AUDIT REPORT

Birchwood House

Date of Visit: 12th & 13th of January 2026

SRG Care Consultancy Limited
Registered in England and Wales | Company Number 13877264
Registered Office: Unit 13E, Miners Way, Lakesview International Business Park, Canterbury, Kent CT3 4LQ.
www.srglimited.co.uk | 0330 133 0174

Contents:

Service Name: Birchwood House

Provider: Liaise (London) Limited

Address of Service: 97 Browning Road, Newham, London, E12 6RB

Date of Last CQC Inspection: 16th August 2022

Ratings

CQC's Overall Rating for this Service:	Good	

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 	65 (out of 100)
Responsive	Requires Improvement 	60 (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 12th & 13th January 2026. 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, deputy manager, and holding discussions with support staff and some people using the service.

Key documentation was reviewed which 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. Birchwood House is a residential care home and provides support for up 7 adults with specialisms in supporting people with learning disabilities, mental health conditions, physical disabilities and sensory impairments. There were 5 people living in Birchwood House at the time of the visit.

Incidents were recorded, and staff were supported with debriefs. Reviews of learning was in place. People said they felt safe living at Birchwood House. Risks to people had been assessed and planned, this meant staff had access to the necessary information to care for people.

There were enough staff to support people, and recruitment was primarily safely managed, although dates of employment in documentation needed clarification. Staff were supported with training, supervision and meetings. However, staff displayed a negative attitude towards the provider and reported that they did not feel valued. Staff were not always aware of their own accountabilities and there was a focus on their rotas rather than outcomes for people using the service. The management team were aware of this and were working with staff.

However, people were supported with their health care needs, staff knew how to keep people safe and also knew individual likes, dislikes and preferences.

PEOPLE'S EXPERIENCE OF THIS SERVICE

People were not always supported to have maximum choice and control of their lives. There was a tendency for staff to 'do things' for people rather than promote independence. Activities were not always promoted.

Staff were seen to be polite and respectful towards people using the service; however, they did not always evidence a person-centred approach. People were not fully supported with goals they wanted to achieve.

However, people were comfortable and relaxed with staff and one person said that staff were kind and caring.

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 3 Incidents were recorded in the Radar system. Staff were completing these in detail and included the intensity of the incident, details of what had happened, triggers, actions taken and if any restrictive practices were used. Where required, staff use a restrictive practice, such as Protective Stance 2, however, following one incident staff had stated that they had used Protective Stance 1. However, the actual restrictive support had now changed and was being reviewed, but this needs to be updated in the support plan. **(SR 1)** Where PRN was used in one incident, there was no reference to what the actual PRN was, only that the person had been given 25 mg. **(SR 2)** Reviews of learning was in place. There was a clear indication of learning following an incident, for example, although staff had not been involved in one incident, the cause of the incident had been reflected on as a learning curve. For example, to ensure that information was given to the person in a clear and structured way. The service was supported by an internal specialist team which included positive behaviour support (PBS). When new behaviours manifested, these were reported through to the team, who then reviewed the incidents, support plans and assessed for patterns and trends. What was not apparent was as to how these reviews were then fed into the support provided. This was discussed with the registered manager, who advised that there were provided with reports, analysis and updates. This needs to be evidenced more robustly. **(SR 3)** **Safe systems, pathways and transitions –** Score 3 There were systems to ensure that people had referrals to other agencies as required. For example, people were referred to health professionals to support with meeting their health needs.

