AUDIT REPORT

Chantry

Date of Visit: 27th & 28th of August 2025

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Contents:

Service Name: Chantry **Provider:** Liaise (South East) Limited

Address of Service: 6 Chantry Road, Worthing, BN13 1QN

Date of Last CQC Inspection: 24th March 2025

Ratings

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

Key Questions	Rating	Overall Score
Safe	Good	65 (out of 100)
Effective	Good	70 (out of 100)
Caring	Good	75 (out of 100)
Responsive	Good	71 (out of 100)
Well-Led	Good	71 (out of 100)

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

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

4 = Evidence shows an exceptional standard

3 = Evidence shows a good standard

2 = Evidence shows some shortfalls

1 = Evidence shows significant shortfalls

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

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

Overall Service Commentary

INTRODUCTION

An audit based on the CQC Key Questions and Quality Statements, aligned with the Single Assessment Framework, was conducted by an SRG Consultant over two days on 27th & 28th of 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 Registered Manager, quality officer, lead nurse, 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 2 support plans in detail and sampled sections of 3 others, 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. Chantry is a residential care home. The service has specialisms in caring for adults over 65 yrs, caring for adults under 65 yrs, Learning disabilities, Physical disabilities, and Sensory impairments. The service provides support for up to 6 people; there were 5 people living in the home at the time of the visit

Staff kept people safe, and one person indicated they felt safe, with relatives confirming this. Risk assessments kept people safe, but improvements in relation to areas such as oxygen management guidance needed improvement, but staff knew how to manage this. The service was safely maintained but equipment such as wheelchairs needed to be cleaned. Some areas of medication management needed improvement.

People were supported with health care appointments and there was good evidence that appropriate referrals were made. MCA assessments were in place; these were decision specific. There was evidence that consideration was given to individual areas of capacity and how people could be involved in any decisions. DoLS were monitored.

Staff communicated well with people and understood many of their individual verbal and non-verbal interactions. Staff and relatives said the service was well led. Governance processes monitored the effectiveness of the service.

PEOPLE'S EXPERIENCE OF THIS SERVICE

For people unable to directly share their experiences, observations during the assessment were used to evaluate the quality of care. Staff were kind and caring and engaged people. Staff were responsive to individual needs

Staff knew people well, and key workers supported people to maintain consistency.

Relatives felt staff were kind and caring and one relative said, *'I have never met a member of staff who does not look after my child to the best of their abilities.'*

Relatives, however, felt communication and external activities could be improved.

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 Electronic records were maintained of accidents and incidents. At the time of the visit there were 12 open recorded events, which were either in progress or pending. Three were DoLS applications, which remained open for monitoring purposes, and one was beyond the control of the service and was subject to external investigation. There was evidence that accidents and incidents were reviewed and follow up actions taken, however, some of the responses to the reviews of the incidents were not timely. For example, an incident had identified an area of concern, which did not match with the care records. However, the investigation had still not been completed despite this occurring a week earlier. Care needs to be taken to ensure that follow up actions are timely. **(SR 1)** There was good evidence of how medication errors had been followed up with staff through assessment, retraining and competencies. Lessons learnt were included in the actions of some of the incidents with good examples of what needed to be learnt. Debriefs were not always in place for different events. For example, where one person exhibited challenging behaviours and had physically and verbally been aggressive to one member of staff, there was no debrief in place. Where debriefs were in place, these were detailed. **(SR 2)** Wording was not always appropriate within the recording of incidents. For example, where one person had displayed behaviours that challenged, staff had recorded that they had *'continued to throw a tantrum'*. In addition, staff were not always using initials but using the person's actual name within the incident report. **(SR 3)** **Safe systems, pathways and transitions –** Score 3

