AUDIT REPORT

Meridian Place

Date of Visit: 19th & 20th of February 2026

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Contents:

Service Name: Meridian Place

Provider: Liaise (London) Supported Living

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

Date of Last CQC Inspection: 18th January 2022

Ratings

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

Key Questions	Rating	Overall Score
Safe	Requires Improvement 	62 (out of 100)
Effective	Good 	66 (out of 100)
Caring	Good 	70 (out of 100)
Responsive	Good 	67 (out of 100)
Well- Led	Requires Improvement 	62(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 19th & 20th February 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 to improve the provision and recording of care and increase overall efficiency and compliance with CQC Standards and Regulatory Requirements.

TYPE OF INSPECTION

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

METHODOLOGY

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

OUR VIEW OF THE SERVICE

The service provides support for 13 people with learning disabilities, ADHD and Autism along with underlying mental health issues. People expressed feeling safe generally although some also expressed concerns about their support. Staff demonstrated a clear understanding of managing risks, and this was evidence during periods when behaviour that challenges was being observed. The service is home to a maximum of 16 people across 3 areas and at the time of inspection there were 13 people in residence supported by 19 carers (including Team Leaders) with 9 at night (no Team Leaders). The service was fully staffed on the day.

Managers investigated incidents thoroughly, taking appropriate actions to mitigate future risks. While the home was generally clean in some areas, not all areas were of sufficient standard although the manager did instruct staff members in remedying the situation. Equipment such as Motability vehicles were well-maintained and met the needs of the people living in the home. Some laundry equipment, communal kitchen areas and communal lounge were tired, distressed, in need of redecoration and looked a little institutional with broken and surplus items scattered around various rooms in one building.

The home had adequate staffing levels, with staff receiving regular training and supervision. Medicines seen were in boxes in individual flats, but not all had a CD cupboard or similar function in them. People and their families did not always appear to be actively involved in the assessment of their needs although one family member stated quite clearly that she was. People had sufficient food and drink but communal kitchen cupboards had food items, and it was not clear who they belonged to even though the staff member present said people managed their own. Staff closely monitored individuals' health, working collaboratively with medical professionals. Consent was sought before providing support on most occasions but there were times when trying to speak with tenants about the service, their staff team did not give them the privacy to do so and at one stage the manager had to clear the office.

Some families were involved in decisions made in the best interests of individuals who lacked capacity, though this was not always clearly documented with no signatures or names mentioned. Any LPA's suggested that may exist could not be found.

People were treated with kindness and compassion, with staff mostly respecting their privacy and dignity except for the example given above. Staff recognised people as individuals and supported them in making choices about their care. Opportunities for activities were very good, with staff observed to respond promptly to people's needs.

People's preferences for end-of-life care were also explored although due to the younger age range and general better health of a younger population most did not wish to speak about end of life wishes. There were one or two examples though of tenants who did and this was documented although not in any detail.

Governance systems were in place, and identified actions were completed. However, audits had failed to identify the uncleanliness observed in the communal areas during the inspection. The management team was visible and approachable, and staff reported enjoying their roles and feeling supported to provide feedback.

Feedback from external partners about the service was hard to find with no evidence of commissioning visits available on RADAR or hard copy in the manager's office.

PEOPLE'S EXPERIENCE OF THIS SERVICE

People and the relatives spoken with expressed some positivity about the quality of care provided but also a little negativity about all tenants not being included some activities such as cultural celebrations, they also commented that their relative were targeted by other tenants and that they did not feel safe.

Both people and their relatives noted that the staff were kind, respectful, and upheld their dignity. One family member said that the staff were "astonishing" and frequently put in their own time. They are invited to reviews and fully participant in those reviews. Families discussed consent and once again that they were regularly involved. One family member spoke about their family member choosing the colour of Motability vehicles and were very praiseworthy of the service.

Family members said that the staff team noticed quickly any changes in health and well-being and acted promptly before situations deteriorated.

Healthcare professional spoken with were positive and felt that the service provided "was quite robust, bearing in mind the numbers of people who are there". No concerns expressed about the standard of care and generally felt that the management team were important as it was their management style which filtered down and influenced the culture of care. They were also happy that the previous manager had been retained within the service as they felt he was "quite good".

For people unable to directly share their experiences, observations during the assessment were used to evaluate the quality of care. On the first day, staff sought consent before providing support but were not consistently engaging in conversation while doing so. By the second day, staff were fully interacting with people during support, holding conversations, and ensuring they were happy with the care provided.