Key Question	Applicable Regulations	Quality Statements and Comments
		Safeguarding – Score 3 There were appropriate systems to safeguard people from abuse. Safeguarding issues were logged and referred to agencies such as the Local Authority and CQC when required. Staff were able to demonstrate an understanding of safeguarding and were aware of how to report any concerns and knew who to report to. One person said they felt safe living at Birchwood House. **Involving people to manage risks –** Score 3 Risks to people had been identified and assessed. Assessments included personal care, mental capacity, positive behaviour support, medication, medical support, communication and finances. Risks were identified and included in the support records. It was seen that these were generally reflective of individual needs. It was noted, however, that the missing person profile for one person stated that they had, '*limited road awareness, which poses a safety risk when he is in the community. He may not recognise traffic signals, judge vehicle speed, or understand safe crossing points, increasing the likelihood of accidents.'* There was reference in the support plan and risk assessment, but this did not clearly describe the individual risks and how to manage in the community. **(SR 4)** In addition, the hospital passport for one person stated that they had a mild/moderate oar-pharyngeal dysphagia which was caused by weak oral muscles. Although the support plan referred to a risk of choking, this was attributed to a weak arm rather than mild dysphagia. **(ER 5)** Some people had behaviours that could challenge. There were PBS (Positive Behaviour Support) plans in place. These identified behaviours and actions for staff to take in these instances, such as redirection for example. **Safe environments –** Score 3

Key Question	Applicable Regulations	Quality Statements and Comments
		Daily fire safety checks were being completed, along with weekly checks on fire door safety, emergency lighting, and the testing of the fire alarm. Monthly checks were completed on the fire extinguishers, the fire grab bag, and monthly fire drills were happening. Personal Emergency Evacuation Plans (PEEPS) were in place and were available in the 'grab bag'. A check on this evidenced that there was appropriate such as torches, Hi-Viz jackets, a first aid kit, and additional appropriate documentation. Health and safety checks included checks on window restrictors, plug sockets, carbon monoxide monitors, water temperatures, and weekly water flushes were completed on empty rooms. Servicing and checks were undertaken on appliances and utilities. For example, the electrical installation condition report had been completed in August 2024, emergency lighting had been serviced in June 2025, fire equipment had been service, and portable electrical equipment had been checked in January 2026. A fire safety assessment had been recently completed, and a health and safety annual risk assessment had been completed in June 2025. Generic risk assessments were in place to help maintain the safety of the service. There was a broken tile in the staff toilet, which had been reported to the maintenance team, and was included on the action plan. The lounge was fairly clean and tidy, although it was noted that where Christmas decorations had been taken down, Sellotape and bits of decoration were left stuck to the wall. **(SR 6)** **Safe and effective staffing –** Score 3 There were enough staff to support the people living in Birchwood House. Staffing was arranged in accordance with assessed individual needs. Dependent on individual needs, there were some shared hours with some people being allocated one-to-one hours for activities or additional support.

Key Question	Applicable Regulations	Quality Statements and Comments
		Two staff files were reviewed to check whether the recruitment process was in line with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A HR audit had been completed which had been used to identify any missing documentation. An application form and C.V. was on file for one person. The C.V. identified their employment history in years rather than months, which meant it was not possible to identify when the full employment actually ended. There is an original application form which does not fully agree with the current updated C.V., which has a couple minor gaps. I suggest this is clarified with the member of staff. The references for one person did not match dates of employment on the CV. **(SR 7)** Appropriate checks were made through the Disclosure and Barring Service (DBS). These checks provide information including details about convictions and cautions held on the Police National Computer, and this information helps employers make safer recruitment decisions. Where needed right to work checks were in place, along with proof of identity and address. Medical declarations were also completed. The Liaise induction consisted of a coordinated programme which included completing the training programme along with exercises and observational practical sessions. Staff were supported with an ongoing training programme. This included both mandatory and required training. Training was online through a recognised training company (Your-Hippo). Training included areas such as autism awareness, equality and diversity, fire safety, food safety, GDPR and data protection, health and safety, infection control, learning disabilities, MCA and DoLS, medication awareness, and safeguarding adults, for example. Generally, most staff were up to date with their training, with some gaps in the MCA training. **(SR 8)** **Infection prevention and control –** Score 2

