AUDIT REPORT

Middleton's Lane

Date of Visit: 7th & 8th August 2025

Contents:

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

Address of Service: 57 Middleton's Lane, Norwich, Norfolk, NR6 5SF

Date of Last CQC Inspection: Not Yet Inspected

Ratings

CQC's Overall Rating for this Service:	Not Yet Inspected	⚪

SRG's Overall Rating for this Service:	Good	🟢

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

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

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

4 = Evidence shows an exceptional standard

3 = Evidence shows a good standard

2 = Evidence shows some shortfalls

1 = Evidence shows significant shortfalls

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

- 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 7th & 8th August 2025. The purpose of this review was to highlight in a purely advisory capacity, any areas of the service operation which should or could be addressed in order to improve the provision and recording of care and increase overall efficiency and compliance with CQC Standards and Regulatory Requirements.

TYPE OF INSPECTION

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

METHODOLOGY

To gain an understanding of the experiences of people using the service, a variety of methods were employed. These included observing interactions between people and staff, speaking with the home manager, deputy manager, and holding discussions with support staff and some people using the service.

A tour of the building was conducted, along with a review of key documentation. This included 3 support plans, 2 staff recruitment files, and records pertaining to staff training and supervision. Medication records and operational documents, such as quality assurance audits, staff meeting minutes, service users' meetings, activities and health and safety and fire-related documentation, were also assessed.

OUR VIEW OF THE SERVICE

The service is registered with CQC for Accommodation for persons who require nursing or personal care. Middleton's Lane is a residential care home without nursing. The service has specialisms for caring for adults over 65 years, caring for adults under 65 years, and learning disabilities. The service provides support for up to 6 people; there were 6 people living in the home at the time of the visit.

Accidents and incidents were recorded and monitored. Debriefs were in place following any incidents of concern. There was a lesson learnt folder in place, with lessons which were generated from accidents and / or incidents. More care needed to be taken to ensure actions were completed appropriately. Risk assessments were in place and people were supported to take responsible risks with restrictions monitored and minimised. Mental Capacity Assessments needed improvement. Recruitment procedures were generally sound, and staff received training and induction. Competency assessments for specific areas of care needed to be addressed and monitored. Staff worked well with health care professionals to support people's well-being. Referrals were made to appropriate healthcare professionals as needed, and advice was acted on. Care records used for monitoring needed some improvement.

Health and safety checks were being carried out in line with procedures, as were governance audits and checks. The service was well-led, and staff reported that they felt supported.

PEOPLE'S EXPERIENCE OF THIS SERVICE

Care was person-centred and promoted people's dignity, privacy and human rights. People were treated with kindness and compassion. Staff protected their privacy and dignity, treated people as individuals and supported their preferences. Staff supported people to engage in their local community with activities they enjoyed. Observations showed that people were relaxed around staff and comfortable in their presence. Staff interacted well with people and knew them well; they understood individual needs and had developed good communication with people. Feedback from people using the service was positive.

People had opportunities to take part in range of activities.

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 Records of accidents and incidents were in place. Staff recorded the event into the RADAR system and steps were followed to review and address individual incidents. A sample were viewed. An incident was recorded where one person made allegations against staff. They have requested that they want to move to another placement and live with their boyfriend. Subsequently the incident record identified that they had made multiple accusations against staff to their advocate. The end result was that a cooling down period was implemented. The incident record stated that the Manager had addressed all the individual allegations with the advocate. However, there was no description of how these were addressed. As yet the incident had not been closed down, although it was noted that it was 23 days overdue. I suggest that before the incident is closed that more detail is added to the explanation provided by the Registered Manager to the advocate. **(SR 1)** However, it was noted that the incident was managed in line with the person's risk assessment and support plan. Where medication errors were identified, there was evidence of a full investigation, checks made to ensure that harm had not been sustained, and evidence of lessons learnt. It was noted that three of the medication errors were similar in nature and two involved the same member of staff. There was an action for the staff member to be observed on a dinner time medication round, but this was overdue and had not been implemented as a matter of urgency, swifter action needs to be taken in relation to medication error monitoring. **(SR 2)** There was a completed action whereby the staff member had been investigated and observed for competence, however there was no record of the competency assessment being carried out, as the most recent was prior to the incidents relating to the medication errors. **(SR 3)** Debriefs were held following events of more severity. Learning outcomes were included following each incident. Lessons learnt were shared at staff meetings and discussed at handovers and debriefs.