DISCLAIMER

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

RATINGS

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 The service uses Radar, which is a healthcare incident management system in which incidents, accidents, complaints and other information are entered into for analysis by the management team. There are some 420 incidents entered into the systems since March 2025 or which 25 remain open at the time of writing. Of these there are 6 which are of high priority. **(SR1)** Radar is accessible to all staff but primarily the Team Leaders enter incident/accidents into the system with oversight from both the Peripatetic and Deputy managers. Each incident is described by the author and there was evidence to support that investigations are undertaken and that learning outcomes are recorded and feedback to relevant parties. Each incident is assigned a "risk score", which indicated the likelihood or recurrent so that staff can highlight this and ensure that preventative actions are taken quickly. E-mail evidence seen to support dated January 17th, 2026. Blyssful is the platform for monitoring and recording care and support and appears to be effective if used correctly. MyHippo is the training platform. Incidents around medication errors demonstrate investigation and identify that the error was picked up through the auditing process. An incident recorded as of 08/01/26, resulted in the individual being suspended from medicines pending re-assessment of competency. The staff member was "competent" at the time. The investigation process remains ongoing until staff member returns from being out of service.

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		Other incidents highlighted where external healthcare professionals have not performed to expectations leading to other medicine errors. Evidence trail seen of e-mail correspondence and calls to the relevant people. Handover notes are entered into the Blyssful software for care planning. The notes seen are basic but provide a useful insight into daily living of the individuals receiving support such as what they have been doing during the day or night, activities or any issues which they may have encountered. Safeguarding information kept on the system demonstrating numbers submitted and outcomes. Mention further under safeguarding Quality Statement. There are policies on the Radar system for staff to access for safeguarding and other related issues. There were 8 complaints registered within the system as from February 8th, 2025. All of these were closed, and evidence was seen of due process being followed from initial complaints through to response from the service and agreement with all parties to close including the Local Authority. Example being of June 2nd, 2025. **Safe systems, pathways and transitions –** Score 2 The service has an up-to-date Business Continuity Plan, Service Continuity Plan and Employers Liability Insurance documents. The CQC assessment findings were clearly displayed on the manager's office wall. No pre-admission assessment documentation was available to view during the visit nor was there any evidence of auditing around admission protocols or pre-admission documentation. **(SR2)** There is a hospital pack which can be printed directly from the system to support individuals with urgent healthcare provision. This provides good supporting information as to what is essential to the person

Key Question	Applicable Regulations	Quality Statements and Comments
		and how they should be supported. One example indicated within the nutritional assessment that a person requires someone with them when eating and this is reflected in the hospital passport. The manager advises that when being admitted to hospital, support from the service ceases as part of the commissioning arrangements although there appears to be some flexibility around individual commissioners. We observed staff responding to individuals queries and concerns during which time one person made allegations about staff swearing at them. The manager immediately asked for the conversation to end and for a meeting to take place with that person in the privacy of their own flat as part of the investigation process. The manager is currently dealing with the issue. We were unable to view any pre-admission assessments on Blyss, although there is policy document for Meridian which was issued in July 2023. There is subsequently a new admission document introduced in November 2025, but we did not see evidence of this in use nor of the referral process trail. There were no visiting healthcare professionals to speak with during the visit nor is a survey to harvest their views on the services provided. This would extend to external visits to various clinics and other areas providing treatment. We did, however, manage to contact healthcare professional connected with the home and they were positive about the management style and the robustness of the service. Tenants who are moving on have no obvious transition plan in place and discussion or documentation regarding this is difficulty to find along with MDT meetings to support future moves. There is therefore no indication of auditing around pre-admission or assessment policy documentation and its effectiveness. **(SR3)** **Safeguarding –** Score 3 There are 23 safeguarding referrals entered onto the system. Of these 20 are closed, one was being closed on the day of our inspection, and two remain open. Those open are dated 03/11/25, concerning

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		behavioural issues during a fire drill. The service had contacted the Local Authority on three occasions to ask for a progress report and an e-mail was evidence as sent on 16th February 2026 again asking for support with the outcome. The second event was recorded on 9th January 2026, concerning a medication omission due to no stock of one medicine. This resulted in one dosage being missed for an individual because of a prescription not being completed by external healthcare professionals in good time to ensure that stocks were obtained prior to stocking levels reaching zero. Individuals receiving care spoken with, generally felt safe and supported by the team and visits to the office were quite frequent for general conversations or queries from individuals about the support they were receiving. Reassurance was given were required and those individuals appeared to be generally happy with the outcomes of those conversations. There are two CQC notifications which match up with the open safeguarding. Local Authority safeguarding policies were reported by the manager to be out of date depending on who the commissioning host is although the service has its own policy. Reporting thresholds appear to vary depending on the commissioning agent and so the management team submit safeguarding's as a matter of necessity to ensure that thresholds are not inadvertently incompliant for reporting. **(SR4)** There is no evidence freely available to individuals which highlight how to report safeguarding or concerns to other external bodies or in-service. Some documentation is easy read, but we were unable to find any that were easily accessible. **(SR5)** Several MCA were observed on files tracked. One person had 7 MCA on file but 3 of these were out of date for review (finance, personal care and end of life planning). The management team were aware of this and working on updating the MCA.