Key Question	Applicable Regulations	Quality Statements and Comments
		People had lived at the service for a number of years. Support plans and risk assessments were reviewed on a regular basis or earlier if there were changes to needs of people to reflect current needs. People were supported with review by health care professional such as the SALT team to ensure the right support was in place. **Safeguarding –** Score 3 One person living in the home indicated that they felt safe. Relatives spoken with felt that people living in the home were kept safe. Although one relative felt communication could be improved to help maintain safety. Staff understood their responsibility to safeguard people and received relevant training and support to do so. Staff spoken with knew how to report any concerns and knew how to contact external agencies should they need to. Staff said any concerns raised were acted on immediately. Where any safeguarding matters were raised, local authority procedures were followed. **Involving people to manage risks –** Score 3 Risks to people's safety were assessed and risk management assessments were in place. These included: Personal support including morning, evening routines, continence management, hygiene and, oral health. Support with free and structured time and relationships. Meaningful activities, including any activities outside of the home, education, work, daily living. Relationships, including personal, social and family. Support with decision making, MCA and DoLS (Deprivation of Liberty Safeguards). Medical and Health Care including Diagnosis, Mental Health and Wellbeing, Memory and medication. One person used oxygen at time of emergency during a seizure. The oxygen generic risk assessment stated that '*Staff must at all times follow the directions in the protocol for the use of oxygen. Staff will record its*

Key Question	Applicable Regulations	Quality Statements and Comments
		use.' A review of the support plan and risk assessment found there was reference to when to use the oxygen, but there was a lack of direct information around an actual protocol. The oxygen policy also identified specific information which should be in a support plan for oxygen, which was not in the risk and support plan. **(SR 4)** One person had been prescribed an anticoagulant (blood thinner) following a stay in hospital. The medical care plan and risk assessment had not been updated to reflect the risks associated with this medication. Moving forward, care needs to be taken to ensure that care plans and risk assessments include information relating to risks around blood thinners, such as Apixaban. **(SR 5)** Support plans and risk assessments identified how to support people with moving and handling. PBS plans were in place and there was evidence staff followed the guidance. There was still a tendency to refer to the original care planning system (Ablyss), which has been out of commission for at least a year. Reviews of care plans and risk assessments should be identifying this. **(SR 6)** **Safe environments –** Score 3 Regular checks of equipment and the environment were completed, which included fire safety. This was to make sure equipment and facilities were maintained safely. Daily fire patrols were happening, which checked the general safety of the service environment in relation Fire extinguisher checks and the grab bag were checked monthly. These had last been completed on 2 June, 7 July and 4 August, and where actions were needed these had been completed such as ensuring there was a master key in the grab bag. The grab bag was located in the hallway near the front door. The contents were jumbled, with no consistent approach. For example, there was a box of 100 patient identification bands, but there were only 5 people living in the home, and there was only one bottle of water and four jelly shots (for sugar). The first aid kit

Key Question	Applicable Regulations	Quality Statements and Comments
		appeared to have most items out of date with the small hourglass time showing the sand at the bottom next to dates which were recorded as August and September 2024. **(SR 7)** Weekly fire alarm checks took place and fire drills were completed monthly, but the last three drills had identified areas of failure. An action had been set which stated, *'Complete fire drill with nighttime scenario, involving the night staff'*. This had been recorded as being completed, and it was verbally confirmed that this had taken place, but there was no evidence such as record of the event or a scenario to demonstrate this. It was confirmed that the drill was recorded, but evidence of compliance with the action should be included on RADAR on within the PPM check. Monthly fire door checks were completed, where they had been an issue raised with the seals on the lounge door it was confirmed that this had been addressed by the maintenance team. People had individual contingency plans in case of emergencies. These were known as PEEPS (personal emergency evacuation plans) which provided staff with information on how to support people. However, these did not always contain the correct information. One person used oxygen, and this was not included in the PEEPS. Information about flammable creams was not consistent. One person who did not use flammable creams had this included in their PEEPS, and another person who did use flammable creams, did not have the information included in their PEEPS. **(SR 8)** Internal and external lighting (Monthly). The last three had been completed on 2 June, 7 July and 4 August, and found the service compliant. Weekly checks were completed on plug safety, carbon monoxide. Water temperatures were tested on a weekly basis. The last three water temperatures check only showed that one outlet was sampled each week, with it not always being clear which outlet was sampled, for example, for one week it was just recorded 'M', with no record of which room it was. It was reported that staff kept a list of the water outlets so they could make sure they were completed in turn. This evidenced that water temperatures for different outlets were taken on a daily basis, but these were not always recorded in a consistent manner, i.e. sometimes through messages or sometimes on Blyssful. As there was

