. A training matrix was in place and showed a high level of compliance. However, Oliver McGowan mandatory training was not specifically delivered, though the provider stated it was embedded within their autism training. In order to meet the Health and Care Act 2022 and CQC expectations, this should be clearly identified and delivered as standalone, recognised training. **(SR18)** There was a lack of bespoke training linked to individuals' specific needs. For example, where a person self-administers EpiPens, staff did not have training in how to support in an emergency if that person was unable to administer the medication themselves. This poses a potential risk and does not meet the standard for safe or personalised care. **(SR19)** The service is part of the Restraint Reduction Network, which demonstrates a commitment to reducing restrictive practices and embedding positive behavioural support principles. The supervision template had recently been updated to allow for a more conversational style. However, this format missed key prompts such as health and safety, safeguarding, staffing concerns, or reflective practice. The tool could be enhanced to ensure critical areas of discussion are not overlooked and to improve opportunities for staff reflection and learning. **(SR20)** Annual appraisals were taking place and were recorded appropriately. **Infection prevention and control** – Score 2 There was evidence from staff discussions that a recent health and safety concern involving inappropriate footwear (a staff member wearing sandals) had been identified and appropriately addressed. This reflects some awareness of safe practice standards. Routine environmental walk-arounds were completed by staff and included attention to infection control issues, showing that IPC is factored into daily checks. During the visit, staff were observed using PPE appropriately, which indicates an understanding of standard precautions.

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		However, there were notable concerns around staff personal hygiene standards. Specifically, some staff were observed wearing bangles and excessive jewellery, which presents a risk of cross-contamination and is contrary to good infection control practice. This was not being actively addressed or monitored. **(SR21)** While a maintenance team was in place to support with environmental standards, there was no evidence of infection control spot checks or audits of staff practice. Observational spot checks, such as hand hygiene audits, were not being carried out. A staff member was observed washing their hands without using soap, which presents a clear infection prevention concern. **(SR22)** These issues indicate a gap between policy and day-to-day implementation of infection control protocols, and opportunities for reinforcing good practice through supervision, training, and monitoring are being missed. Gas risk assessments were in place; however, they were not prescriptive regarding how frequently checks should occur. The current approach was sporadic, which could lead to delays or missed reviews, posing a potential safety risk. A clearly defined schedule is required to ensure consistency and compliance with health and safety standards. **(SR28)** **Medicines optimisation** – Score 1 Medication management was an area that the service acknowledged required further improvement. Currently, medication is being administered from the staff office, which was described as chaotic and not conducive to safe practice. This environment creates a risk for errors in administration. Management has recognised this and ordered individual lockable cabinets for administration to take place within each person's flat. This is a positive and proactive step to ensure safer, person-centred medication practices. **(SR23)** The methods of administration varied across staff teams. In some instances, staff were observed or reported to be delivering entire medication boxes to the person, while others were delivering individual pots—neither method appeared to follow a consistent or clearly defined safe practice model, indicating a lack of standardisation.

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		The service had a high-quality medication policy, and competency assessments and spot checks for staff were in place, demonstrating that governance systems were being used to some degree to monitor medication safety. However, there was a serious concern raised regarding reports that a staff member with limited written English was involving their child in completing their medication training. This is a clear breach of safe practice and must be addressed immediately as it undermines the integrity of training and competence. **(SR24)** The PRN and homely remedy policy and procedures were in place but were awaiting GP approval before implementation. While this shows a step in the right direction, it remains important that safe interim protocols are followed. **(SR25)** Where medication errors occurred, there was evidence that learning was shared and discussed during team meetings. Additionally, management planned to deliver medication workshops to address staff knowledge gaps and to support consistent, safe administration. **(SR26)** Medication audits were routinely completed by both management and team leaders. These audits informed action plans and were followed up with individual staff discussions when concerns were identified. Medication cabinets were found to be clean, organised, and well-maintained. Medication Administration Records (MARs) were in hard copy format and included essential client-specific information. However, there were concerns around people's understanding and consent to medication. In one case, a person was administered medication but also took additional paracetamol independently, and the service did not have a safe protocol in place to manage this situation. The associated mental capacity assessments were unclear, indicating that the person “may” have capacity. This reflects a wider issue in the service’s understanding and application of the Mental Capacity Act (MCA). **(SR27)** At the time of the visit, no individuals were prescribed controlled drugs, but the service did have appropriate storage and recording facilities in place should this change.

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		• This service scored 44 (out of 100) for this area.

SRG RATING: REQUIRES IMPROVEMENT – The service did not consistently maximise the effectiveness of people's care and treatment, as assessments and reviews of health, care, wellbeing, and communication needs were not always carried out in a timely or person-centred manner.

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

Key Question	Regulations	Quality Statements and Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: Need for Consent** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 18: Staffing**	**Assessing needs** – Score 1 Historic care documentation did not evidence that pre-admission assessments had consistently taken place. As outlined in the SAFE domain, there were gaps in key information, which could impact the service's ability to plan appropriate care from the outset. Personalisation was lacking in several areas. Information was not always person-centred or reflective of individuals' preferences and lived experiences, which limited the effectiveness of care planning. **(ER1)** Robust care plans and risk assessments were not consistently in place. This posed a risk to individuals receiving care and support that did not fully meet their assessed needs, placing them in potentially vulnerable situations. The support planning and risk documentation for GD contains both useful insights and areas for improvement. Positive findings include the documentation of oral hygiene risks, identification of swallowing difficulties, and the inclusion of eating and drinking guidelines, which were located during the review. There is also evidence of links between behaviours of concern and known triggers, and some alignment with his conditions. However, GD's MCA assessment includes a significant and concerning error, stating that he "could not communicate" despite the fact that non-verbal communication is clearly present. This reflects a lack of understanding of capacity and communication. Moreover, the MCA was reportedly completed via Teams, which is inappropriate for someone with complex or limited communication needs. The absence of a valid CoP DoLS (Community Depravation of Liberty) last recorded in 2021 and not followed up since 2023 is a breach of statutory duties where restrictions are in place. GD's care plans need to be more person-centred and provide greater detail on his communication methods, advocacy arrangements, and how his finances are managed (e.g., whether an appointee or deputy is in place). The presence of choking risks is noted, but specific management guidelines were initially not attached to the care plan. Yellow boxes were in place, but associated documentation (e.g. SALT guidance and eating/drinking plans) were not always readily accessible or integrated.