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		Some MCA would benefit from more detail and we discussed this. We checked the financial personal monies for two people. All money accounted correctly and all receipts except for one are detailed (receipt 74, said “Takeaway” without detailing which outlet). Income and expenditure appeared correct for the purchases made and had two signatures for all entries. On completion of accounting, the Deputy Manager changed identification tags on the bags containing the money and this was good practice to demonstrate when and who last had access to the money and information. Only one person has direct control of their own money. **(SR6)** From May 2025 there were a total of 7 DoLS applications submitted. Of the 7 submitted, 2 had been granted and both had the relevant CQC notifications submitted. None granted had any specific conditions attached by the Court of Protection (COP) and both remained within the 12-month period prior to review. Evidence of regular communication with the Local Authority was seen asking for an update from the authority as to the position of those outstanding. No responses were seen during the visit to those e-mails. There is an organisational safeguarding policy in place which was issued on 30th August 2025 which contains good detail and a flow chart outlining and supporting with actions. Staff member spoken with was able to describe what action she would take if suspecting abuse and this included making representation to The Care Quality Commission if necessary. During the visit there was an incident involving a staff member and a tenant communicating over the telephone, the managers dealt with the issue immediately and outlined what action they intended to take, this also involved the Operation Manager.

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		Tenants spoken to directly or observed directly at times voiced concerns about staff members, other tenants and various individuals not employed by the service. These issues were managed calmly by the management team, and they spoke with the tenants in their own rooms to discuss those issues. Some of the allegations are part of ongoing care planning and known behavioural tendencies but all were dealt with patiently and with kindness. **Involving people to manage risks –** Score 3 When talking to individuals and observing their interactions with the management team, it was apparent that they are involved with their own care planning and this was directly addressed by two people during the visit who acknowledged that they had meetings about their support. During the visit they spoke directly to the Positive Behaviour Support Lead about their plans and meetings that they had recently had with him. The interactions appeared to be positive and constructive. One person with capacity was managing her own service during the inspection and speaking with the staff member about how long they had for lunch breaks and how they wanted checks to be undertaken during the night and other times. This person acknowledged their own issues for receiving care and support, but were quite clear that they wanted to do things that they might not be comfortable with. There were some issues around this and their interpretation of staffing commentaries and compliance, but this was dealt with by the management team at the time. Other tenants spoken with were quite open about the challenges to them, due to mental health or physical mental health issues, and the trips they wanted to take in the local Community with support and they asked staff for support in those opportunities which were provided quickly such as going shopping into Woolwich or using public transport or a walk to the local shops. Tenants were able to describe medicines that they took and what they were for and interactions with alcohol and what they should and should not drink or do, or indeed the consequences of what might happen in terms of drug interactions with other substances.

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		Some tenants with capacity are supported to order their own medication which although increasing the risk of incorrect ordering, there is staff support to provide some oversight with this. Examination of the PBS planning in the care plans demonstrated inclusivity and decision making by the individual supported. This extended to important family members. The plans were detailed, descriptive, with desired outcomes and interventions signposted to staff members. The management team and other staff members were able to describe scenario's relevant to some people and how these were generally managed and supported. All appeared confident and the training matrices did not show any deficiencies in this area. The service advocates physical intervention only when necessary and details this in the PBS as to how this should be implemented and under what circumstances. People are supported to take risks in the environment such as using public transport and controlling money. One tenant was noted to have issues with dental health and nutritional assessment and oral care assessments indicated risk 3 for dental care and an appointment was recommended. Subsequent appointment noted on 14th January but there is no evidence of notes taken by the staff members for that day, so the outcome is unclear or if indeed he attended that appointment. There is nothing in the daily notes to indicate he kept the appointment and therefore does the issue remain unresolved causing pain or a reluctance to eat. **(SR7)** Another tenant has good examples of risk identified around allergies, potential for exploitation in the community and other issues. These appear to have been discussed with them, and their first-person responses are indicated within the plan along with commentary about capacity. We spoke with the

Key Question	Applicable Regulations	Quality Statements and Comments
		tenant, and they knew about their care plan and what was contained. They acknowledged being involved with the planning process. **Safe environments –** Score 2 Staff and visitors are required to sign in on arrival to Meridian for security and insurance purposes. The entrance and exit is sealed by large iron gates with a security keypad and all tenants leave and enter with staffing support. During the visit we had the opportunity to walkaround in the company of a staff member to familiarise with the layout of the service. Whilst all people had their own flats, some of these did not have laundering or kitchen facilities and thus shared a communal area, kitchen and laundry. The communal lounge is used for parties on a Friday and generally provides a function where people can mingle and spend time together if they so wish. This area was rather bland and had an old television propped up against a settee. The general décor was untidy and would benefit from some decorative interventions, fixtures and fittings were rather spartan and the area felt unclean. Trim was missing from furniture edging and a large rug in the centre was a trip hazard. There is a kitchenette attached for meal preparation and there were several issues with this from an infection, prevention and control (IPC), perspective. Records of cleaning and hygiene that were seen indicated that cleaning was undertaken but the area itself required large scale intervention. Cooker hobs were dirty and had no sealant around the hob top to prevent ingress of dirt or food. Kitchen cupboards are in a poor state of repair with chips, missing edging, rubbish and general detritus contained therein. There were used gloves on top of the fridge freezer, and the staff member could not advise what they had been used for. Our understanding was that food kept in this area was individualised, but there was no labelling of this food to identify who it belonged to, such as cereals, nor who had bought it. Food labels were present had no use by dates once opened in the fridge. Some had no labelling at all. Previously made toast with