Key Question	Applicable Regulations	Quality Statements and Comments
		only one record each week of a water temperate test, this meant that this was not robust. However, water temperatures were taken before people had a bath, shower or wash. I suggest that the procedure for the weekly water temperature tests is checked and these are followed. **(SR 9)** An external organisation also visited on a monthly basis to check TMV outlets. A monthly check was made on the lift, and the last three had been completed on 2 June, 7 July and 4 August, and found the service compliant. Quarterly checks for extractor fans, garden equipment, external pathways and use of ladders had been completed on 7 July. The fire risk assessment and health and safety risk assessment had been completed in October 2023, with the water risk assessment completed in November 2024. Additional servicing and checks included: Asbestos Management Survey: December 2022: Electrical (Hard wiring): September 2024 Electrical (PAT testing): September 2024 Fire (Alarms Servicing): May 2025 Fire (Door Inspection): February 2025 Fire (Emergency Lighting 3hr Drain Down): May 2025 Fire (Extinguisher Maintenance): May 2025 Gas Safety Certificate: May 2025 Loler 6m (Hoists): May 2025 Loler 6m (Lifts): May 2025 Loler 6m (Platforms): May 2025

Key Question	Applicable Regulations	Quality Statements and Comments
		Hoists: May 2025 Passenger Lifts: April 2025 Nurse Call: September 2024 Water (Shower Descale): June 2025 Water (TMV Servicing): July 2025 Environmental assessments detailed risks in the care environment and how these were managed. There was a CoSHH register and data safety sheets in place for hazardous substances. Where maintenance issues were identified, there was a system in place to raise an alert to the maintenance team for repairs which needed to be completed. The maintenance team reported their schedule each week to ensure that the services knew when they were getting the support they needed. Overhead hoists were in place in bedrooms and communal areas to help ensure that people could be transferred safely. The communal areas were open plan with easy access to the lounge/dining areas and kitchen. The areas were clutter free, which allowed for manoeuvrability for wheelchairs. People tended to congregate in the lounge area, and staff placed down 'crash mats' to enable people who were unable to balance on a chair without support to either lie down or sit on the mats. Bedrooms were decorated in a manner of people choices and preferences. **Safe and effective staffing –** Score 3 Staff told us there were generally sufficient staff levels in place to meet people's needs. People were supported on a one-to-one or two-to-one basis, which was dependent on assessed levels of need. Staffing levels were maintained safely with enough on duty to meet individual needs and support them with their daily living activities.

Key Question	Applicable Regulations	Quality Statements and Comments
		Where sickness meant that staff were unable to work at short notice, the management team covered these shifts with bank workers. Agency staff were only used as a last resort. Both the Registered Manager and the Deputy Manager supported people, with the Deputy Manager having allocated shits, and the Registered Manager providing support where needed. A check was made to assess whether staff were being recruited in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems were in place to ensure staff were recruited safely and they were suitable to work with people living at Chantry. Recruitment processes included a Disclosure and Barring Service (DBS) check, identity check, previous employment checks through an employment history, references from previous employers, and right to work checks, where needed. New staff undertook a programme of induction and on-going training to ensure they maintained the knowledge and skills necessary to support people in the right way. The induction was detailed and aligned with the care certificate, including online modules, observations, care practices, and work exercises to ensure competency in staff roles. Evidence was seen of progress for new staff. Ongoing training further supported staff with a programme of mandatory and required training which was reviewed and updated on a regular frequency. Both mandatory and required training was at 95%, with new staff in the progress of completing their training. Along with training to keep people safe, such as safeguarding, and infection control, for example, staff were also supported with specialist training in areas such as oxygen therapy and peg care. This meant that staff were given the support they needed to care for people using the service. Staff competencies were assessed in relation to medication, although there was some slippage with medication being at 81.8% and oxygen therapy at 59.1%. **(SR 10)**