Key Question	Regulations	Quality Statements and Comments
		Some health documentation was vague e.g. a GP appointment was documented as “fine” with no summary, and a weight management appointment had no date or follow-up. Annual reviews were in place, but outcomes from specialist appointments were poorly recorded. GD’s end-of-life planning was mentioned but lacked depth. Activities and engagement were not clearly documented, and there was no evidence of CoP DoLS or advocacy involvement where required. **(ER2-8)** **Delivering evidence-based care and treatment** – Score 1 Where possible, the service planned and delivered care and treatment to meet people’s needs, including access to activities. However, the involvement of individuals in this planning process could be enhanced, as their voices were not consistently captured in records or reflected in how activities were shaped. **(ER9)** Care plans did not consistently include evidence-based tools to assess and monitor individuals' health and wellbeing. For example, there was no use of BMI (Body Mass Index), MUST (Malnutrition Universal Screening Tool), or other recognised assessments to guide support planning. For individuals who were overweight, care plans lacked clear outcomes or pathways to access appropriate support. **(ER10)** People’s health risks were recorded inconsistently. In one example, there was a reference to a risk of choking, but it was unclear whether this was a known, assessed risk or a generic inclusion. This lack of clarity poses a risk to safe and effective care. **(ER11)** Body maps were in place and used appropriately when individuals had caused injury to themselves, and there was evidence that the service accessed mental health and multi-agency support as needed. **How staff, teams and services work together** – Score 2 The care team had access to electronic records containing individuals’ risk assessments and care plans, supporting ease of access to key information. However, while staff clearly knew people well and were able to describe their needs confidently in discussion, these needs were not always accurately or fully reflected in the care documentation. This inconsistency creates a risk that care delivery may not be aligned with the person’s current needs or preferences. **(ER12)**

Key Question	Regulations	Quality Statements and Comments
		There was evidence that the service had established positive working relationships with external professionals, and multi-agency support was accessed when required. However, visits and guidance from external professionals were not always consistently recorded. This inconsistency could impact continuity of care and reduce oversight of decisions or advice provided by health and social care partners. **(ER13)** **Supporting people to live healthier lives –** Score 2 There were inconsistencies in how individuals' health and cultural needs were being supported and documented. In one case, there was evidence that a person was morbidly obese, yet no support plan or health-based intervention had been documented to address or monitor this. This reflects a gap in proactive, evidence-based care planning. **(ER14)** Feedback from one individual and their family suggested that staff were responsive to cultural needs, including adapting meals to meet dietary preferences. However, this was not consistently reflected across the service, and other feedback indicated that cultural needs were not always well understood or embedded in day-to-day practice. **(ER15)** People were supported to access GP services, and annual health checks were being completed, which demonstrates commitment to maintaining general health. A healthy eating activity led by the service's Speech and Language Therapist (SALT) further supported health promotion within the setting. Faith-based preferences were also supported and observed in practice during the visit. However, these preferences were not consistently recorded in care or support plans, creating a risk that they may be overlooked by staff who are unfamiliar with the individual. **(ER16)** Feedback about activities was mixed. One individual reported that their chosen activities were always respected and supported by staff, while another indicated that opportunities were limited. This suggests that activity provision may not be consistently person-centred or flexible to individual preferences. **(ER17)** **Monitoring and improving outcomes** – Score 1

Key Question	Regulations	Quality Statements and Comments
		Care reviews were not consistently completed, and where they had been carried out, the quality and depth of review varied significantly. This inconsistency in review processes reduces the ability of the service to effectively monitor progress, update care plans, and ensure that support remains appropriate over time. **(ER18)** Health monitoring records, such as weight charts and bowel records, were not consistently maintained. It was unclear which individuals required these to be completed regularly, and there were identifiable gaps in the records. This raise concerns around the monitoring of key health indicators. **(ER19)** Daily care records and night checks were also found to be inconsistently recorded, which may impact continuity of care and the ability of the team to identify emerging patterns or concerns. **(ER20)** **Consent to care and treatment** – Score 1 Overall, staff understanding of consent and the application of the Mental Capacity Act 2005 (MCA) was limited. There were multiple examples of non-compliant MCA assessments. In several cases, individuals were assessed as lacking capacity, but were still asked to sign consent forms, which is procedurally incorrect and undermines the principles of the Act. Staff require specific and practical training on how to assess capacity, what constitutes a time and decision-specific assessment, and how to support individuals based on the outcome. **(ER21)** Applications for Court of Protection Deprivation of Liberty (CoP DoLS) were made inconsistently, and staff lacked clarity about what constitutes a restriction in a supported living setting. There was also limited understanding of when and how to escalate concerns. External guidance, such as from the Law Society, should be sought to strengthen practice. **(ER22)** Staff were not maintaining accurate or up-to-date records related to CoP DoLS. There was no clear log or system in place to monitor applications, renewals, or follow-ups with the local authority. In one instance, incorrect dates had been recorded, creating ambiguity about whether a person was being legally restricted. **(ER23)** References were made to DoLS advocates under the framework; however, this is applicable to residential care settings, not supported living. This indicates a fundamental misunderstanding of the legal