Key Question	Applicable Regulations	Quality Statements and Comments
		Safe systems, pathways and transitions – Score 3 Staff at the service ensured they worked positively with external social and health care professionals. Referrals were made where needed. **Safeguarding –** Score 3 People demonstrated that they felt safe living at the service. Throughout the visit positive interactions were seen, where people were confident in relating to staff and were happy and relaxed when being supported by the staff team. People either said or indicated they felt safe living at the service. Staff were trained in safeguarding and knew how to report signs of abuse both internally and also to external bodies such as CQC or the Local Authority safeguarding team. The home manager and staff team ensured safeguarding concerns were reported appropriately, and worked with safeguarding team, where necessary. People's money was managed safely. There were systems in place to record money in and out. Staff kept receipts. Audits and checks were carried out. **Involving people to manage risks –** Score 3 There were a range of risk assessments in place. These included: Personal support, support with free and structured time and relationships, support with decision making, MCA and DoLS (Deprivation of Liberty Safeguards), medical and health care, and individual activities. Overall risks were managed well and staff understood how to keep people safe and manage individual risks. Risk assessments reviewed showed that they were broken down into individual areas to identify specific areas of risk, such as poor personal hygiene, choking, mobility, taking part in different activities, and going out in the community. Overall, the risks were identified, how to mitigate and the guidance was incorporated into the support plans, in the care records viewed.

Key Question	Applicable Regulations	Quality Statements and Comments
		PBS (Positive behaviour support) plans were in place. PBS plans identified individual behaviours, along with triggers and strategies of how people were to be supported.
		Staff knew people well, and when incidents of behaviour occurred due to not following individual support plans, this was recognised and reflected on.
		One person was at risk of making allegations of abuse against staff and others. This was often when they felt rejected or vulnerable. The support plan included clear information about the types of allegations, examples of then they had been made and reasons of potentially why they had been made.
		It was agreed with the person and a multi-disciplinary meeting that a period of reflection, known as cooling off would be implemented following the allegations, so the person could reflect on any allegation prior to reporting to the local authority or significant others. This was so they could understand whether they had told the truth or made it up. After the cooling off period, the allegations were again discussed, if the allegations were repeated, appropriate referrals would be made, if the person confirmed that they had made it up, staff would check and then close the incident.
		The support plan contained clear guidance on how to manage any such incidents and records of allegations made showed that staff followed the guidance and allowed for a cooling off period. When speaking with the person they acknowledged that they could make things up but was in the process of rebuilding relationships.
		Consideration was given to supporting people to take responsible risks by removing unnecessary restrictions. Any restrictions within the environment were managed in the best interests of people living in the home. Where there was an identified risk, such as one person would rip and tear clothes, their wardrobe and drawers were locked to help reduce this. However, where they had stopped going into their kitchen all the time to remove food, the kitchen door was now unlocked.
		Safe environments – Score 3

Key Question	Applicable Regulations	Quality Statements and Comments
		There were health and safety checks in place to ensure the environment was safely maintained. These included (but not limited to):

There were health and safety checks in place to ensure the environment was safely maintained. These included (but not limited to):

➢ Fire patrol (Daily). These were being completed on a daily basis. Checks were made on general safety such as fire exits were clear, and there was no rubbish in the area.

➢ Carbon monoxide checks (Weekly). These were seen to be compliant.

➢ Emergency lighting (Weekly). These were seen to be compliant.

➢ Fire alarm test (Weekly). These had failed on three occasions since 12 May, and most recently 28 July, with actions being addressed.

➢ Fire door checks (Weekly). These were seen to be compliant.

➢ Water flush (Weekly). These were seen to be compliant.

➢ Water temperatures (Weekly). These were seen to be compliant.

➢ Plug Checks (Weekly). These were seen to be compliant.

➢ Window restrictors (Weekly). These were seen to be compliant.

➢ External and Internal lighting (Monthly). Checks were made that all the lights were working. These were completed monthly with the last three checks having taken place on 2 June, 7 July, and 4 August, with all being 100%.

➢ Fire drill (Monthly). Fire drills had taken place on 2 June, 7 July, and 4 August, with all being 100%. Staff who had attended the fire drill were recorded.

➢ Fire extinguisher (Monthly). Fire extinguisher checks had taken place on 2 June, 7 July, and 4 August, with all being 100%.

➢ Grab bag (Monthly). Checks had taken place on 2 June, 7 July, and 4 August, with all being 100%.

Key Question	Applicable Regulations	Quality Statements and Comments
		➢ Lift Call (Monthly). Checks had taken place on 2 June, 7 July, and 4 August, with all being 100%.
		➢ Extractor fan (Quarterly). This was last completed on 7 July, which identified that this was not working.
		➢ Ladder check (Quarterly). This was last completed on 7 July and was compliant
		➢ Gardens equipment (Quarterly). This was last completed on 7 July and was compliant
		There was a tendency for staff not to record the time of the checks or always their names. This had been identified on the action plan but does need addressing. **(SR 4)**
		Risk assessments for the environment and checks on appliances and utilities were in place, including fire door inspection, fire risk assessment, emergency lighting service, fire extinguisher service, lift service, electrical and gas safety.
		Generic risk assessments were in areas such as infection control, gas safety, lone working, gas safety, food preparation and flammable creams. These had been reviewed in May 2025.
		There were emergency personal emergency evacuation plans (PEEPs) in place for people living at the service that reflected their current ability in relation to recognising the dangers and ability to self-evacuate and included additional risks such as flammable clothing/skin due to the use of emollient substances.
		Observations showed that the environment was safe with no hazards identified. Individual flats were maintained in accordance with people's needs and preferences, for example one person did not want any soft furnishings or personal items to decorate their environment, and this was respected. Another person liked lots of personal items and belongings, and again this was respected.
		Safe and effective staffing – Score 3
		Staffing levels were appropriately maintained, with support delivered in accordance with individuals' assessed requirements. One-to-one or two-to-one support was provided as necessary, and staffing