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		There was some feedback from relatives to indicate they lacked confidence in the training provided to staff. It would be useful to provide reassurance for this. **(SR 11)** **Infection prevention and control –** Score 2 Infection control was generally managed safely and overall; the environment was seen to be clean and tidy. However, some of the wheelchairs needed cleaning. One in particular had food debris, crumbs and spillage within the seating areas, sides and framework and another had marks over the framework. A visitor said that they had previously had to request for the wheelchair of their relative to be cleaned. Staff said that they would clean the wheelchairs immediately at the visit, however moving forward wheelchairs need to be cleaned in line with the cleaning schedules. **(SR 12)** Staff followed infection control procedures and used PPE effectively, when needed. **Medicines optimisation –** Score 2 People's medicines were kept in locked cabinets in their own rooms. Each person had a personalised medication folder with information about the support and medicines included. Stock counts were not maintained safely. There was a discrepancy in the amount of cream in stock for one person. In relation to liquid paracetamol there was a discrepancy in relation to the amount in stock. The date of opening was recorded as 1 August, and it had not been administered in the current cycle. However, the MAR chart only records 500 mls carried forward and did not include a second bottle of 200 mls. The count- down sheet recorded an audit on 20 August as there being 690 mls of paracetamol, but on the 26 August – this recorded that there were approx. 680 mls of paracetamol left and this had not been administered between the audits, which meant there was a discrepancy of 10 mls. More care needs to be taken in relation to stock management and consider how liquids are checked. **(SR 13)**

Key Question	Applicable Regulations	Quality Statements and Comments
		Where a tube of cream had been used, this had split and was leaking which could compromise the integrity of the cream. This was reordered at the visit. However, care needs to be taken to ensure tubes are handled with care. **(SR 14)** Wrong codes were used on MAR charts at times, such as destroyed when a person was on home leave. **(SR 15)** A gap on a MAR chart was identified. Reasons for administering PRN were mainly in pace, but there were two occasions, where this had not happened. **(SR 16)** PRN medication profiles were in place. These included any special instructions, why it was required and what to try before offering PRN, results and possible side effects. There were systems in place for collecting, recording and disposal of medicines. Medicines wer stored safely in people's rooms. • This service scored 65 (out of 100) for this area.

SRG RATING: Good

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

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

Key Question	Regulations	Quality Statements and Comments
Effective	**Regulation 9: Person Centred Care** **Regulation 11: Need for Consent** **Regulation 14: Meeting Nutrition and Hydration Needs** **Regulation 18: Staffing**	**Assessing needs –** Score 3 Assessments were completed of people's individual health, care, wellbeing and communication needs. Everyone had a support plan on the Blyssful system which included, support required, all 'About me', information about likes, and dislikes, background history along with medical information. These were reviewed on regular basis. **Delivering evidence-based care and treatment –** Score 3 There were no pain profiles in place in the MAR charts. On the front page of Blyssful there was a short statement as to how someone expressed pain. In some of the communication support plans and risk assessments there was some reference to pain but given the communication needs of people using the service, I suggest that this is an area that could be developed. **(ER 1)** One person had all their medicines administered via a PEG due to swallowing. There was clear guidance on the administration of medicines through the PEG, and staff spoken with were knowledgeable and able to describe the procedures in detail. Epilepsy management guidelines were in place to help keep people safe in the event of a seizure. Staff were able to access the SALT (Speech and language therapy) team and information was included in the support plans on how to support people with any modification of diets. Staff were supported with training in the individual needs of people using the service. This included the use of oxygen, management of epilepsy, and peg feeds, for example. **How staff, teams and services work together –** Score 3 Hospital passports could not be located on the system, although it was reported that these systems were in place, these were not seen. These need to be made available. **(ER 2)**