Key Question	Regulations	Quality Statements and Comments
		framework. Staff and managers would benefit from specific training tailored to CoP DoLS within supported accommodation. **(ER24)** The CoP DoLS policy was brief and lacked practical guidance for staff or managers. It did not outline how to identify restrictions, when to complete capacity assessments, or the process for applying to the Court of Protection. As such, staff were left without sufficient direction in applying the legislation safely and lawfully. **(ER25)** • This service scored 33 (out of 100) for this area.
SRG RATING: INADEQUATE - This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. **"Characteristics of services the CQC would rate as' Good' People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work".**		

Key Question	Regulations	Quality Statements and Comments
Caring	**Regulation 9: Person-centred Care** **Regulation 10: Dignity and Respect**	**Kindness, compassion and dignity** – Score 3 There was a clear atmosphere of staff cohesion, visible management support, and kindness during the visit. Several incidents were observed, and staff responded calmly and appropriately, demonstrating that they knew the individuals well. Staff took time to de-escalate situations, offer reassurance, and provide emotional and practical support. People appeared well cared for, and their presentation reflected attentive support. One person was experiencing a crisis at the time of the visit, and staff were seen offering consistent, compassionate assistance throughout. Feedback from individuals indicated that they felt supported and valued their relationships with staff. Staff spoke about the people they supported with warmth, kindness, and respect, reflecting a culture that promotes dignity and compassion. **Treating people as individuals** – Score 2 People were supported and treated as individuals, with their needs and preferences observed throughout the visit. Staff interactions demonstrated respect, patience, and a person-centred approach to care. However, care plans did not always reflect this in written documentation. They lacked detail relating to individuals' strengths, abilities, and personal backgrounds. Important aspects such as beliefs, faith, disability, and relationships were either missing or not accurately documented. This indicates a gap in how well the service captures what truly matters to each person in their care planning. **(CR1)** The staff team was multi-cultural and multilingual, which helped ensure that people's communication needs were met. Staff demonstrated an awareness of cultural beliefs and preferences, which contributed positively to the quality of support provided. **Independence, choice and control** – Score 2 People were generally supported to make day-to-day decisions about their care and routines, with staff observed offering choices in a respectful and supportive manner. Staff promoted autonomy where possible and encouraged individuals to be involved in decisions affecting their lives.

Key Question	Regulations	Quality Statements and Comments
		However, documentation did not always reflect how people were supported to maintain or develop their independence. Care plans lacked detail around the promotion of life skills, decision-making, and the person's level of involvement in shaping their care. While staff practice was seen to promote choice, this was not consistently captured in records. Some people were able to self-administer medication or manage aspects of their personal care, but risk assessments and capacity assessments in these areas were not always in place or clearly documented. This created uncertainty about whether individuals had been appropriately supported to retain control in line with their abilities and rights. Overall, the culture of the service supported choice and independence in practice, but improvements are needed to ensure this is consistently reflected in planning, documentation, and legal frameworks such as the Mental Capacity Act. **(CR2)** **Responding to people's immediate needs** – Score 3 Staff listened to and understood people's needs. Staff were observed to be attentive to peoples immediate needs and prompt to provide support and assistance when required. **Workforce wellbeing and enablement** – Score 3 Staff acknowledged that there had been a recent change in management, but all feedback obtained during the visit indicated that this was viewed positively. Staff described feeling optimistic about the future, noting that the new leadership was supportive of career development and progression. They reported that managers had adopted an open-door policy, which made them feel more valued and included. All staff spoken to said they felt comfortable raising concerns or discussing issues, reflecting a culture of openness, trust, and approachability. There is a wellbeing programme and staff member of the month. They receive an amazon voucher. • This service scored 65 (out of 100) for this area.

Key Question	Regulations	Quality Statements and Comments
SRG RATING: GOOD - This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. **"Characteristics of services the CQC would rate as 'Good' People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible."**		

Key Question	Regulations	Quality Statements and Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 17: Good Governance** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred Care** – Score 1 Each individual had a care plan in place; however, the content was not always reflective of their actual needs, preferences, or lived experiences. In several cases, care plans lacked detail or were out of date, which reduced their effectiveness in guiding consistent, responsive support. **(RR1)** Risk assessments were present but were often either inaccurate or too generalised to meaningfully inform care. This limited their ability to support proactive risk management and person-specific strategies. **(RR2)** Although staff were observed to know the people they supported well and responded to them with familiarity and understanding, this knowledge was not adequately reflected in written records. The lack of alignment between practice and documentation creates a risk of inconsistency, especially for new or temporary staff. Service audits and reviews had identified these documentation issues as an area for improvement, yet they had remained unresolved over a sustained period. This suggests a lack of follow-through and ownership of actions. Staff would benefit from additional training and workshops to strengthen their understanding and application of person-centred care principles. **(RR3)** Newsletters are a valuable communication tool in health and social care services. They help ensure people using the service are kept informed, feel included, and have opportunities to engage with what's happening around them. **(RR9)** **Care provision, integration, and continuity** – Score 1 Health and care needs were not always accurately recorded in people's documentation. This created a risk that staff may not have access to the correct or up-to-date information needed to deliver safe and responsive care. Inaccurate records could lead to missed or inappropriate interventions, especially where complex health conditions were present. **(RR4)** Despite this, there was evidence of positive multi-agency working. The service had established links with health and social care professionals and had involved them in aspects of people's care, demonstrating