Key Question	Applicable Regulations	Quality Statements and Comments
		Improvements were needed to manage the safety of infection control. Some areas needed more robust cleaning, such as the wall under the hand dryer in the staff toilet which was dirty from splash marks where staff dried their hands. In addition, the hand sink was seen to be dirty and the shelf under the sink had areas of a greenish/blue substance staining the edge of the tiles and the wall. A radiator in the main lounge was sticky and dirty around the temperature panel. **(SR 9)** Two of the settees in the lounge were of a washable material but were torn and worn in areas, which meant that they could not be properly wiped or washed. This meant that this was an infection control risk. **(SR 10)** **Medicines optimisation –** Score 3 Only three people were supported with medicines, one person kept their medicines in a locked cabinet in their bedroom, other medicines were kept in locked cupboard in the office area for reasons of safety. Each person who was supported with their medicines had an individual profile and folder where the information was kept. This included their profile, temperature recording, any reports of changes, MAR charts, the pain profile, PRN (as and when medicines) protocols, stock control records, a hospital passport, and signing in and out of medicines. It should be noted that temperatures were now being recorded on the electronic Blyssful system, and the deputy manager reported that the paper records had been removed from the profiles. However, these were in the records viewed, and as such need to be removed. **(SR 11)** Profiles included key information such as how people took their medicines, and whether they had any allergies, for example. Protocols were in place, which guided staff for when to administer. Reasons for the administration of PRN was recorded within the MAR charts records. New processes had been put into place to monitor the administration of medicines. A second sheet had been added so a second member of staff could check that the tablets had been administered properly. This was being used appropriately, which helped to maintain oversight.

Key Question	Applicable Regulations	Quality Statements and Comments
		Countdown records were in place, so when a tablet was administered, these were counted down to help maintain oversight of stock. A check on medicines and records evidenced the correct amount were in stock. • 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' 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 'All about me' records were in place. These formed a basis for support plans and risk assessments. Regular reviews were being undertaken of support plans and risk assessments, and changes were made where needed. Support from the internal PBS and SALT team ensured that regular reviews were being completed for individual needs in relation to behaviours and communication. **Delivering evidence-based care and treatment –** Score 2 Information and guidance from professionals was not always included in the support plans, for example, advice from the psychiatry team in relation to two hourly evening activities for one person. **(ER 1)** Where people had conditions which could affect their daily, there was information within the support plans. However, these varied in detail with some containing more information than others. **(ER 2)** Oral care assessments had been completed and identified risks associated with individual oral care needs. PBS plans were in place to support people with any behaviours which may challenge. Medicines were prescribed and managed in line with STOMP ('stopping over medication of people'), which ensured that regular reviews took place and changes to medicines were made where needed where it was identified that people no longer needed a particular medicine. **How staff, teams and services work together –** Score 3 People were supported to access health and social care professionals and teams required to support them with individual needs. These included the psychiatrist, district nurses, G.P.'s, and community mental health team for example.

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 Pain profiles were in place, but these did not always contain sufficient detail, in that the records of those viewed were not completed. **(ER 3)** Weights were taken on a regular basis and monitored. Where people were at risk of constipation, this was identified within the support plans. **Monitoring and improving outcomes –** Score 3 Dependent on individual needs, a range of monitoring records were in place. These included food and fluid charts, bowel charts, oral hygiene charts, and general observations. Monthly health checks were in place where staff checked people's general health care needs in relation to their skin care, oral care, nails, weight, and bowel management, for example. These were not always held at regular intervals. For example, one person had their monthly health review on 26th of November, then again on the 9th of December, but had not been supported with a review since this date. **(ER 4)** There were inconsistencies where recording meals with staff recording a range of food levels for the same person, such as easy-to-chew, regular and soft and bite sized. **(ER 5)** **Consent to care and treatment –** Score 2 The Mental Capacity Act 2005 requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to make decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Key Question	Regulations	Quality Statements and Comments
		There were mental capacity assessments in place for different areas, where people did not have a capacity to make a specific decision. In the sample viewed, there was some information in relation to evidencing how the person was supported to understand the question. However, there was a lack of detail around the actual conversations which were held. **(ER 6)** People can only be deprived of their liberty to consent to care and treatment with appropriate legal authority. In care homes, this can be done through a procedure called the Deprivation of Liberty Safeguards (DoLS), which is part of the Mental Capacity Act 2005 (MCA). Checks were made as to whether the service was working within the principles of the MCA and how they managed DoLS within the service. Applications were made, where needed and records of DoLS authorisations were in place. • This service scored 66 (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 reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work".