Key Question	Applicable Regulations	Quality Statements and Comments
		numbers were adjusted based on scheduled activities. Consequently, when community support was required, additional staff were assigned to facilitate these needs.
		Agency were only used to support with last minute sickness or annual leave. It was reported during the last month, only 44 hours of agency had been used.
		There were individual agency worker profiles in place. These included a photograph, and confirmations of right to work status, DBS, whether registered on the update service, additional checks such as references, to ensure that all appropriate checks were in place. Where agency had not worked for the service within a 12-month period, their profiles were archived. Although, agency staff were not archived if they had left the agency, however, they would not be used, but this could cause confusion. I suggest also removing staff from the agency profile if they no longer work for the agency. **(SR 5)**
		Recruitment practices were reviewed, with two staff files reviewed in depth assess whether staff were being recruited in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Recruitment was managed by the HR department who carried out all checks.
		Most of the information required by regulation was in place. This included:
		➢ Full employment histories
		➢ References
		➢ Proof of DBS (Disclosure and Barring Service) checks were in place.
		➢ Proof of address and identify was obtained.
		➢ Right to work checks were in place.
		➢ Health declarations were in place to demonstrate that staff were medically fit to provide care and support.

Key Question	Applicable Regulations	Quality Statements and Comments
		Although full employment histories were requested, and in staff files viewed, these appeared to be in place. There were discrepancies with dates of employment, where on occasions the application form did not agree with the C.V. or different dates were provided by previous employers through references. Care needs to be taken to ensure that employment dates match on different documents. **(SR 6)**
		Staff were made aware of their responsibilities and accountabilities through a comprehensive induction, and ongoing training. A full and formal induction process had been implemented for all new staff members, with documented evidence of completion. This was established and was standard practice for onboarding. This induction encompassed an introduction to both the organisation and its services, including an overview of organisational mission and values. Additionally, it incorporated a thorough training programme aligned with care certificate standards and the Liaise training framework. Staff progress was monitored through observational assessments during induction and regular supervisory sessions. Evidence was seen of completed inductions for a sample of staff.
		Agency staff were supported with a small induction into the home which included a tour of the environment, orientation to key procedures, health and safety, people who were supported and their care records.
		Staff were supported with an ongoing training programme. This was primarily online through the training provider Your-Hippo.
		Training was mainly up to date, although there were some minor gaps with some staff needing to complete or update one or two courses. Staff completed PROACT-SCIPr-UK training which was a recognised model of support for people with learning disabilities and autism. All staff had completed this, except for one. **(SR 7)**
		Agency profiles included a list of training, when it was completed and when it expired. A sample of agency profiles identified that all current agency staff were up to date with training.

Key Question	Applicable Regulations	Quality Statements and Comments
		Supervisions were happening, but there were two supervisions outstanding, one from July and one from earlier in August.
		Annual appraisals were to take place, but the matrix for Your-Hippo identified that four staff were overdue their appraisal and five staff required an appraisal. **(SR 8)**.
		Infection prevention and control – Score 3
		There were systems in place to prevent and control infection. Regular infection control audits took place. Staff completed training in infection control, both during induction and on annual basis.
		PPE was available as required.
		There was a CoSHH register in place, along with all the relevant safety sheets and risk assessments.
		Medicines optimisation – Score 3
		Each person had their own medication folder. These contained relevant information such as individual profile, easy read profiles, pain profiles, individual PRN protocols, consent forms, Respect or DNACPR, and medication monitoring such as MAR charts and temperature charts.
		There were 'easy read' profiles in place, but these did not always coincide with the MAR charts, for example there were medicines on the easy read, which were not on the MAR charts. Instructions were not always on the same, for example the easy read recorded to take two paracetamol, four times a day, but the actual instructions were to take one paracetamol, four times day which could be increased. **(SR 9)**
		One person had their medicines administered covertly, should they refuse to take their medicines. There was information in the care plan about trying with three different staff, and then to administer covertly, but there was no clear guidance on how to administer covertly, such as with food or drink. The medication profile in the medication folder did not identify about the covert medicines and needed updating. **(SR 10)**

Key Question	Applicable Regulations	Quality Statements and Comments
		A check against medicines administered found that these had been administered accurately, with correct codes being used. Countdown sheets were also in place.
		However, it was difficult to establish exactly how many tablets were in the home. Staff signed the full number of tablets into the service but only counted down from the current box in use. It was reported that this was because it helped to reduce errors in medication counts. I suggest this is monitored for best practice.
		PRN (as and when medicine) protocols were in place and these included information about the directions, reasons for use, signs and symptoms, things to try before the use of the PRN, what the effect should be, side effects and when to seek further help.
		There were systems in place for collecting, recording and disposal of medicines.
		Temperatures were taken and maintained.
		• This service scored 71 (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.