Key Question	Regulations	Quality Statements and Comments
		People were encouraged to attend appointments, and support was provided for health care professionals to visit, when people were unable to attend in the community. **Supporting people to live healthier lives –** Score 3 Monthly health checks were carried out to monitor individuals' well-being. These checks included examining skin conditions, oral care, nail care, concerns related to bowels, specific health care needs, and recording individual weights without any issues. These health checks were performed monthly. The reviewed selection indicated that staff worked with people to maintain their health. Although there was a tendency to record 'fine', with no further details in many of these records. **(ER 3)** People were supported to attend appointments. This included specialist health care professionals and regular checks up with the G.P., dentist and optician. Dietitian support was accessed when needed, and people were provided with a varied diet. **Monitoring and improving outcomes –** Score 2 There was an inconsistent approach to recording of meals. Staff were recording different levels of food consistency for people living in the home, which was not always based on specific SALT guidelines. For example, meals for one person were recorded as regular, easy to chew, or soft and bite sized. The person was assessed as requiring soft and bite sized. **(ER 4)** Staff recorded wounds and untoward marks onto body maps on Blyssful. However, there were 43 body maps recorded which were overdue for review. A check on these noted that staff were recording when they first identified a wound or mark but were not reviewing or updating the record. **(ER 5)** In addition, where there were records of bruises or other marks, there were no explanation or review in relation to possible causes. It is important to ensure that possible causes are considered to ensure that people are safeguarded.

Key Question	Regulations	Quality Statements and Comments
		For one person, the vitals record for the last month did not record one person's blood pressure being taken on a daily basis. In addition, where the care plan stated that the blood pressure should be taken one hour after a specific medication, the times of the readings varied throughout the day. This is because the actual task for the blood pressure is to take anytime during the day, which contradicts the actual support plan guidance. **(ER 6)** There was an eating and drinking support folder kept in the kitchen. This contained SALT guidelines and support plans for nutrition; however, it was noted that the support plans were dated 2023 and were significantly different from the most recent recorded on the Blyssful system. **(ER 7)** **Consent to care and treatment –** Score 3 The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for themselves. MCA assessments were in place. These were decision specific and included any assessments in relation sharing information, use of video and audio monitoring, wearing of lap straps, management of finances, support with medication and support with personal care for example. MCA assessments were person-centred and there was evidence that consideration was given to individual communication needs. MCA assessments recorded how staff had made to attempts to assess capacity through the use of communication aids and there was information on best interest decisions.

Key Question	Regulations	Quality Statements and Comments
		Where people had capacity and refused specific treatment, this was respected, but risk assessments were in place to ensure that people were not at risk of self-neglect. Staff understood how to offer people choices and make decisions. Staff were able to explain how they gave people options. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. This is known as Deprivation of Liberty Safeguards (DoLS). Applications had been made appropriately. • This service scored 70 (out of 100) for this area.

SRG RATING: Good

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

"Characteristics of services the CQC would rate as' Good' People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment 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 Respect**	**Kindness, compassion and dignity –** Score 3 Staff and management interactions with people using the service were observed during the visit. Throughout the time spent at the service showed that staff demonstrated kindness, consideration, and a good understanding towards people. There was a friendly atmosphere where people and staff interacted in a comfortable manner. Relatives said that staff were kind and caring. **Treating people as individuals –** Score 3 There was some nice, personalised information about individual people within the support plans. A relative felt there had been improvements in the relationship with a key worker and that their relative now had someone who knew them well. Discussions with staff evidenced their familiarity with people. Staff were able to explain how they supported people and describe individual preferences, including how they liked to spend their day. **Independence, choice and control –** Score 3 People were supported to maintain contact with family and friends and maintain relationships with others. People were unable to express fully their choices, there were communication aids in place for some people to be able to support with choice and make decisions about their care, treatment and wellbeing as much as possible. Processes were in place for best interest meetings and capacity assessments to take place to ensure people's best interests were considered. **Responding to people's immediate needs –** Score 3