Key Question	Applicable Regulations	Quality Statements and Comments
		a spread of some nature was in an open plastic container in the kitchen cupboard and there was no indication of how long that had been there. The staff member removed it to waste. Pedal bin in the kitchen had neither a top nor a foot pedal mechanism which worked and was heavily marked with fluids externally. Internal kitchen cupboards all required cleaning to maintain hygiene. Overall, the kitchen fixtures and fittings appeared in a poor state of repair and best practice would be to consider replacement. The Laundry area was poorly maintained with one washing machine missing parts externally. The filters on the dryers had large amounts of lint fibres in them and clearly are not being cleaned daily increasing the risk of fire as further residue would be within the machine itself. A fire extinguisher in the laundry was in a wall mounted plastic enclosure to which there was no key and so rendering it as unusable. This issue was seen in a previous fire risk assessment of 2025 by Progress at hazard level 3 and continues to be unresolved. The area requires extensive cleaning and organisation to make it more user friendly. No records to indicate cleaning schedules for the area. Secondary rooms in the building contained large amounts of detritus, broken items, old unused equipment of various descriptions. The room used for storing archiving was unlocked and contained lots of hand sprays and other chemicals in a plastic container and generally there is a lot of useable space which if organised well could be beneficial. **(SR8)** The external areas of the premises had been painted relatively recently and were presented in a satisfactory condition. However, on entering the building, the overall environment appeared poorly maintained. The internal areas required a thorough deep clean and a more robust cleaning schedule with regular management oversight to ensure standards are consistently maintained.

Key Question	Applicable Regulations	Quality Statements and Comments
		We observed areas that would benefit from redecoration and repair, and there was an accumulation of general items and waste which detracted from the overall presentation of the service. Consideration should be given to the removal of surplus items and improvements to fixtures and fittings to ensure the environment is safe, well-maintained and promotes people's dignity and wellbeing. At the time of the inspection, we were unable to access or view tenants' bedrooms. Fire drills were minimal, and recently this had caused some upset with tenants because of noise levels and disruption to the environment. We would suggest that these are undertaken when that tenant is out for the day or engaging in community activities. Previous fire risk assessment recommended that drill take place monthly, but we were unable to evidence this. Fire drill dates provided were January 5th, 2025, for nights and February 5th 2026 for days. Several PEEPs are either due for renewal or are overdue this may present an increased safety risk for individuals. Fire door inspection report was published February 5th indicates large scale non-compliance within Meridian Place and Meridian Court. A fire inspection was undertaken approximately two weeks prior to this visit but the report is not yet available to view. Fire precautions and prevention appear to require more oversight in general. Evidence sheets available on Radar but remedial evidence for some items is not obvious. Electrical installation reports appear satisfactory until 2029. PAT testing completed Jan 2026. Fire alarm service Sept 2025. Emergency lighting cert issues April 2025. TMV June 25. COSHH assessments July 2025. All documents and certs available on RADAR. **Safe and effective staffing –** Score 3

Key Question	Applicable Regulations	Quality Statements and Comments
		We were advised that the staffing for the service was 19 during the day which included Team Leaders, and 9 during the night which was purely care staff. On examination of the rota, there was occasion where there was 18 staff members and not 19. The service had not been able to cover on that day. The service uses agency staff when necessary and we were able to view the one-page profile of that agency staff member supplied by the agency and with the help of the Operational Manager for the service. This indicated compliance with training and all checks and details as required although these were kept by the agency and the management team could not view these such as DBS checks, references. Recruitment is ongoing and a new manager is to join the service. Staff expressed some concerns regarding management turnover. A document shown by the Deputy Manager indicated that 6 tenants had not been having their commissioned hours met although not by any great degree. There did not appear to be any clarity regarding these as other members of the management team said that all hours had been met so the situation remained confusing. Some difficulties with accessing two staff files as the system was not working as it should on the manager laptop. All files are held away from the premises but are online. The Operational Manager was able to use the screen of his laptop to show information, which was difficult, although the outcome was that we could see references, right to work, DBS and sufficient information to establish compliance. These documents should be more easily accessible upon request. Training matrices and information are held/provided through HIPPO which is the e-learning and management system. Baseline for compliance with the service is 95-96% for all areas. There were some shortfalls noted with Fire drills at 70%, Appraisals at 87% and Oliver McGowan training at 30%. Oliver McGowan is particularly relevant to this service type and this should be remedied.