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

Key Question	Regulations	Quality Statements and Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: Need for Consent** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 18: Staffing**	**Assessing needs –** Score 3 Staff made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing, and communication needs with them. Staff understood people's individual needs and made sure referrals were made where needed. The service worked closely with other external agencies on sharing information for the best outcome for people. There were risk assessments in place, and these were reviewed **Delivering evidence-based care and treatment –** Score 3 Staff at the service followed good practice processes. For example, medication reviews were held regularly to ensure 'least restrictive practice in line with the principles of 'STOMP' (Stopping over medication of people with a learning disability and autistic people). Where it had been identified that two people were prescribed a lot of anti-psychotic medicines, which were not being used, an external referral was made, and medicines had been reduced. PBS plans were in place to support people with any behaviours which may challenge. Support plans identified where people were able to express pain and how they did this. For example, if people were able to tell staff if they were in pain or how this may manifest itself in their behaviours, if they were in pain. Weights were taken on a regular basis and monitored. Competency assessments were in place for medication and catheter care, to help ensure staff delivered evidenced based support. Medication was at 100%, however, only three out of 24 staff had completed a competency assessment for catheter care. Although staff were booked in for September, the person who

Key Question	Regulations	Quality Statements and Comments
		had a catheter had this fitted earlier in the year (around February/March), which meant that these competencies were overdue.
		Discussions were held with the home manager who reported that they were facing barriers in the community to access this support through an assessment or appropriate training from a suitable professional. They reported that they had finally managed to contact one professional who had said they would be able to help them. I do suggest that this is evidenced through an action plan. **(ER 1)**
		In addition, as catheter care is not included in the Your-Hippo training, it would be useful to access some further on-line training as a supplement until the competencies can be completed. **(ER 2)**
		However, it was noted that good practice guidance had been sourced and was included in a detailed catheter support plan.
		How staff, teams and services work together – Score 3
		The service worked with social and health care professionals in the community. These included the psychiatrist, district nurses, G.P.'s, community mental health team, O.T.'s, dieticians, SALT team and the local authority. There was evidence of referrals to continence care, bladder and bowel health due to concerns around the health for one person.
		There was weekly contact with the G.P., who completed a 'ward round'.
		There was evidence that advice from health care professionals was listened to and acted on. Medical support records were detailed.
		There was also evidence that people were supported to see the community dentist, optician and chiropodist.

Key Question	Regulations	Quality Statements and Comments
		People had a hospital passport, which is a document that helps to share information between services. A sample were viewed which identified the support need, communication, preferences and any conditions which may affect people. **Supporting people to live healthier lives –** Score 3 There were health support plans in place. These included information on how to support people to remain healthy and included guidance and information for staff. People who were at risk of choking were referred to the SALT team. Assessments were completed and the information was included in the support plans. Individual folders were maintained in people's kitchens. These identified the IDDSI framework, support needed, level of food modification, and what to do in the event of a choking risk. Staff had worked with the dietitian where needed and developed individual menu plans for people. For example, one person needed additional fortification. Evidence was seen that the menu included Greek yogurt, pasta bake, parsnips, broccoli, cauliflower, peppers, mushrooms, omelette, milkshakes, sausage sandwich, and fortification of meals. For one person who had additional support there was an aim to help increase their weight, however, they had recently lost rather than gain weight. The keyworker meetings identified the weight loss or gain; there was no real information as to how the person was being supported to address this. There was reference in the last staff meeting to the weight loss and the importance of following the menu guide, and that they can lose weight in the summer. The support plan was last reviewed in July; however, this could be improved with more information about the nutritional needs and the risk of losing weight, particularly in the summer months. **(ER 3)** A check on the food charts noted that staff were not always recording meals and snacks and where they were these not always in detail. This will not help safeguard the weight loss.

Key Question	Regulations	Quality Statements and Comments
		Monthly health checks took place, and these checked whether people were keeping well. This included a general check on skin conditions, oral care, nail care, any concerns in relation to bowels and that individual weights had been recorded with no concerns. Ones viewed evidenced that these were happening on a regular basis. **Monitoring and improving outcomes –** Score 2 Dependent on individual needs, a range of monitoring records were in place. These included food and fluid charts, bowel charts, oral hygiene charts, body maps, and general observations. There was guidance in the support plan for one person on the management of the catheter and what staff should record when they emptied this. Staff were not following the guidance in the care records. **(SR 4)** Food charts were in place, but these were not always completed in detail, with gaps and a lack of information, which did not safeguard people who were at risk of malnutrition. **(ER 5)** Oral care records were poorly maintained, in particular where the support plans identified that people could not manage this and needed full support. **(ER 6)** Body maps were maintained when an injury or mark were identified, and photographs were uploaded. However, any treatment provided was not always identified, and body maps were closed down before marks had healed without any outcome record. For example, for one person it was recorded that they had a cut and bruise on their forehead, which was recorded as it looked like 'done days ago' [sic]. There was no record how it may have occurred and no outcome. The care notes did not expand on the detail or what was done about it. It is best practice to record any progress and the final outcome. **(ER 7)** **Consent to care and treatment –** Score 2 The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental

		capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
		There were some standard MCA assessments in place for people using the service. These were for finances, care and support and medication, and nutrition, for example. There was evidence that attempts were made to support people to understand the decision to be made, with a record of the location and how the information was presented. Some of these required a review, as they were either overdue or the person's circumstances had changed, such as referring to a locked kitchen door, which was no longer in place. **(ER 8)**
		MCA assessments or consents for other decisions were not routinely in place, for example where one person had a sensor mat. Where decisions had been agreed with others such as one person having a catheter and another having regular HRT treatment, there was no evidence that capacity had been explored, although it was confirmed that best interest decisions had been considered. **(ER 9)**
		Applications had been made where people were subject to limitations on their freedoms under the deprivation of liberty safeguards (DoLS). These were monitored for progress.
		Staff completed training around consent and capacity, understanding was also explored through the 'Inspector Calls' reviews which were undertaken with staff.
		Observations showed that staff asked for people's consent and did not make choices on their behalf. One person said that staff always checked with them before offering support.
		• This service scored 66 (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

Key Question	Regulations	Quality Statements and Comments
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 reflect 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 | **Kindness, compassion and dignity –** Score 3 |

Key Question	Regulations	Quality Statements and Comments
	Respect	There were positive interactions between people who were being supported and staff. All people who were being supported appeared to be comfortable in the presence of staff.
		Staff were kind, considerate and very understanding towards people. There was an easy friendly atmosphere which was encouraged with high levels of interaction. Observations showed that staff had a good rapport with people and had open conversations and discussions about what people wanted to do.
		Relationships were promoted and encouraged, and people were supported to see family and friends.
		Treating people as individuals – Score 3
		Staff and the management team knew people well and were able to describe people's preferences on how they liked to be supported and activities to ensure they were treated as individuals and care was personalised according to their preferences.
		Each person had an 'About Me', which clearly described the individual, along with their likes and dislikes and preferences.
		Support plans were individualised to the person and identified individual needs. For example, one person needed set routines, and their support plan was person-centred focussing on how to support the person with these routines. They liked things done in a certain order and their belongings arranged in a particular way, and the support plan clearly identified their routines.
		Independence, choice and control – Score 3
		Staff promoted people's independence, so people knew their rights and had choice and control over their own support and could choose how they wanted to spend their day.
		Staff actively supported people to manage as much for themselves as possible, by dynamically promoting daily living activities. People were supported to carry out household chores such as cleaning their flats, and they were supported to do as much for themselves as they could. For example, one person could manage

Key Question	Regulations	Quality Statements and Comments
		most of their daily tasks, but needed support with mopping floors, and the support plan clearly identified this.
		Staff supported people to develop more independence through monitoring their capabilities and encouraging them to do more for themselves. For example, one person used to put their clothes in their washing machine but was now able to do their own washing by adding the soap powder and setting the washing machine dials.
		Care records showed what people managed for themselves, such as making their breakfast, managing their own personal care, and household tasks. One person explained how staff were supporting them to be more independent, and they were working towards reducing the support they received in the community.
		Responding to people's immediate needs – Score 3
		Staff were vigilant and responsive to people's needs. They knew and understood when people needed attention or additional support. For example, observations showed that staff responded appropriately when people became heightened or needed full attention and ensured that they responded appropriately.
		Staff were key workers for people which meant they took responsibility for supporting people to review goals and identify individual support needs. Records showed that regular monthly reviews were taking place.
		Communication tools were used to help people identify to staff support needs. Observations showed that there was effective communication between staff and people using the service, which promoted an effective response from staff, when needed.
		Behaviours of concern records showed how staff responded and supported people during such incidents.
		Referrals were made to external health or social care professionals if concerns about their welfare were identified.
		Workforce wellbeing and enablement – Score 3

Key Question	Regulations	Quality Statements and Comments
		Information was made available to staff regarding the support mechanisms within Liaise. This was also included in the induction pack.
		There was a 24-hour counselling and advice support service available for staff. Additionally, staff received a blue light card, granting them access to discounts at various shops.
		There was a referral program for friends, and a colleague recognition program which allowed staff to nominate peers who exceeded expectations.
		Feedback from staff confirmed that there was a supportive and collaborative ethos, where they felt their opinions mattered. One staff member said, *'I feel we are listened to, and we can contribute to the support people need.'*
		• This service scored 75 (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.

"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 are respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible."