Key Question	Regulations	Quality Statements and Comments
		a willingness to collaborate for improved outcomes. This is inclusive of people working in the service such as PBS workers and SALT as well as external professionals. **Providing information** – Score 2 The service had taken some steps to promote health awareness, such as implementing a healthy eating workshop. Additionally, a STOMP (Stopping Over-Medication of People with a Learning Disability, Autism or Both) poster was displayed in the staff room, reflecting awareness of national health initiatives. However, people's individual communication needs were not consistently taken into account when care plans or key working sessions were written. This risks excluding people from meaningful participation in their care and limits their ability to fully understand or contribute to their support planning. **(RR5)** Accessible information such as easy read guides about the service and what is available to individuals was not in place. This is essential for ensuring people are informed, can make choices, and are empowered in their day-to-day lives. **(RR6)** **Listening to and involving people** – Score 3 Compliments, concerns, and complaints were recorded appropriately, with evidence that lessons had been learned and shared to improve practice. A clear complaints procedure was in place, alongside a staff grievance policy, both of which were accessible to staff and people using the service. People and staff stated they knew how to raise a concern and felt confident doing so. Staff spoke positively about the new management team and explained that when they raised an issue, it was now addressed promptly and effectively. This demonstrates a responsive and transparent culture, where concerns are acknowledged and actioned. **Equity in access** – Score 2 The service ensured that people could access care, support, and treatment when needed. Referrals to external professionals were made appropriately and followed up to ensure continuity of care and support. Duty rotas were prepared in advance, giving staff clarity on when they were working and supporting consistent staffing arrangements for people.

Key Question	Regulations	Quality Statements and Comments
		However, while access to services was in place, there was limited evidence that staff were proactively supporting individuals to achieve better health and social care outcomes. For example, there was no evidence that people had been offered support around smoking cessation or other lifestyle interventions. This reflects a missed opportunity to promote long-term health and wellbeing. **(RR7)** **Equity in experiences and outcomes** – Score 2 Feedback was being gathered within the service; however, there was limited evidence of structured or consistent engagement with people who use the service, their families, or advocates. Opportunities to enhance how feedback is captured and used to inform service development were missed. Greater involvement of those with lived experience would support a more inclusive and responsive service model. **(RR8)** Staff were knowledgeable about the people they supported and demonstrated awareness of when individuals required assistance and by whom. This contributed to continuity of care and responsiveness to individual routines. **Planning for the future** – Score 1 Management were aware that staff had not consistently addressed future care planning for individuals, including important considerations such as DNAR (Do Not Attempt Resuscitation) decisions where appropriate. This gap was recognised and included in a staff action plan for improvement. However, at the time of the visit, these discussions were not yet fully embedded into care planning practice. **(RR10)** • This service scored 42 (out of 100) for this area.
SRG RATING: REQUIRES IMPROVEMENT -This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. **"Characteristics of services the CQC would rate as 'Good' People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics".**		

Key Question	Regulations	Quality Statements and Comments
Well led	**Regulation 17: Good Governance** **Regulation 5: Fit and Proper Persons Employed - Directors** **Regulation 7: Requirements Relating to Registered Managers** **Regulation 18: Staffing** **Regulation 20A: Requirement as to Display of Performance Assessments**	**Shared direction and culture** – Score 3 The service is currently undergoing a period of positive change, with staff culture evolving in a way that promotes greater accountability and commitment. Staff appeared engaged and motivated, with a clear focus on delivering high-quality, person-centred care to the individuals they support. Company directors were reported to attend the service once a month to complete staff walkarounds, which helps maintain visibility, support the team, and reinforce leadership presence across the service. **Capable, compassionate and inclusive leaders** – Score 2 At the time of the visit, there was no Registered Manager in post, which is a breach of Regulation 7. However, the provider is actively recruiting, with interviews underway. In the interim, two newly appointed Deputy Managers are in place. They demonstrated awareness of the service-wide issues that need to be addressed and are currently being supported by senior management to ensure continuity and oversight. This arrangement provides a level of stability while the recruitment process is ongoing. **(WR1)** **Freedom to speak up** – Score 3 Staff meetings were taking place regularly, and the process had recently improved to include the carrying over of actions from previous meetings. This supports accountability and ensures that ongoing issues are followed up effectively. The complaints procedure was clearly displayed within the service, helping to ensure that people know how to raise concerns. Additionally, an annual survey is distributed to gather feedback from families and professionals, contributing to the service's understanding of stakeholder views and experiences. **Workforce equality, diversity and inclusion** – Score 3 The service benefits from a multicultural and multilingual workforce, which reflects the diversity of the people living in the service and the wider local community. Staff consistently reported that they were treated well by the organisation and spoke positively about the management team. Staff acknowledged that there had been a number of changes within the service, but expressed an understanding of why these changes were necessary and agreed that they were needed. This positive

Key Question	Regulations	Quality Statements and Comments
		attitude towards change, along with the support of managers, has contributed to a constructive and inclusive staff culture. HR write the policies, but they were not always in date. **(WR2)** **Governance, management and sustainability** – Score 2 The service has a range of audits in place covering key areas including medication, health and safety, infection control, and general governance. Audits are aligned with CQC Key Lines of Enquiry and scoring systems, which helps guide internal monitoring and improvement. However, many of the audits reviewed were basic in detail and lacked clear outcomes or accountability. For example, a monthly medication audit simply stated "to be reviewed" despite identifying multiple issues. This reduces the effectiveness of the audit in driving meaningful improvement. **(WR3)** Out-of-hours audit records showed that a staff member failed to follow policy, but there was no evidence of follow-up action. This highlights a gap in accountability and learning from incidents. Several actions on the service's quality improvement plan remain overdue and require follow-up from management. The plan is linked to trends and patterns identified in audits and shared with operational managers, but the pace of progress in resolving issues needs to improve. **(WR4)** Documentation such as the communication book and bowel charts were not being consistently checked. While trends and patterns are shared weekly and discussed in meetings, some areas such as bowel monitoring and recording remain insufficiently addressed. There is evidence that staff competencies are being completed, and action plans are shared with the team through team meeting agendas. **(WR5)** Medication storage is planned to move into people's bedrooms, which may support safer and more personalised medication administration. However, this must be implemented with careful risk assessment and clear protocols. Grumbles and complaints are tracked through RADAR, but these must be recorded with clear actions and outcomes. **(WR6)** Mental Capacity Act (MCA) and Best Interests (BI) documentation was found to be incomplete, with several assessments missing. Risk assessments, care plans, and key working documentation were not