Key Question	Applicable Regulations	Quality Statements and Comments
		One example was discussed whereby a staff member had a poor training record and was failing to comply. This resulted in the manager sending home the person without pay until the training had been completed as this made that individual an unsafe practitioner. This evidenced good practice. A learning and development policy is in place, and this is due for renewal in July 2026 Supervisions are undertaken every 3 months and appraisals annually. The staffing cadre is divided between the Team Leaders who are responsible for ensuring that these take place with oversight from the deputy and Peripatetic manager. There is a notice on the wall in the managers office which clearly outlines this. There is a supervision policy dated March 2025. The current management team are experienced, with the deputy studying for Level 4 NVQ managers aware whilst the peripatetic manger has Level 2,3 and 5 in health and social care supported by many years' experience in health and social care. Staff advise that most live locally or within easy commuting, and contact each other to support with shift changes and absence voids. On occasions, staff were observed to be sitting in isolation in rooms marked "office" on their mobile phones and other at tables in a similar fashion whilst undertaking 1:1 support. However, the tenants they were supporting were either asleep or not requiring direct intervention. On other occasions, when trying to speak with tenants, the 1:1 supports were standing over the tenant whilst talking to us, and this could be interpreted as controlling, resulting in a lack of privacy, and not providing tenants with the opportunity to speak freely. At one point the manager had to ask everyone to leave the office. **(SR9)** **Infection prevention and control –** Score 2

Key Question	Applicable Regulations	Quality Statements and Comments
		As stated previously, during walkaround there were several areas of concern in communal areas such as the kitchen and lounge areas. There was some damage in toilets behind the seats which would have allowed for bacterial development. Food items in the fridge were not labelled correctly, or at all, in some instances and although food was apparently purchased on an individual basis there was no indication of who had bought what. People with dietary intolerances could in theory have used food items not suitable for them. Cereals were in packets ripped open and these should be decanted into lidded plastic containers with the persons name on them. Cleaning schedules were poorly maintained. There was no evidence of food probe calibration although there is a policy document available dated November 2025. Staff appeared not to know where the probe was or how to use it when found. There is an infection control policy dated 13th June 2025. There was some documentation outlining allergen advice. One tenant appeared to have heavily stained upper clothing which, although was possibly a personal choice, a gentle reminder may have served to prevent any embarrassment when out in the community. An IPC quarterly audit was undertaken on 9th January 2026. We would recommend a revisit to this, as some areas inspected on the day require further intervention. The foot pedal bin in the kitchen had no lid, and was heavily stained and needed to be removed. No evidence of a food calibration probe was present, and staff member seemed uncertain where it was or what the calibration process was about. **(SR10)**

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		We asked staff about how they would manage an outbreak in the home, but the answers were confusing and uncertain, so we had to prompt and discuss about isolation and donning/doffing. The staff member was able to demonstrate handwashing techniques. One soap dispenser had no soap in it, but we were advised that they are not used anymore. **Medicines optimisation –** Score 2 The deputy manager undertakes weekly medication audits with the last entered audit completed on January 9th, 2026. This audit picked up an issue - *There was missed medication for NS on 29th December and Jan 5th. Safeguarding notification and incident report have been completed.* A photograph was taken of the MAR document which is good evidence gathering. This was evidenced in the daily notes section of the tenant's care planning documentation. Allergies were noted on the MAR seen and medicine stock was correct. Lorazepam was being used for sleep, and this was clearly identified that it was because of anxiety. Lactulose did not appear to have a PRN protocol attached. MAR folders had a section for staff sections, but I could not see any. Some MCA for medicines appeared to require reviewing. Risk assessments for the use of topical medicines were seen regarding the use of paraffin in these and fire risk. Quarterly medication audit undertaken by Quality Assurance on 15th January 2026. There was an Action Plan in place with good detail outlining the issue recognised and what needs to be done. The management team in the home have a total of 20 action points with 8 completed and 12 remain either overdue or planned. The area was rated as "inadequate". Weekly audits are being undertaken and each has an action plan and signed off. Photographic evidence is used to support the audit, and the workflow indicates what actions have been completed.

Key Question	Applicable Regulations	Quality Statements and Comments
		Where there have been issues around administration errors or stock shortfalls, these appear to have been safeguarded as necessary, and actions taken such as removing persons from medicine administration, retraining or human resource intervention. All medication audits are entered onto RADAR and available for inspection and thus transparent and open. The quality team meet monthly with managers for a day and discuss various Key Performance Indicators such as medicines. We undertook a stock check in one flat, and this was correct. Whilst there was no CD medication in the flat, it might be worth ensuring that a small lockable space is available should the needs of that person change. Each tenant has a medication profile within the Blyss system and this list medicines prescribed to that individual. There is PRN information available in both the folders held in hard copy format and in the system as explained but the information in the medical section is vague and lacks detail. For example, Paracetamol "up to 4 times a day as directed". Or Epimax moisturising cream applied as directed without stating where to apply it. This information was last reviewed in July 2025. A medication administration policy is in place dated 31st July 2025. The PRN policy appears to be overdue for re-issue which should have been on or about November 2025. We were not made aware of any covert medication plans. One tenant with specific care needs such as Chronic Obstructive Pulmonary Disease (COPD) does not appear to have a care plan in place for this. This is mentioned as a primary diagnosis in his care planning notes and as such there should be some indication of how this affects him and how best to support him with this. There are also issues around cardiology which perhaps would benefit from development in terms of care planning. There is a risk assessment for smoking on file, but this makes no mention of the effects on someone with COPD.