Key Question	Regulations	Quality Statements and Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 17: Good Governance** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred Care –** Score 3 Support plans included social relationships and networking, personal care, personal relationships, sensory needs, activities and community access, culture, religion and end of life, family, medical and health care, diet and nutrition, and communication. Support plans were detailed and specific to the person and broken down into individual areas of care and support needs. Support plans included what people could manage for themselves and where they needed support. Routines were important to some people, and these were clearly described within the support plans. People living in the home often needed or wanted a routine and a structure. Observations showed that staff knew and understood this and helped people to manage their day-to-day activities in a positive and proactive way. Staff were able to describe what person-centred care meant, through giving choices and listening to what people had to say. Care was coordinated to maximise independence and planned to incorporate people's choices and preferences. For example, people could choose when they woke up and what they wanted to wear and eat. Sensory needs were identified for one person were identified. They had been constantly ripping their clothes and with O.T. support it had been identified that this was because they did not like the feel of the garments and preferred clothes to have a certain texture. To help support this, staff helped the person shop in charity outlets and had introduced a basket, where they could put clothes in that they did not like the feel of, instead of ripping them, and then these could be recycled. Goals were included in the Blyssful system. This included the goal, and how it was to be achieved. These were then to be updated with progress. Goals viewed currently were not monitoring or identifying progress. They were not reviewed and dates to be achieved by had passed. **(RR 1)**

Key Question	Regulations	Quality Statements and Comments
		Goals were reviewed at the monthly keyworker meetings. Some of these agreed with those identified within the system, such as one person's aim to gain weight, others however did not, such as planning a holiday. **(RR 2)**
		Care provision, integration, and continuity – Score 3
		People's care needs were assessed to ensure staff were available to provide support at time of their choosing. Staff said, *'We work with other professionals, and ensure that referrals are made when needed.'*
		People received consistent care and support from a stable staff team that knew them well and understood their diverse needs. Feedback from people indicated that they felt well supported.
		Family involvement was supported and encouraged.
		Providing information – Score 3
		Pictorial activity planners were in place for people using the service, to help identify their choices for the day.
		Visual food menus were also used to help some people make their mealtime choices. One person had a full pictorial menu, and other people used a 'sticky board', where they could attach their choices of meals onto Velcro, so staff knew what they wanted.
		There was a notice board in the activity room, but there was a lot of information on the board, which was jumbled and made it difficult to identify different information, and this would be useful to 'tidy up.' **(RR 3)**
		The complaints procedure was on display in an easy read version.
		Some people used social stories to help them navigate their day. One person said that they were useful when they needed to use them and were aware of the what the social stories were for.
		One person used short social stories to help them such as accessing the community, maintaining or building a relationship, being open and honest, with the end goal of accessing the community with one-to-

Key Question	Regulations	Quality Statements and Comments
		one support rather than two-to-one support. They said how important their social story was to them, in particular the goals of building a relationship with their family.

Observations showed that staff understood individual communication needs and were able to interpret what people said or what they needed. Communication passports were in place, which included information about how people communicated, and how to communicate with them.

Listening to and involving people – Score 4

Tenants' meetings were held once a month. Most people joined in the meeting, except for one person who preferred to have an individual meeting.

People had opportunities to discuss activities, what they liked or disliked about living at Middleton's, whether there were happy with their weekly schedule, any takeaway's they fancy, if there were any issues and if there were any personal goals. This gave people opportunities to be involved.

People had been supported to take part in a survey to further give their opinions and thoughts on the service they received.

People were supported with key workers, who met with them on a monthly basis. This gave people opportunities to discuss support provided in relation to individual health, achievements, goals, meals, things that had gone well, activities, if anything was troubling the person and if there were any actions identified. Records showed that people were involved in a review and discussions about their recent experiences and progress.

People were supported to choose their preferences of key workers, with support being provided to help people work with staff they felt comfortable with. Alongside this people who went on holiday could nominate the staff member they preferred to go with them.

Where one person had their flat redecorated, they had been involved in choosing the colours, and a key worker monthly meeting identified that they were happy with the result. |

Key Question	Regulations	Quality Statements and Comments
		Visual tools such as pictorial menus, and a Velcro-based menu board helped people to show staff their individual choices and preferences.
		One person developed their personal relationship support plan with staff. They had sat with staff and identified how they wanted a relationship to develop, and how they wanted to be supported by staff in relation to this. They said they were proud that they had helped to write it, and it showed that they were listened to.
		One person was also involved in the interviews for prospective staff, and the management team listened to their opinions and thoughts as to whether they felt applicants would be suitable to work in the home with them, and other people living at the service.
		The provider had Nominated Individual service users in different services as an 'influencer', who were people using the service. Their role was to visit other services and listen to people's experiences. The area influencer has visited, and they had spoken with people to see how things were at the service, this gave people the opportunity to speak to other people and share their thoughts on how they found living at the home.
		Equity in access – Score 3
		Relationships were promoted with people being actively supported to maintain contact with people who were important to them.
		For some people it was important that they were able to speak to their immediate relatives on a daily basis, and staff supported people to facilitate this through the use of individual mobile phones or tablets, where people could use video calls.
		One person had been isolated from their family, and following a phone call from a relative, staff were supporting them to build a relationship with this relative and other family members.