Key Question	Regulations	Quality Statements and Comments
Caring	**Regulation 9: Person-centred Care** **Regulation 10: Dignity and Respect**	**Kindness, compassion and dignity –** Score 3 Staff were seen to be polite and respectful towards people using the service, although as identified in the responsive section, they did not always embrace a person-centred approach. However, staff knew people well and were familiar with their routines. likes and dislikes. People were seen to be comfortable in the presence of staff. People were supported to maintain contact with family and friends and maintain relationships with others. One person said they thought staff were kind. **Treating people as individuals –** Score 3 There was individualised information within the support plans which identified things that were important to the person, things that others needed to know and individual likes and dislikes. Support plans were specific to the individual person and clearly identified individual needs relating to all aspects of care and support. **Independence, choice and control –** Score 2 Staff did not always support people's independence. Staff had ease of access to the electronic support plan documentation, which was also used to record the care and support provided. Although staff knew people well and were able to describe individual support needs, care records were not showing how people were being involved and supported to maintain their independence. There was a tendency for staff to 'do things' for people rather than encouraging them to take part in activities and promote independence, for example when preparing meals, staff did this for people rather than support them to take part, and records also showed that at times staff completed tasks such as cleaning bedrooms rather than support people to take part. **(CR 1)**

Key Question	Regulations	Quality Statements and Comments
		People were generally supported to make day-to-day decisions about how they wanted to spend their day. **Responding to people's immediate needs –** Score 3 If there were changes in individual needs, these were reflected in support plans and risk assessments. Referrals were made to external health or social care professionals if concerns about people's welfare were identified. Concerns in relation to any behaviours were reported through to the internal PBS team, who carried out reviews. Systems for monitoring accidents and incidents were in place. **Workforce wellbeing and enablement –** Score 2 There were processes in place to support staff. Liaise, as an organisation, had a staff wellbeing programme, which included an Employee Assistance Programme offering 24/7 support, a financial wellbeing app, a fully funded blue light card, and a colleague recognition scheme for staff who went above and beyond. However, staff spoken with felt they were not supported by the provider and displayed a negative attitude towards some of the benefits offered, with one member of staff saying that some of it did not apply to them. When asked what they meant they said that no one was nominated for the above and beyond scheme, this was why they felt some of the benefits did not apply to them. In addition, staff felt that they had not been given any recognition at Christmas and were not appreciated. It was suggested that they raise their concerns through the staff representative, but staff did not feel that this would be effective. The Registered Manager was aware of the staff focus and was working to try and resolve their concerns. • This service scored 65 (out of 100) for this area.

Key Question	Regulations	Quality Statements and Comments

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 are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible."

Key Question	Regulations	Quality Statements and Comments
Responsive	**Regulation 9: Person Centred Care** **Regulation 17: Good Governance** **Regulation 16: Receiving and Acting on Complaints**	**Person-centred Care –** Score 2 Some of the interactions between staff and people using the service lacked compassion. For example, one person gave a staff member their lighter, but the staff member just took this and did not say thank you and then walked away. During one of the days, a member of staff was sitting with people using the service but did not interact or initiate any conversation. **(RR 1)** Staff were not always aware of the most current information, for example when the activity planners were requested, out of date ones were provided, although the management team had implemented new planners. **(RR 2)** Support plans were taking a person-centred approach to include individual preferences. Some checks do need to be made that they are fully appropriate in places. For example, for one person, one section of a support plan identified that they wanted to stay in touch with a family member, and there was information on how to contact them. However, in another part of the support plan, there was information to say that the family member did not want any contact. This contradicted information elsewhere within the support plan. **(RR 3)** **Care provision, integration, and continuity –** Score 3 Staff worked with health and social care professionals to promote outcomes for people. Reviews of care was undertaken. People were being supported to access health care professionals as needed. Internal specialists provided consistent support. **Providing information –** Score 2 Pictorial menus were on display in the kitchen, which enabled people to choose their meals. New activity planners were being introduced but were not yet fully embedded.