Key Question	Applicable Regulations	Quality Statements and Comments
		One gentleman with epilepsy does not have a list of medicines on Blyss. There is no indication of how any rescue medication should be administered if prescribed, is the epilepsy type undiagnosed or is it known, what frequency of events are occurring, is there a recording chart and so on. There is insufficient information about how epilepsy affects this person and how to recognise signs and symptoms. Medication audits undertaken by the Quality Team indicate several errors or issues which need to be addressed with several of these remaining outstanding or overdue. The home is 96% compliant on medicine competency training. • This service scored 62 (out of 100) for this area.

SRG RATING: REQUIRES IMPROVEMENT – This service does 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' 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 There is limited evidence of pre-admission assessment documentation, although care plans generally have good detail. Communication passports and planning is good, although, during the inspection we overheard commentary about people not being able to communicate, but only in respect to verbal information as opposed to considering all of those other forms of communication such as body language, gesturing. Care planning assessments are reviewed as/when things change, although some are reviewed monthly. Some tenants spoken with were able to tell us that they are involved in all their care planning or for some it wasn't that important to them. Those involved were very active and were quite assertive about what it is they felt was required for them and approached the management team regularly to voice their opinions. Many of the review planning documents have a place where others can sign as part of their contribution to the plan, but this is not obvious on the system and the plans themselves where the person does not voice their opinion are not written in the first person, which implied the tenant may be excluded from the planning process. There are exceptions to this and were that is the case, then the planning documents are detailed and feels much more alive and realistic. Some planning sections which indicate what support is required to help with decision making have no mention of family involvement even though it was pointed out that certain family members were very involved and supportive. There are several communication passports in place for people, and some of these are detailed and full of useful information.

Key Question	Regulations	Quality Statements and Comments
		PBS documentation is good and well supported by specific specialist teams. **(ER1)** **Delivering evidence-based care and treatment –** Score 3 Training compliance stands at 96% although some areas such as Oliver McGowan training requires further attention, and would benefit the care provided to some of the tenants within the service. Training is cross referenced with national guidance and legislation such as MCA. There are several documents uploaded into the system because of various contacts with external healthcare professionals, and these give an insight into care and treatment planning as advised by those professionals. Tenants are also supported to attend counselling services for anxiety, and this is evidenced both on file and from direct discussion with relevant tenants. There are also leaflets and documents uploaded to the system that relate to specific conditions which can then be printed off on request. The systems have not identified any deficits in care planning review dates and most documentation appeared to be up to date. Tenants spoken with appeared to be able to identify some of their health conditions, especially around mental health and knew about treatments and who they needed to see. Medication guide documents did not always match the mediation in the system. For example, the medication guidance document for GV said sertraline once a day but the medication on the system had no mention of this. We suggest that this issue is more about updating documentation held on Blyssful rather than any errors, but all medication guidance documents should be checked for regularity. **How staff, teams and services work together –** Score 3 One person has safety protocols in place when engaging in community activities to prevent them coming to harm from other parties. This is evidence in the planning documentation.

Key Question	Regulations	Quality Statements and Comments
		Handover notes are clearly entered onto Blyss, and these are for both days and nights containing details of that person's activities or any events which might be noteworthy. Appointments and medical communication logs are recorded in the medical history section of Blyss, and this provides useful insight into the involvement of others. Plenty of examples of collaboration with learning disability nurses, clinical psychologists, SALT interventions. Notes from MDT meetings are also available. Medical history notes are also available outlining the tenant's life medical history with intervention dates and diagnosis. GP services have reportedly improved with the changeover in practitioners. **Supporting people to live healthier lives –** Score 3 Each person has a nutritional risk assessment and an activity log which has entries from each day at various times. This evidences what that person has chosen to do or be supported in doing. This could be cooking, washing, watching television or engaging in community activities. A Nutritional risk assessment was seen for tenant with increasing weight issues, this encouraged joining a weight loss programme. However, there is no evidence that the tenant has attended, and their BMI index continues to rise. There is evidence of ongoing and regular support with this issue through network meetings, GP letters and discussions with the SALT team. The tenant is involved, and has chosen at times not to engage with some of the meetings. There is evidence through activity and daily notes online to show that tenants are leading healthy and active lifestyles with plenty of walks, community engagement and travelling around the local area. Food shopping is generally completed on an individual basis and so there are no communal food stocks, and