Key Question	Regulations	Quality Statements and Comments
		The family relationship for another person had broken down, but staff again, were working with the family and the person to mend bridges, through promoting visits and contact and providing additional staff support to help facilitate this. People used regular and specialised healthcare services depending on their needs, and staff advocated for them where necessary to ensure they received the services they were entitled to. Referrals were made where needed. **Equity in experiences and outcomes –** Score 3 Staff supported people to do activities they enjoyed both at the service and in the community. People chose individual activities they wanted to take part in. Staff spoke knowledgeably of activities people took part in, and people were supported with their own activities of their choice, with some people preferring a routine where they went out to certain activities on set days. In house activities included games nights, arts and crafts, listening to music and film nights. People attended different clubs and centres such as PHAB club, a community centre, sensory sessions, a trampoline club, and one person went regularly to a nightclub arranged for people with a learning disability or autism. One person regularly visited the local airport to watch the airplanes and swimming, another person enjoyed going out for meals to the local pub, and some people just enjoyed going out for a drive in the countryside. People were supported to go out and do their own shopping, with one person who did not like crowds and busy places being supported to visit a shopping centre and choose new clothes. People were supported to visit the church to attend services.

Key Question	Regulations	Quality Statements and Comments
		One person had recently been on holiday, and another person was planning their own holiday. They told us how they had worked with staff to choose where they wanted to go, choose the staff who would be accompanying them, and budget for the trip.
		Staff had worked with an employment coordinator to support some people to have volunteer roles. One person had just secured a volunteer role at a garden centre and staff were looking into supporting another person find a role.
		Planning for the future – Score 2
		There was no-one who was on end-of-life care. People using the service were primarily younger, although some people had conditions, which could put them at risk.
		End-of-life support plans were in place, but these tended to lack detail and recorded that there was no end-of-life or contained details of a funeral plan. There was some reference to discussing in more detail when the time was needed. There were no end-of-life plans in an easy read format uploaded to the Blyssful system. **(RR 4)**
		• This service scored 75 (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.

"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 are easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics".

Key Question	Regulations	Quality Statements and Comments
Well-Led	**Regulation 17: Good Governance** **Regulation 5: Fit and Proper Persons Employed - Directors** **Regulation 7: Requirements Relating to Registered Managers** **Regulation 18: Staffing** **Regulation 20A: Requirement as to Display of Performance Assessments**	**Shared direction and culture –** Score 3 There was a shared direction for staff development, with both the home manager and deputy managed having been promoted and supported to fill their roles. The home manager reported that their induction into their role had been robust. In addition, support staff had been supported to develop shift leader roles to support and promote succession planning. Staff said that there was a positive culture in the service. They described how they supported people with their daily life choices and different activities they enjoyed, as described within this report. It was evident that staff put people using the service first and considered their opinions. There was an open and transparent culture, where duty of candour was understood. **Capable, compassionate and inclusive leaders –** Score 3 The current home manager is in the process of applying for registration with the Care Quality Commission (CQC), with their fit person's interview due shortly after this visit. Discussions with the home manager evidenced that they knew and understood the key aspects of regulation and was knowledgeable about the service. The service was organised. Handovers were seen and daily shift planners were in place to ensure a smooth day to day running of the home. **Freedom to speak up –** Score 3 Staff felt there was a culture of openness and transparency and were confident in speaking up and raising any concerns.

Key Question	Regulations	Quality Statements and Comments
		Staff said they received supervision, and this gave them opportunities to raise any concerns, discuss individual service user needs and any training needs staff felt they had. Some staff described how they were being supported with additional training to help them develop their role.
		Staff team meeting minutes were maintained in a folder in the office. Meetings were held every other month, with the last meetings happening on 21 February, 25 April and 27 June 2025.
		Staff could join in meetings both in person and virtually to support as many staff as possible to join in the meeting. There was a list of staff who had attended, this had varied between 8 and 12 staff over the last few meetings. There was no record of how the minutes had been distributed to staff who had been unable to attend, and it would be useful to identify this. **(WR 1)**
		Different areas were discussed including any safeguarding, service user specific issues, training, and working practices. It was noted, that although actions were discussed in the meeting, there were no actions identified at the end of the meeting and progress was not always checked at the next meeting and it would be useful to include this. **(WR 2)**
		A recent school of thought is that CQC inspectors are reporting that if areas such as visions and values are not discussed along with strategic goals, staff may not be aware of where the service is heading, and it would be useful to routinely include this on the agenda. **(WR 2)**
		Workforce equality, diversity and inclusion – Score 3
		There was a diverse and multi-cultural team working at the service. Each year the service hosted a cultural day where staff brought in and shared traditional dishes from their backgrounds, celebrated with different traditional music and staff were encouraged to wear traditional attire. This helped to promote inclusivity with both staff and people using the service.
		Staff said that they felt that they worked in an inclusive and equal environment where everyone was treated the same.