Key Question	Regulations	Quality Statements and Comments
		Communication support plans were in place, although improvements were needed. For example, for one person, where they did not verbalise, their communication support plan lacked detail. Actions to support stated to enhance communication tools and 'Develop a personalised communication board with pictures, symbols, or words representing Xs' commonly expressed needs (e.g., food, drink, toilet, emotions).' But this actually did not describe how to communicate with the person. Another section of the support plan stated to facilitate 'peer education sessions' and 'Develop a clear emergency gesture or signal' that x can use to indicate distress or danger, but none of this actually guided staff on the person's communication needs. In addition, the communication support plan stated the person used a limited set of gestures and then gave an example of two or three. In order the promote effective communication, there needs to be more detail of how to communicate and what different gestures, some of which were seen during the visit and were not explained. This was reviewed at the time of the visit, but moving forward communication support plans would benefit from more detailed information. **(RR 4)** Communication support plans were accompanied by individual communication passports. The most recent communication passport for two people was dated January 2022. **(RR 5)** **Listening to and involving people –** Score 2 Key-worker monthly catchups were happening. This was where staff sat with the person and discussed how things had been during the last month. People had opportunities to discuss any goals, meals and if they had been out, things people may not have liked much or if there was anything troubling them, activities, relationships, and health care related matters, for example. However, these were not always reflective of individual preferences and choices and tended to lack detail. Where any particular issues were identified, these were not discussed in more detail. **(RR 6)** House meetings were not happening, which people did not have the opportunity to contribute regularly to decisions about the running of the home. **(RR 7)** Staff reported that people had been involved in choosing new menus, however this was not recorded.

Key Question	Regulations	Quality Statements and Comments
		Equity in access – Score 3 People were provided with support to arrange and attend healthcare appointments with other professionals involved in their care. Staff supported people to attend appointments and to follow any advice given by other professionals. **Equity in experiences and outcomes –** Score 2 On the first day of the visit, there was little in the way of activities or interactions happening, staff sat with people but did not positively engage with them on a regular basis. Although on the second day, some people did go out into the community and one person was engaging in artwork, which they enjoyed. For one person, the support plan for activities lacked detail, there was reference to football in the garden, but no other activities or hobbies were included in the support plan. **(RR 8)** The PBS plan for one person stated, *'Staff to provide 3 slots of a 1:1 session each day for structured preferred activities. Each session should last between 10-20 min. Activities could include chat time, baking, craft making and playing a game.'* Daily notes and activity records were not routinely evidencing that this was happening, for example. Staff were not recording these robustly and, on some days, there were no records of any 1-1 activities or support, such as 7th and 8th of January 2026. **(RR 9)** Meaningful goals had not been developed with people, and where goals were discussed in key worker meetings, these were not reflective of individual goals identified within the support plans. For example, for one person at the last three keyworker meetings, the person had talked about getting their passport and travelling abroad. There was no record of how the person could be supported to achieve this goal. This was not included in the goal section of Blyssful and was not included in the goals and outcomes support plan. The key worker meetings did not review how the person could get their passport. It was confirmed that due to difficulty in obtaining birth documentation, this mean that this was impacting on obtaining a passport. However, none of this was reflected in the support plan or goal section. **(RR 10)**

Key Question	Regulations	Quality Statements and Comments
		Planning for the future – Score 3 People were invited to discuss any matters around end-of-life, if they wanted to. Where people had not wanted to discuss this area, it was seen that this was respected. • This service scored 60 (out of 100) for this area.

SRG RATING: REQUIRES IMPROVEMENT

This service did not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

"Characteristics of services the CQC would rate as 'Good' People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood, and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics".