Key Question	Regulations	Quality Statements and Comments
		everything is bought to maintain a healthy diet although there are instances where tenants choose to eat unhealthily, and this is evidenced in individual plans. One person, however, suffers from high cholesterol, but continues to choose unhealthy eating preferences such as burgers. This needs to be emphasised with more detail within their plan. **Monitoring and improving outcomes –** Score 2 A family survey was published on 24th May 2024 and consisted of one person's feedback. This requires further development as it is too small a return for an accurate picture of how family members feel. Easy read surveys sent to tenants and published on 6th June 2023, but these were blank. There is a November 2025 You said we Did document which is vague, and it is unclear if it has relevance to the staff survey of 2023. The outcome is confusing, and would benefit from clearer definition about what is going to change and when in detail, rather than a presentation document. This was seen on the wall in the managers office. Service user surveys last on RADAR are dated for 2023. There is no survey information relating to healthcare providers. Care plans indicate that people's mental health and well-being are generally well monitored and supported. There are issues with communication where one tenant had been given a warning notice about behaviour and is apparently to leave the service. Although this person does have capacity, there does not appear to be any transition planning in place to support this person with that transition. The process is not clear in her documentation, and she is anxious about this and aspires for what she wishes to do. We were unable to see any supporting documentation that will support her through this. There are no timescales or letters from social workers although it is appreciated that this person chooses not to share communication as a matter of course. **(ER2)** **Consent to care and treatment –** Score 2

Key Question	Regulations	Quality Statements and Comments
		All tenants have a list of completed MCA and consent issues. This also indicates what the support decision is and what that person's relationship to them is also. There were limited indications of anyone except for staff members being involved with the decision-making process. There is also a lack of clarity around who has a Lasting Power of Attorney or COP in many instances with the occasional exception. One tenants plan says she is subject to COP, but this cannot be seen on her plan. During the visit, it was clear that tenants who had capacity or were prepared to engage are happy to express themselves and state their views. They said what they wished to be supported with and by whom. It was also noted in one plan that an independent mental capacity advocate referral should be made, but there was no evidence that this had been acted upon. Staff training records indicated no issues with training compliance in this area. There is a mental capacity and deprivation of liberty policy which was due for renewal in November 2025. The policy provides guidance for the decision maker, and attention should be paid to the contents of this document as there is a lack of evidence demonstrating support with decisions from other people. Support decisions are reviewed regularly, or as required, although there are one or two decisions where a best interest assessment had not been made were someone lacks capacity. Another issue noted is that of co-workers signing tenancy agreements on behalf of someone who lacks capacity. The tenancy agreement on file for DM has been signed on his behalf by a co-worker. In addition to this there was no evidence of a best interest decision being made before the tenancy agreement was signed. His MCA says that his family or advocate should be involved for any decision making and this does not appear to have happened. Additionally, there was no evidence of any COP documentation which appoints a representative for him. We would recommend that it is determined whether it is appropriate for a co-worker to sign the agreement on DMs behalf, when they have not been legally appointed to act in such a manner. **(ER3)**

Key Question	Regulations	Quality Statements and Comments
		• This service scored 66 (out of 100) for this area.

SRG RATING: GOOD - This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

"Characteristics of services the CQC would rate as' Good' People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instil a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work".

Key Question	Regulations	Quality Statements and Comments
Caring	**Regulation 9: Person-centred Care** **Regulation 10: Dignity and Respect**	**Kindness, compassion and dignity –** Score 3 There is one example within a family survey of examples of good practice being raised by family members, this was dated in 2023. There were no examples of compliments made available during the Inspection. Tenants spoken with were able to identify individual staff members with whom they had a good relationship and explained that staff treated them with respect, kindness and dignity. Interactions observed were good, and the management team were consistently approached for support and guidance by tenants and staff alike. Ther are no active complaints within the service, and all 8 recorded in the last 12 months had been closed. The language used in planning documents was generally personalised. The commentary would benefit from being written in the first-person narrative. **(CR4)** During the visit there were occasions when challenging behaviour was impacting on others in the immediate area. These were managed in line with PBS planning and resolved with patience whilst respecting the dignity of those tenants involved. Other tenants were observed to be anxious by what they had witnessed, and they were supported with those anxieties and given reassurance and space to talk about what they were directly or indirectly involved in. The impression of the interactions and relationships between the tenants and the staff was friendly and informal. **Treating people as individuals –** Score 3 Activity records and plans were detailed and comprehensive. Tenants changed these sometimes to attend other events such as the Friday party which is held in the service weekly. Some people chose not to attend and do their own things whilst others appeared to welcome the opportunity to mingle with others in a more communal setting.