Key Question	Regulations	Quality Statements and Comments
		consistently up to date. Record-keeping in general requires significant improvement to ensure consistency and legal compliance. **(WR7)** Environmental checks were being carried out routinely and included daily fire panel checks, monthly emergency grab bag reviews, weekly emergency lighting checks, water flushing, plug socket testing, fan and window restrictor checks, and garden equipment safety reviews. Financial monitoring was in place. These demonstrate a commitment to health and safety compliance. **(WR8&9)** **Partnerships and communities** – Score 3 There was evidence that the service actively utilised community resources to support people's social, emotional, and health needs. For example, individuals were supported to attend a local autism-friendly church group, helping to promote inclusion and meet both social and spiritual preferences. The service also demonstrated strong links with external professionals. A Speech and Language Therapist (SALT) had provided face-to-face communication training to staff, enhancing their ability to meet individuals' diverse communication needs. Occupational Therapy (OT) input had also been accessed to support individuals in daily living and promote independence. A new healthy eating workshop had recently been introduced, showing the service's commitment to promoting wellbeing through proactive health education. Photos were taken during the session to evidence participation and engagement, and to support reflective practice. These examples highlight a positive approach to multi-agency working and the use of community-based opportunities to enhance people's experiences and outcomes. **Learning, improving and innovation** – Score 3 The service demonstrated a willingness to learn and improve, with systems in place to identify and respond to areas requiring development. Lessons learned from complaints and incidents were discussed within team meetings and used to inform practice. Staff spoke positively about recent changes in management and described a growing culture of accountability and openness to feedback.

Key Question	Regulations	Quality Statements and Comments
		Quality improvement plans were in place and linked to audits, though some actions remained overdue. There was a recognition from managers that improvements were still needed in documentation, consistency of care planning, and the application of legislation such as the Mental Capacity Act. Training sessions and workshops were being introduced to address these gaps, including communication training, person-centred planning, and healthy living initiatives. While innovation was still developing, the service had begun to explore more creative approaches, such as the introduction of in-house workshops, improved team meeting structures with action tracking, and increased use of community resources. Staff expressed optimism about the direction of the service and felt involved in shaping future improvements. Overall, the foundations for learning and innovation were present, and with continued focus on completing outstanding actions and embedding change, the service has the potential to develop into a more forward-thinking and responsive environment. **Environmental sustainability – sustainable development** – Score 2 Although environmental sustainability is not currently assessed as part of CQC's key questions, it is considered good practice for health and social care providers to demonstrate environmental awareness and responsibility. At the time of the visit, there was no evidence of active recycling practices in the staff kitchen, and no recycling bins were in place. A recycling poster was displayed, but it was positioned out of sight at the back of the area, limiting its effectiveness in promoting environmentally responsible behaviour. Staff were not observed separating waste. • This service scored 68 (out of 100) for this area.
SRG RATING: GOOD - This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.		

Key Question	Regulations	Quality Statements and Comments
“Characteristics of services the CQC would rate as ‘Good’ There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities”.		

ACTION PLAN:

CQC Key Question - SAFE

By safe, we mean people are protected from abuse and avoidable harm.