Key Question	Regulations	Quality Statements and Comments
		Staff communicated well with people and understood many of their individual verbal and non-verbal interactions. People were supported by staff who understood their needs and preferences and knew how to minimise any discomfort or distress they might experience. Staff were responsive to individual needs. Observations showed that staff checked with people to ensure they were feeling well. Where one person could become agitated staff knew to allow them some time to be alone, so they could relax and become calm. Support staff understood how to report any concerns and ensure that accidents and incidents were reported. **Workforce wellbeing and enablement –** Score 3 Staff felt well supported and found the registered manager approachable. An employee assistance programme offered a confidential helpline for mental well-being support. Staff had access to the blue light card, providing discounts from various retailers. "Above and Beyond" nominations recognised staff who went the extra mile for people. The registered manager worked with staff to make reasonable adjustments to ensure that there was a fair work life and homelife balance. Supervisions gave staff the opportunity to discuss their wellbeing. • This service scored 75 (out of 100) for this area.
SRG RATING: Good This service maximised the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs		

Key Question	Regulations	Quality Statements and Comments
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 There was a person-centred approach and there was some nice person-centred information within the support records. Support plans were specific to the person, and conversations with staff evidenced that they knew people well. Relatives felt that staff knew people and one relative felt that this had improved. One relative said, *'I have never met a member of staff who does not look after my child to the best of their abilities.'* Some people had limited communication abilities. Communication support plans were in place, and these gave staff information about how to support people with their communication. Observations during the visit really demonstrated how people could express their feelings, and some staff noted this and understood what people were trying to express. Other staff were not as confident when communicating and this may be an area worth developing. **Care provision, integration, and continuity –** Score 3 Where required, external services were accessed. People were supported to attend or engage with health professionals and other services to help monitor health and welfare. **Providing information –** Score 3 Some of the signage needed review, there was a 'residents board', this tended to identify the staff who were on duty, but was written in a green pen, and was not easy to read. There were some health and safety signs around, some of which were necessary as they related to fire, but others tended to give a clinical impression and removed from the homely feel of the environment. **(RR 1)**

Key Question	Regulations	Quality Statements and Comments
		The complaints procedure was on display and placed on the wall in the main hallway. This was at a height that was suitable for people using wheelchairs. Menus were on display and were in a pictorial format. **Listening to and involving people –** Score 3 House meetings had been taking place, with the last meetings take place in June, July and August. Although the minutes of the August meeting were not available. The meeting minutes lacked detail, some identified specific areas of discussion, and although it is recognised that most people using the service had limited verbal communication skills, the interactions recorded were very limited with short one-word responses. Where staff identified that people wanted to change or achieve something, there was no record of any actions or plans to address this. For example, where people were asked what could be done to improve life at Chantry, one person said for night staff to be quiet, another person said to be taken out more often, one person said that their key worker needed attention, and at another meeting additional activities were identified, but there was no actions recorded for any of these areas to be addressed or if they had been actioned. It is important to evidence that people are involved and that they are listened to. I suggest that the meeting minutes are reviewed and there is more consistent format which includes a set agenda, an action plan and a check at the next meeting to see if feedback was acted on. **(RR 2)** The last service user survey had taken place in June of this year. Staff had sat with people and discussed their opinions on the service. Although some people had limited capacity and vocabulary, staff did try to gain feedback. Following on from the survey, similar to the meetings, there was no update of any action taken as a result of feedback or recognition of any positive feedback. I do suggest that findings from surveys are identified, and actions taken as a result shared. In addition, the monthly newsletter could be used to share positive feedback along with the activities undertaken by people. **(RR 3)**

Key Question	Regulations	Quality Statements and Comments
		Equity in access – Score 3 Staff made sure that people could access the care, support and treatment they needed when they needed it. The service had good communication with people's health care professionals and ensured that lines of communication were maintained. The Registered Manager and staff advocated for people and supported them to attend appointments. **Equity in experiences and outcomes –** Score 2 Records showed there were some community activities happening with evidence of some people going into the town, visiting the cinema and going out for walks. However, activity records varied in relation to different activities people were taking part in, and these did not always align with their support plans. Observations showed that staff knew people well and understood their individual needs. Most people preferred to relax and spend time listening to music in the afternoon, staff treated with dignity and respected their choices, they interacted well with people and spent time at people's level to ensure that they were able to communicate effectively. However, there was a lack of confidence from relatives spoken with in relation to some of the activities. One relative felt that community activities only happened when they organised them, and although they were happy to do this, they felt more could be provided by staff at the home. Another relative was disappointed because despite previous reassurances about support to go swimming, this had never happened. Feedback from relatives was that at times they felt the availability of drivers impacted on choices available and that people could not always go out and about in the community due to the lack of drivers. Relatives said they felt staff were kind and caring but were not focussing on different activities. **(RR 4)** Goals were not embedded into the service. The goals for one person were recorded onto Blyssful as have a trip to Butlins, more walks, swimming every week, and use public transport more. Three of these did not record any progress, although they had been recorded as being implemented on 1 April 2025. Also, these did not match or include a goal identified at a house meeting in July. The last keyworker meeting for one