Key Question	Regulations	Quality Statements and Comments
Well-Led	**Regulation 17: Good Governance** **Regulation 5: Fit and Proper Persons Employed - Directors** **Regulation 7: Requirements Relating to Registered Managers** **Regulation 18: Staffing** **Regulation 20A: Requirement as to Display of Performance Assessments**	**Shared direction and culture –** Score 2 Staff were not always taking accountability. For example, where they had been requested to complete pain profiles, the ones in place were blank and not filled in. When asked for details of the activity plans, outdated ones were supplied, although new activity plans had started to be implemented. As noted within this report, staff tended to carry out tasks for people, such as preparing meals without always offering people the opportunity to take part. Staff were focused on their rotas and provider support rather than outcomes for people using the service. The management team were aware of the negative staff culture and were working towards supporting staff to address this. The Registered Manager and the Deputy Manager were taking proactive steps to enhance the quality of care provided. They were carrying out regular supervisions and where staff had committed gross misconduct, appropriate disciplinary actions were taken. **Capable, compassionate and inclusive leaders –** Score 3 The management team prioritised the needs of the people using the service and actively involved with individual and staff support. The management team were continually in and out of the communal areas to maintain oversight and provide advice and guidance if needed. The deputy manager also spent time working on the floor with people using the service. Senior Managers visited the service and were available for support as and when required. **Freedom to speak up –** Score 3 Staff had ample opportunities to speak up, and the Registered Manager operated an open-door policy.

Key Question	Regulations	Quality Statements and Comments
		Staff meetings were now happening on a monthly basis. These tended to discuss different areas including compliance, accidents and incidents, lessons learnt, feedback, and staff wellbeing. Supervisions were happening. A sample of supervisions were viewed, and it was seen that actions were agreed with people. These were included in the supervision, but there was no process or system to follow up on actions at the next supervision, this should be considered. **(WR 1)** There was a staff champion who represented the staff team at organisational meetings, but once again the majority of the staff team spoken with were negative about the effectiveness of this process. **Workforce equality, diversity and inclusion –** Score 3 There were policies and procedures for equality and diversity, and staff received training in this area. Staff were supported with reasonable adjustments so they could balance their working and home life. **Governance, management and sustainability –** Score 3 There were a range of audits in place to help monitor the quality of the service. These included key areas such as medication, health and safety, infection control, and care planning. A manager's assurance audit had taken the place of the managers weekly 'walkaround'. This was now being completed every other day, and checks were made on the cleanliness of the environment, general safety, safe storage of food, medication and chemicals, processes such as use of the communication book, and support provided to people using the service. An IPC quarterly audit was in progress at the time of the visit. This looked at the environment, hand hygiene, PPE, laundry management, and outbreak management, for example. This had identified areas of improvement around cleanliness, although some areas were not noted, as identified within the infection control section of the safe domain. It was also noted that the most recent manager's assurance audit

Key Question	Regulations	Quality Statements and Comments
		slightly contradicted the IPC audit which had taken place on the same day, as one said the environment was clean and the other said there were cobwebs. **(WR 2)** Monthly manager medication audits were completed. In November, the findings were inadequate, but significant improvements had been made for the December audit, and the findings were that medication management was now good, although the weekly audit found the service required improvement for week beginning 6th January 2026. Checks made on medication at the visit found the service compliant with medicines at this time. Monthly health and safety audits had taken place with the last score being 84%, actions had been developed. Monthly finance audits took place on the 10th of each month. Night visit audits took place at different times of the month to check on staff working during the night, this had previously found that two members of staff were sleeping and this had resulted in appropriate action being taken. Monthly support plan audits had now been re-introduced which would be an improvement on the previous quarterly schedule, which had been in place. Oversight was maintained by the provider through a monthly trends and monitoring information analysis (TaMI). This monitored information maintained on the different systems including Radar and Blyssful. This included the results of audits, staff training, supervision, appraisal and competency assessments, support plans, MCA assessments, key worker meetings, compliance in relation to complaints and safeguarding, for example, and the quality team annual mock inspection compliance. The score was currently at 86%. Regular manager meetings were happening on a regular basis. These meetings gave opportunities to share ideas and any issues, which helped to identify areas of improvement