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
SR1	The service should not rely solely on system-led audits, as this approach has resulted in gaps and missed themes. CQC expects audits to be comprehensive and reflective of practice across the whole service, rather than limited to prescriptive or automated checks. The provider should ensure that audits include meaningful oversight from managers, triangulating information from observations, staff feedback, documentation, and outcomes for individuals. This will help to develop a more robust quality assurance process that supports continuous improvement and proactive risk management.						
SR2	The service must strengthen its referral and admission procedures to ensure a safe and well-informed transition for new clients. All referrals must include a full assessment of previous placement breakdowns, including documented causes and triggers, to enable proactive planning and reduce the risk of further breakdown. A matching risk assessment must be completed prior to admission to ensure compatibility with						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	existing residents and safe staffing responses. Additionally, the service should implement a checklist to confirm that key supporting documentation such as mental health assessments, GP summaries, and previous care plans has been requested and reviewed before accepting a placement. This will support safer admissions and protect the wellbeing of all individuals residing in the service.						
SR3	Managers must implement and maintain a central log of all incidents, safeguarding concerns, and statutory notifications (including those to the local authority, CQC, and RIDDOR where applicable). This log should clearly record the nature of the incident, actions taken, notifications made, and any follow-up required. Keeping an accurate and up-to-date record will support the service in ensuring that all required notifications are submitted in a timely manner and that incidents are monitored and reviewed effectively to safeguard the wellbeing of individuals. This will also allow for oversight, trend analysis, and assurance that reporting obligations are consistently met.						
SR4	The service must review and adapt its safeguarding policy to ensure it is not only comprehensive but also tailored to reflect the specific context, structure, and needs of the						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	service and the people it supports. While the existing policy includes all required information and a clear procedural flowchart, it should be individualised to ensure it is relevant to the staff team, service model, and client group. This will support greater clarity, consistency, and confidence in applying safeguarding procedures in practice.						
SR5	The service must ensure that all staff have up-to-date safeguarding training in line with statutory requirements. Managers should implement a system to routinely cross-reference training compliance during staff supervisions. This should include reviewing training records as part of the supervision process and documenting any gaps, with clear timescales for completion. This will ensure that staff remain competent in safeguarding and that training needs are proactively identified and addressed.						
SR6	The service must ensure all assessments, support plans, and risk assessments are person-centred, detailed, and specific to each individual. Staff should be trained and supported to move away from generic approaches, using information gathered from the person, their advocates, and professionals. Quality assurance checks must be introduced to review documentation regularly, ensuring it is consistent, accurate, and reflects individual risks and support						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	strategies. There should be accurate triangulation of documentation to ensure accuracy.						
SR7	The service must ensure all risk assessments are tailored to the individual, with clear identification of specific risks, triggers, and strategies for mitigation. Individuals and those who know them well (e.g. family, advocates, professionals) should be involved in developing risk assessments to ensure they are accurate, relevant, and promote positive risk-taking where appropriate.						
SR8	Key-working sessions should be reviewed to ensure they are meaningful, person-led, and flexible in format. Staff should receive guidance on how to personalise these sessions, encourage active participation, and use alternative methods (such as family involvement or advocacy) where communication or engagement is a barrier. Keywork records should reflect the individual's goals, progress, and voice.						
SR9	The service must reintroduce resident feedback mechanisms in a format that suits the people supported. This may include informal group sessions, one-to-one discussions, or creative engagement methods. Staff should be encouraged and trained to use professional curiosity and adapt their approach based on communication needs and engagement						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	levels, ensuring people's views are consistently captured and acted upon.						
SR10	The service must establish regular and varied opportunities for people, families, and external stakeholders to provide feedback. This could include suggestion boxes, structured review meetings, or open forums. Feedback should be reviewed routinely, with clear evidence of how it informs service improvement and decision-making. I know that surveys are in place, this is to enhance the feedback obtained. Especially from the people using the service.						
SR11	The service must ensure that the emergency grab bag is fully stocked and ready for use at all times. A regular checklist should be implemented to audit the contents, ensuring that any missing or expired items are replaced promptly. This is essential to maintain preparedness in the event of an emergency and to safeguard the individuals living at the service.						
SR12	Management must ensure that fire safety checks and audits are consistently documented, with any gaps addressed immediately. A system of routine oversight should be introduced to monitor fire safety compliance, and actions must be taken where records are incomplete. This will ensure that fire prevention systems are not						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	only in place but regularly verified to be functioning and compliant.						
SR13	Where call bell systems are not in use, any related signage or instructions should be removed or replaced to avoid providing misleading information to people using the service. The service should also ensure that individuals understand how to request support and that the method is accessible and appropriate for their needs. Communication should be reviewed regularly to ensure it remains accurate and meaningful.						
SR14	The service must enhance cleaning protocols for staff-only areas, ensuring the same standard of cleanliness is upheld as in communal and client areas. A daily or weekly cleaning schedule should be introduced for staff spaces, with monitoring by management. Training or refreshers may also be required to reinforce expectations around hygiene and infection control.						
SR15	The service must work toward creating a more homely and personalised environment, even where damage from behaviours of concern is a factor. While safety is essential, using materials such as wooden boards in place of windows should be a temporary and last-resort measure. The provider should seek creative, robust, and domestic-looking						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	alternatives and ensure that repair works are prioritised in a timely manner. Individuals should be involved in decisions about their environment where possible, in line with CQC's expectations of dignity, autonomy, and positive behavioural support.						
SR16	The service must implement a system of regular infection control spot checks to monitor staff compliance with IPC practices, including hand hygiene, use of PPE, cleaning standards, and waste disposal. These should be documented and used to identify training needs, reinforce good practice, and address any concerns promptly. Embedding these checks will support a proactive approach to infection control and ensure staff maintain high standards consistently.						
SR17	The provider must continue to actively recruit a Registered Manager for the location and ensure CQC is kept updated throughout the process. While interim management is effective, this does not meet the statutory requirement under Regulation 7. A formal plan, with recruitment timescales and clear delegation of duties in the interim, should be documented.						
SR18	The provider must ensure all staff complete the Oliver McGowan Mandatory Training in Learning Disability and Autism, as required						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	by the Health and Care Act 2022. This must be clearly distinguishable from other autism training on the training matrix and delivered in accordance with national standards.						
SR19	The service must provide bespoke training to staff based on the specific health needs of the people they support. This includes emergency medication training (e.g., EpiPens) even if the person self-administers, to ensure staff can respond appropriately in an emergency.						
SR20	The supervision template should be revised to include structured prompts for key areas such as health and safety**,** safeguarding**,** staffing issues**,** and reflective practice**.** This will enhance the quality of supervisions and support a more comprehensive approach to performance monitoring and professional development.						
SR21	The service must ensure that all staff adhere to infection control policies, including appropriate dress code standards, such as the removal of jewellery and ensuring sleeves, nails, and clothing comply with IPC guidance. Spot checks should include visual inspections of compliance with personal presentation standards, and expectations should be reinforced through training and supervision.						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR22	The provider must implement a system of regular infection control spot checks, including hand hygiene audits, to monitor staff compliance in real time. Staff should receive refresher training on effective handwashing techniques, including the use of soap and the correct duration and method. Observational audits should be recorded, with any concerns followed up through supervision or additional training to ensure safe and consistent practice.						
SR23	The service must urgently transition to the planned model of administering medication within individuals' flats using the newly ordered cabinets. In the meantime, steps must be taken to reduce environmental risk in the staff office. A consistent, standardised procedure for medication administration must be developed, communicated, and followed by all staff.						
SR24	The provider must investigate the allegation that a staff member has involved their child in completing training. Clear communication must be given that all mandatory training must be completed independently by the staff member. Any staff found not to have completed their training appropriately must be re-assessed for competence and supported through appropriate re-training or disciplinary action if necessary.						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR25	The service must ensure that a temporary safe system is in place while awaiting GP approval of the PRN and homely remedy protocol. Once approved, the policy should be fully implemented, and all staff trained in its use. Staff should be clear on the criteria, documentation, and recording requirements.						
SR26	Medication workshops must be developed and delivered to address inconsistent staff knowledge. Workshops should include scenario-based learning and refreshers on safe storage, administration, and documentation. Attendance and outcomes should be recorded and used to support ongoing competency assessments.						
SR27	The service must review all mental capacity assessments related to medication to ensure they are decision-specific, clearly worded, and reflect the principles of the Mental Capacity Act 2005. Where individuals self-administer or have fluctuating capacity, clear risk assessments and protocols must be developed. Staff should receive refresher training on the MCA to ensure safe and lawful decision-making regarding medication administration.						
SR28	The service must ensure that gas risk assessments clearly specify how often checks are to be carried out, in line with legal and safety requirements. A documented						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	schedule should be implemented and monitored to ensure all assessments and safety checks are completed consistently and on time.						