Key Question	Regulations	Quality Statements and Comments
		person stated that the person didn't know if they had reviewed their goals and for another it was recorded 'yes' but not what progress was. **(RR 5)** **Planning for the future –** Score 3 No-one in the home was receiving end of life care at the time of the visit. However, end-of-life was considered within the support plans, with consideration as to where people would prefer to be and if any known wishes were in place, these were identified. • This service scored 71 (out of 100) for this area.

SRG RATING: Good

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

"Characteristics of services the CQC would rate as 'Good' People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood, and they are actively involved in planning care that meets these needs. Care, support and treatment 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 The management ethos was about people using the service, and all staff spoken endorsed this and observations showed that everyone worked as a team. One visitor spoke of how they were working with the management team to make improvements to the support provided to their relative and said, *'Sometimes there are little inconsistencies to get sorted, but we are working together to sort these out.'* It was reported that communication between different shifts was effective, and this meant that information was shared so different staff were aware of any updates or changes to individual needs. There was a daily planner which helped staff to organise their day and be aware of their accountabilities. All relatives spoken with felt communication could be an issue, not necessarily from management, but from within the team, and this may be an area worth considering how to develop. **(WR 1)** **Capable, compassionate and inclusive leaders –** Score 3 Staff said that the manager was fully involved with the running of the home and would work on shift with them if needed. They said the manager was supportive and visible within the service. Relatives confirmed this. Relatives said the manager was very nice and was approachable. **Freedom to speak up –** Score 3 There was a staff champion in place who has attended larger staff meetings. This was used to share feedback from staff at Chantry.

Key Question	Regulations	Quality Statements and Comments
		Staff meetings were held on a monthly basis, with usually around 50 – 60% staff attending. The meeting minutes for the last three were reviewed. These had been held in June, July and August. These included updates of individual care needs, reminders to staff of best practice, and roles and responsibilities. In some of the meeting minutes there was reference to incidents, but a lack of clarity around any lessons learnt or reflective practice. Where reference was made to medication errors, there was a lack of detail of the expectations of how to address this moving forward. I suggest that more information around lessons learnt are included. **(WR 2)** Staff said they were well supported and felt they had opportunities to speak up, and that they were listened to. Staff were supported with supervision and had opportunities to discuss learning and development, practice, relationships and well-being. A staff survey had been sent out and information was in progress of being collated. There had been one formal complaint made in 2025. There was evidence that a full investigation had been carried out and a full response had been sent to the complainant, with details of the investigation, outcome and actions to be taken to reduce the risk of recurrence. Lessons learnt were generated from the complaint and this included staff education and training around MCA, improvements to the support plan and communication in relation to record keeping and documentation. A relative reported that they had raised a concern, and a follow up with the registered manager identified that they had responded and addressed this. However, as it had not been raised as a formal complaint, this had not been recorded. It would be useful to ensure that all concerns are recorded. **(WR 3)** **Workforce equality, diversity and inclusion –** Score 3

Key Question	Regulations	Quality Statements and Comments
		All staff spoken with felt that they were treated equally and diversity was considered. They said they felt included and that they were supported appropriately. Policies and procedures were in place and staff received training in this area. Staff reported that cultural days were arranged where staff could share food from their home countries. **Governance, management and sustainability –** Score 3 Governance systems and processes were in place. Quality audits were carried out to maintain oversight of the service. These included areas such as medication, care records, health and safety, infection control, and regular walk arounds were carried out. Quarterly audits were also in place to help maintain oversight. Where areas of improvement were identified these were included in the governance audits and included on the action plan. Oversight was maintained by the provider's quality team through a regular trends and monitoring analysis which reviewed information from different systems used in the service. **Partnerships and communities –** Score 3 A business continuity plan outlined how unforeseen circumstances would be managed such as the impact of adverse weather or loss of essential supplies. An on-call telephone system supported staff out of office hours in emergencies. The staff and management team worked in partnership with other organisations to support care provision, service development and joined-up care. **Learning, improving and innovation –** Score 2