Key Question	Regulations	Quality Statements and Comments
		Partnerships and communities – Score 3 The management team were open and transparent, and collaborated with all relevant external stakeholders and agencies. When needed referrals to health and social care professionals were made both to the internal specialist team and external health and social care professionals. **Learning, improving and innovation –** Score 3 There was an action plan in place which had been developed from audits and external visits. At the time of the visit there were 32 open actions, quite a few of which were overdue. However, some of these were in progress as actions were not being signed off as being completed, until all sections of this had been finalised. These actions do need to be addressed. When staff were employed on a bank staff basis, when they logged onto the system, they were automatically identified as bank staff which was a universal term used for all staff who were on bank. This meant that all bank staff were identified as one, which made it not possible to identify who had actually provided the care and support. There needs to be some way of identifying the actual member of staff. **(WR 3)** **Environmental sustainability – sustainable development –** Score 3 Consideration had been given to environmental sustainability. Where possible recycling was implemented and staff followed local authority procedures. There was an aim to reduce the use of paper through electronic systems. • This service scored 71 (out of 100) for this area.
SRG RATING: GOOD		

Key Question	Regulations	Quality Statements and Comments
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' 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	*Ensure PBS plans include up-to-date protective stance support*						
SR2	*Ensure that the actual PRN used is recorded, when used in incidents*						
SR3	*Ensure that where the PBS team are involved with reviews and analysis, there is robust evidence of how this changes practice*						
SR4	*Where risks are identified in areas of the support plan, ensure that these are fully assessed.*						
SR5	*Ensure that information is consistent and not contradictory.*						
SR6	*Ensure that the left-over Sellotape and bits of decoration from Christmas are removed properly*						
SR7	*Clarify discrepancies of employment dates on application form, CVs, and references*						
SR8	*Ensure that the slippage in the MCA training is addressed*						

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR9	*Ensure that areas of the home are cleaned to prevent the risk of the spread of infection.*						
SR10	*Repair or replace worn furniture.*						
SR11	*Ensure that paper records that are no longer in use are removed*						

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 advice and guidance from health and social care professionals is included in the support plans*						
ER2	*Further develop information about individual conditions, where they lack detail*						
ER3	*Ensure that pain profiles are completed*						
ER4	*Ensure that monthly health checks are held at regular intervals*						
ER5	*Staff to record accurate levels of food consumed by people*						
ER6	*Include more information about conversations held in relation to decision specific assessments.*						

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	*Promote a more person-centred approach by supporting people to develop and maintain their independence*						

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	*Educate staff to promote a more consistent person-centred approach*						
RR2	*Ensure that staff access the most current information, and are aware of what this is*						
RR3	*Review and ensure that support plans contain accurate and consistent information about contact with families.*						
RR4	*Ensure communication support plan clearly identify the actual communication support needs of the individual person*						
RR5	*Review current communication passports to ensure they are up to date and current.*						
RR6	*Further develop how people are supported through their key-worker meetings so there is evidence of their contribution*						
RR7	*Ensure people are supported to contribute to the running of the home*						
RR8	*Further develop activity support plans to identify individual preferences of choices or activities.*						
RR9	*Ensure that people are provided with their 1-1 support as per support plan and that it is evidenced*						
RR10	*Ensure that individual goals are included in the goals and outcomes support plans.*						

CQC Key Question - WELL-LED **By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.**							
Reference Point	**Recommendation Made**	**Action to be taken**	**Who By**	**Date to Complete by**	**Evidence of Completion**	**RAG Status**	**Comment**
WR1	*Implement systems which monitor progress of actions agreed at staff supervision.*						

WR2	*Maintain consistency when completing audits which had similar measures such as cleanliness*						
WR3	*Consider ways that bank staff can identify who are they are when recording care notes.*						