CQC Key Question - EFFECTIVE

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
ER1	The service must ensure that all care plans and risk assessments are fully person-centred and reflect each individual's preferences, needs, history, and communication style. Staff should be supported through training and supervision to develop meaningful, personalised documentation. Pre-admission assessments must be consistently completed and used to inform care planning from the outset. Regular audits should be conducted to monitor the quality and accuracy of documentation, with clear actions taken where personalisation is lacking.						
ER2	Redo MCA assessments with appropriate methods for communication, for individuals with complex needs.						
ER3	Chase and update DoLS applications with management logs in place where restrictions apply; ensure DoLS are valid and in place.						
ER4	Make all communication needs more person-centred, including clarification of advocacy support and consent pathways.						
ER5	Ensure choking and health-related risks (e.g. SALT guidelines) are clearly integrated into the care plan.						
ER6	Improve recording quality of health appointments, including outcomes, dates, and required follow-up actions.						

ER7	Strengthen end-of-life planning documentation with person-centred wishes and risks.						
ER8	Clarify financial management arrangements and reflect these consistently across MCA and risk documents.						
ER9	The service must enhance how people are involved in the planning and delivery of their care and support, particularly around activities. Care plans should reflect individuals' preferences and choices, and staff should regularly consult with people to tailor support meaningfully. Evidence of involvement should be clearly recorded. This would align with CQC, nothing about me without me.						
ER10	The provider must ensure that recognised assessment tools such as BMI and MUST are used to inform health and wellbeing care planning. Where concerns are identified such as being overweight or underweight clear outcomes and support pathways must be documented. Staff should receive training on how to use and interpret these tools effectively.						
ER11	Health risks, such as choking, must be clearly and specifically recorded based on individual assessment rather than generalised risk statements. Risk assessments should reflect input from relevant professionals (e.g. SALT) where required and must be regularly reviewed to ensure accuracy and relevance.						

ER12	The service must ensure that all care and support needs described by staff are accurately and consistently reflected in care plans and risk assessments. Documentation must be updated to align with actual practice, and regular reviews should involve staff who deliver day-to-day care to ensure records remain current and person-centred.						
ER13	All professional visits, advice, or guidance provided by external agencies must be clearly recorded in individuals' care records. The service should implement a standard procedure for logging such interactions, ensuring that all relevant advice is documented, shared with the team, and followed up as necessary to maintain safe and coordinated care.						
ER14	The service must ensure that individuals with health conditions such as obesity have clearly documented support plans that reflect their needs, including goals, interventions, and referrals to relevant professionals. These plans should be regularly reviewed as part of proactive health management.						
ER15	Cultural preferences must be clearly documented and consistently applied across the service. Staff should receive training to improve cultural competency, and care plans should be co-produced with individuals and families to ensure cultural needs are respected and embedded in daily practice.						
ER16	Faith-based preferences and practices must be clearly recorded in support plans to ensure						

	they are consistently respected by all staff. Regular audits should include checks for the inclusion of spiritual and religious needs.						
ER17	Activity planning must be more personalised and varied to reflect the individual preferences of each person. Feedback should be gathered regularly and used to inform activity schedules. Where a person expresses dissatisfaction or boredom, this should trigger a review of their engagement and support plan.						
ER18	The service must implement a system to ensure that care reviews are completed at appropriate intervals, with a clear structure and quality standard. Reviews should be used to evaluate progress, reassess risks, and update care plans with the involvement of individuals and, where appropriate, their families or advocates.						
ER19	A clear protocol must be established identifying which individuals require weight and bowel monitoring, with clear guidance for staff on frequency and documentation expectations. Regular audits should be carried out to ensure health monitoring records are complete, accurate, and used to inform care.						
ER20	The service must ensure daily and night-time care records are completed consistently and accurately. Staff should be reminded of the importance of thorough record-keeping through training and supervision, and management should routinely audit entries to						

	ensure compliance and identify areas for improvement.						
ER21	The service must provide targeted training for all staff on the Mental Capacity Act 2005. This training should focus on how to complete decision-specific assessments, how to determine outcomes, and how to support individuals lawfully. All consent procedures should align with the outcomes of these assessments.						
ER22	Staff must be trained to identify what constitutes a restriction in supported living and when a CoP DoL is required. Clear escalation pathways should be put in place, and where uncertainty exists, legal advice (e.g. via the Law Society) should be sought to ensure compliance.						
ER23	A central log must be created to track all CoP DoL applications, follow-ups, and renewals. This log should include key dates, communication with the local authority, and legal status updates. Records must be accurate to ensure individuals are not unlawfully restricted.						
ER24	The provider must ensure all staff, especially those in leadership roles, receive training specific to CoP DoLs within supported accommodation settings. This should address the differences between supported living and residential care, and clarify the legal duties under the Mental Capacity Act and Human Rights Act.						

ER25	The CoP DoL policy must be reviewed and expanded to provide clear guidance for staff and managers. It should include step-by-step processes for identifying restrictions, completing MCA assessments, applying to the Court of Protection, and maintaining legal oversight of each individual's status.						