Key Question	Regulations	Quality Statements and Comments
		Learning was shared from the larger organisation following any internal reviews and rolled out to the individual services. Actions were generated from untoward events such as medication errors, accidents, incidents and complaints. There were 27 actions on the RADAR plan at the time of the visit, with three overdue and the remainder either pending or planned. Some of the planned target dates to complete the actions were not timely, with long dates for actions to be achieved such as training following a complaint and actions to clear fire exits. **(WR 4)** Where some of the actions were completed, there was no evidence or record of how the action had been addressed. For example, where an action to complete an additional fire drill was identified as being completed, there was no information as to how this was achieved, and the action was just signed off as being completed with no supporting evidence. **(WR 5)** The Registered Manager worked with other managers within the locality to communicate and share ideas with to improve service outcomes. **Environmental sustainability – sustainable development –** Score 3 Policies and procedures were in place to promote environmental sustainability. Electronic systems promoted the reduction of the use of paper. Consideration had been given to environmental sustainability with recycling being implemented and staff followed local authority procedures. • This service scored 71 (out of 100) for this area.
SRG RATING: Good This service maximised the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs		

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

ACTION PLAN:

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
SR1	*Incident investigations to be completed in a timely manner or record why there is a delay*						
SR2	*Debriefs to be in place where needed*						
SR3	*Work with staff to educate to complete records in a person-centred way*						
SR4	*Further develop information around support with oxygen in line with policy*						
SR5	*Ensure that risk assessments are in place for blood thinners.*						
SR6	*Remove references to Ablyss*						
SR7	*Review the contents of the grab bag and ensure that the is appropriate emergency equipment in place to meet the needs of the people using the service, this should include a first aid kit which is in date.*						
SR8	*Review PEEPS and ensure that where people use oxygen there is detailed*						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
	information included, and flammable creams are correctly identified.						
SR9	*Review the testing of water temperatures to ensure they are completed in line with procedures*						
SR10	*Support staff to complete competency assessments.*						
SR11	*Consider how to reassure relatives in relation to training*						
SR12	*Wheelchairs to be cleaned regularly*						
SR13	*Review how stock is counted and managed*						
SR14	*Ensure that creams are handled with care*						
SR15	*Ensure that correct codes are used on MAR charts*						
SR16	*Ensure that reasons for PRN are recorded.*						

CQC Key Question - EFFECTIVE

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
ER1	*Further develop pain profiles and how to support people with pain management*						

ER2	*Ensure that hospital passports are available*						
ER3	*Include more detail in monthly health checks to evidence people's wellness*						
ER4	*Ensure there is consistency when recording food and meals*						
ER5	*Ensure that body maps are reviewed and updated with any progress of any wounds or marks.*						
ER6	*Ensure that blood pressure is taken in line with the support plan*						
ER7	*Remove outdated information from the nutritional folder kept in the kitchen.*						

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	*Review some of the signage*						
RR2	*Formalise the house meetings so there is evidence of actions set and a follow up to check feedback has been acted on*						

RR3	*Produce a report from any surveys with a 'you said – we did' format to help demonstrate actions taken as a result of feedback.*						
RR4	*Promote communication channels with relatives to help develop and share information about activities*						
RR5	*Further develop how people are supported within dividual goals*						

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	*Consider how to develop communication between staff and relatives*						
WR2	*Include more information on lessons learnt in staff meetings with specific detail of how these changed practice.*						

WR3	*All concerns formal or otherwise should be recorded, with actions taken.*						
WR4	*Actions from learning to be timely*						
WR5	*Good practice is to evidence completed actions rather than recording that it is completed*						