Key Question	Regulations	Quality Statements and Comments
		Reasonable adjustments were made for staff who needed additional support. Where one member of staff had needed additional support due to family circumstances, they reported that the registered providers senior team, *'could not do enough to support me during this time.'* Equality and diversity policies were in place and staff had been trained in this area. **Governance, management and sustainability –** Score 3 Audits were in place to monitor all aspects of the service including people's care needs, the environment and staffing performance. These were completed on a weekly, monthly and quarterly basis. Quality audits and checks included a regular manager walk around audit, medication audits both weekly and monthly, health and safety monitoring, out of hours checks, a service user finance audit, a manager's quarterly support plans and risk assessments audit, and a vehicle maintenance audit. Records showed that for the last three months these had been completed in line with the providers schedule with actions being recorded and evidence of compliance attached to the audits. In addition, the operations manager completed independent audits of the whole service on a regular basis. Oversight was maintained by the provider through a trends and monitoring analysis (Tami). This collated information from the different systems including Radar, Blyssful, the training department and the quality team and reviewed key areas of staffing, auditing, people who were supported, events and assurance. The most recent showed that the service was at 91% compliance. **Partnerships and communities –** Score 3 The management team and staff were open and transparent, and collaborated and worked in partnership with all relevant external agencies and key organisations to support care provision, service development and joined-up care.

Key Question	Regulations	Quality Statements and Comments
		Staff gave examples of how they worked with external professionals in supporting people to achieve positive outcomes, including through referrals and advice from external health care professionals.
		Learning, improving and innovation – Score 3
		Staff were supported with a learning culture to help develop their skills and knowledge. Seven staff were completing NVQ qualifications, two staff had been enrolled on a new enhanced safeguarding training programme and will become safeguarding champions for the service.
		Action plans were developed from audits, accidents and incidents. Actions in RADAR confirmed that learning took place following audits, incidents and reviews.
		Manager forums and quality and risk meetings helped to identify any learning, and these were shared with staff.
		Quality monitoring by the provider identified themes and patterns to help individual services identify and address these.
		Environmental sustainability – sustainable development – Score 3
		Policies and procedures were in place to promote environmental sustainability.
		Paper records were limited to save on paper with digital systems in place to help to reduce the use of paper.
		Recycling was promoted.
		- This service scored 75 (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	*Complete more detail about how individual allegations were discussed prior to closing down the specific incident (INC-24850)*						
SR2	*Ensure that swift follow up actions are completed where identified such as observing staff with medication, following errors.*						
SR3	*Ensure that staff have a competency assessment following any errors in medication administration and there is evidence of this*						
SR4	*Ensure staff record the times and their names on the health and safety checks.*						
SR5	*Remove agency profiles for agency staff who are no longer working for the nominated agency.*						
SR6	*Ensure that employment dates match on different documentation such as C.V.'s, application forms and references.*						
SR7	*Address any overdue training.*						

CQC Key Question - SAFE
By safe, we mean people are protected from abuse and avoidable harm.

SR8	*Outstanding and overdue appraisals to be scheduled in and completed*						
SR9	*Check easy read profiles against current MAR charts to ensure they are up to date.*						
SR10	*Ensure that where people are supported with covert medicines the actual support is clearly identified.*						

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
ER1	*Ensure that an action is recorded in relation to accessing catheter competency support*						
ER2	*Consider interim training, mentoring or support for staff for catheter care, this could be utilised from on-line videos from a reputable source.*						
ER3	*Ensure that nutritional support plans identify in more detail the risk of weight loss, when this happens and how staff can support*						
ER4	*Staff to record in more detail as per support plan, catheter care*						
ER5	*Ensure that food charts are completed with more detail*						
ER6	*Ensure that oral care records are completed*						
ER7	*Ensure body maps are reviewed with the progress of any injuries or bruises and updated before closing down.*						
ER8	*Review current MCA assessments and ensure they are up to date and accurate.*						
ER9	*Ensure that MCA assessments or evidence of capacity and consent are in place for areas such as sensor mats, and health care treatment.*						

CQC Key Question - CARING
By caring, we mean that the service involves and treats people with compassion, kindness, dignity and respect.

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment

CR1	NO RECOMMENDATIONS MADE						

CQC Key Question - RESPONSIVE
By responsive, we mean that services are organised so that they meet people's needs.

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
RR1	*Monitor the progress of goals within the Blyssful system*						

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
RR2	*Ensure that goals are reflective of those identified within the Blyssful system and include where there are gaps.*						
RR3	*Review the notice board in the activity room and make it more user friendly.*						
RR4	*Monitor end-of-life plans and consider how these can be developed.*						

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-centered 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	*Identify how minutes are distributed to staff who cannot attend.*						

WR2	*Include actions and a review at the next staff meeting.*						
WR3	*Include a review of visions and values on the staff meeting agenda as routine.*						