CQC Key Question - CARING

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
CR1	The service must review and update all care plans to ensure they accurately reflect each individual's strengths, abilities, background, and what matters most to them. This includes documenting personal values, faith and cultural beliefs, disabilities, relationships, and other aspects of identity. Staff should receive guidance and training on how to gather and record this information meaningfully, with regular audits in place to ensure person-centred principles are embedded in both practice and documentation.						
CR2	The service must ensure that care plans and associated documentation clearly reflect how individuals are supported to maintain and develop their independence, make choices, and retain control over their daily lives. This includes documenting where individuals are involved in decisions, outlining any support or adaptations needed, and ensuring that capacity and risk assessments are completed where relevant (e.g., medication, personal care). Staff should be trained to recognise and record opportunities for promoting independence and autonomy in a person-centred and legally compliant way.						

CQC Key Question - RESPONSIVE

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
RR1	Care plans must be reviewed and updated to ensure they are truly person-centred and accurately reflect each individual's needs, preferences, routines, and goals. Staff should be supported to capture meaningful information and ensure care plans guide responsive, individualised support.						
RR2	Risk assessments should be made more specific, with clear links to the person's behaviours, health needs, and support strategies. Regular reviews must be embedded to ensure these remain relevant and responsive to changes in need or circumstance.						
RR3	The provider should develop and deliver targeted training and workshops on person-centred care planning and documentation. This should include practical examples, real-life scenarios, and guidance on translating what staff know about a person into high-quality written plans and assessments. Audits should follow to ensure improvements are embedded.						
RR4	The service must ensure that all health and care needs are accurately recorded in individuals' care plans and associated documentation. Health information must be						

	clear, up to date, and reviewed regularly. Staff should be supported through supervision and training to understand the importance of accurate documentation, particularly when working alongside external health professionals.						
RR5	The service must ensure that care plans and key working sessions are adapted to reflect each individual's communication needs. This may include the use of symbols, pictures, simplified language, or other formats as appropriate. Staff should be trained to use inclusive communication strategies to ensure people understand/engage with their care.						
RR6	Easy read guides and other accessible materials must be developed and made available to all individuals using the service. This should include information about the service itself, available support, complaints procedures, rights, and other key information. These should be co-produced where possible and regularly reviewed for accessibility and relevance.						
RR7	The service must strengthen its approach to promoting positive health outcomes by actively identifying areas where individuals may benefit from additional support, such as smoking cessation, healthy eating, exercise, or substance misuse. Staff should be trained to recognise and support these opportunities, and care plans should reflect individual goals related to health improvement. Referrals to appropriate services should be recorded and						

	followed up to ensure meaningful engagement.						
RR8	The service must develop and implement a more robust system for obtaining feedback from people using the service, their families, and advocates. This should include regular surveys, informal and formal discussions, and the use of accessible formats. Feedback should be analysed, shared with staff, and used to inform continuous improvement, ensuring the service is shaped around the views and experiences of those who use it.						
RR9	The service should develop and regularly distribute a newsletter for people using the service that shares relevant updates, upcoming events, health and wellbeing tips, and celebrates achievements. The newsletter should be co-produced with people wherever possible and made available in accessible formats. This will help promote inclusion, support communication, and strengthen engagement between individuals, their peers, and the service.						
RR10	The service must ensure that future care planning, including conversations around DNAR and advance decisions, is routinely considered as part of each person's support plan. Staff should receive training and guidance on how to approach these discussions sensitively and in line with legal and ethical frameworks. All outcomes must be clearly documented and reviewed						

	regularly, ensuring individuals and their families or representatives are fully involved.						

CQC Key Question - WELL-LED

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
WR1	The provider must ensure the timely appointment of a Registered Manager to meet the requirements of Regulation 7 and provide consistent, accountable leadership for the service. While interim support is in place, the absence of a registered manager may impact governance and oversight. Once appointed, the Registered Manager should be supported with a clear induction and handover process to address identified service-wide issues and embed a strong, person-centred leadership culture.						
WR2	The service has an internal Human Resources (HR) department, which provides dedicated support for staff recruitment, development, and personnel matters. All policies are written and maintained by the in-house HR team, helping to ensure they are tailored to the organisation's structure and operational needs. This supports consistency across the service and ensures policies are aligned with current employment legislation and care standards.						
WR3	All audits must contain clear findings, actions, responsible persons, and timescales. Management must ensure follow-up actions are recorded and						

	monitored. Where policy breaches are identified, documented evidence of response or corrective action is essential.						
WR4	Medication audits must be detailed, with actions taken where concerns arise. As medication storage transitions to individuals' bedrooms, risk assessments must be completed and procedures reviewed to ensure safe, person-centred administration.						
WR5	Managers must review and address overdue actions on the service's quality improvement plan. Progress should be monitored by operational leads and reported during team meetings.						
WR6	All capacity assessments and best interest decisions must be up to date and decision-specific. Staff should receive refresher training to ensure compliance with the Mental Capacity Act 2005.						
WR7	Risk assessments, care plans, bowel charts, communication logs, and key working records must be regularly reviewed and completed. Gaps in documentation must be audited and addressed through staff training and supervision.						
WR8	Continue to maintain rigorous health and safety checks and ensure they are recorded and followed up where issues are identified. Include checks for finances, infection control, and environmental safety in audit oversight.						
WR9	Ensure that all informal concerns, grumbles, and formal complaints logged on RADAR include clear outcomes, learning points, and						

	are tracked to resolution. Feedback loops should be shared with staff to support transparency and improvement.						
WR10	The service should consider implementing a basic recycling system within staff areas and promoting environmental awareness among staff. Visible signage and accessible recycling bins would support the development of environmentally responsible habits and contribute to a more sustainable working environment.						