Key Question	Regulations	Quality Statements and Comments
		Each person has an activity diary on the system, and this shows briefly what is happening daily subject to changes by the tenant. Several tenants have religious or cultural preferences, and these were clearly identified in their plans. One tenant wished to attend his local mosque to reignite his religious faith. The staff member supporting, whilst not Muslim themselves, wore the traditional long robe known as a Jubbo to support the tenant who also dressed appropriately to attend. Other tenants enjoyed "Arabic" dancing in line with their cultural backgrounds, whilst a number had connections to Nigeria and were enjoying some traditional Nigerian snacks which staff cooked for them and shared around. Equality and diversity policies exist and are available for staff to link into. There are no issues with equality, diversity and inclusion training and the home has met its compliance targets. Each plan identifies the person "preferred" name, and each person has an assigned keyworker. Plans also identify key goals important to that individual and for some these include watching Arsenal football club playing at the Emirates stadium and going to college. However, there has been no progress in this goal since it was set in September 2025. Other tenants have made a little progress with their own goals but overall other entries are not being made, or the goals need to be revisited. **(CR1)** **Independence, choice and control –** Score 2 There is little evidence to suggest that all tenants have a copy of their tenancy agreement, and nothing to suggest they are available is in an easy read format. MCA around the tenancy agreements is inconclusive, and evidence of support from relevant stakeholders in the decision making is not obvious. **(CR2)**

Key Question	Regulations	Quality Statements and Comments
		The support process for one tenant being asked to leave and another who is suggested should leave the placement may be inappropriate, and there is not sufficient evidence available of transition planning, MDT working or other evidence that these processes are being explored. Tenants are encouraged to make decisions and take control, although at times due to anxiety states and personal issues, there is an element of support required to help them achieve these and this includes acceptable risk taking. One tenant is encouraged to use public transport, but a staff member will sit on the bus with them in a different area of the bus, so they are not together. The staff member does not intervene unless support is called for and in line with a community protection plan which is in place and on file. Meals, routines and social activities are all encouraged and supported and these are evidenced in the planning documentation. Only one tenant has control of their own money, although others carry small amounts whilst leaving the security of their finances in the office for which the deputy and manager hold the keys. Two tenants also have their own Motability vehicles which they use to access community engagements and go to places at their choosing. Payments of these are clearly identified in their financial records in the office. One tenant clearly recognises that they need support with finances as they state within their care plan that they don't want to be exploited for their money and therefore, whilst they retain their money in a safe within the flat, they ask staff for support to access, record and ensure that it all balances correctly. As stated previously, although some plans are written in the first-person, others are not and this gives the impression that people are having things done for them rather than being enabled to do so for themselves or to make their own choices. MCA documentation needs more evidence of input from important "other" people in that person life, records only generally show staff as being part of decision-making process.

Key Question	Regulations	Quality Statements and Comments
		As mentioned earlier in the report, staff were witnessed to be overcrowding tenants during private conversations, which can be seen to remove their right to express their feelings/opinions. One tenant has hypercholesterolemia and this requires a specific plan around the management of this as the tenant choses to make unhealthy eating choices. Whilst unwise decision making is their own choice, there remains a duty of care to ensure that all avenues are explained to the tenant more clearly and conversations are documented. There is evidence to suggest that a Co-worker has signed a tenancy agreement on behalf of a tenant, and this requires attention to ensure the legality of that. **(CR3)** **Responding to people's immediate needs –** Score 3 Several incidents took place during the two-day visit, and these generally involved tenants in a high state of anxiety with behaviour that challenges. All of those concerned had comprehensive PBS plans in place and the PBS lead was present in service on the first day, and had meetings with tenants. There was detailed discussion around the plans and how these are implemented for individuals PBS documents seen had been reviewed by the in-house head of specialist support in late December 2025 and have an annual review lifespan. Whilst the PBS is linked to the relevant MCA documentation in his care plan, there is no apparent involvement from family members which is stated in the MCA that his family or advocate should be involved. One tenant made several negative statements about staff members supporting and was clearly upset and struggling to cope with the situation. The management team were patient and understanding. They offered suggestions and guidance and moved around the staff team slightly to provide exposure to a different individual and defuse the situation. The PBS specialist explained and outlined the plans for some people, and these helped to focus care interventions. Tenants were familiar with the specialist team members and appeared reassured to be having conversations with them.

Key Question	Regulations	Quality Statements and Comments
		Workforce wellbeing and enablement – Score 3 Staff spoken with felt supported by the management team both in the service and those who visit on occasions, saying “they come and say hello and have a drink with us”. During the visit, staff were in constant attendance at the office which at times felt a little overwhelming, but the managers dealt with each query in good faith and with patience including dealing with roster issues. Rota seen showed that generally the service was well staffed and both the deputy and peripatetic manager are supernumerary and can fill any shifts at short notice. Supervision planners had staff allocated to relevant Team Leaders so there was no confusion over who would be undertaking the supervision. The on-call arrangements are service wide, and several people of appropriate seniority take it in turn to be on-call, so this lessens the pressure on managers. The on-call rota was clearly displayed in the office. Staff surveys had not been undertaken during the last year. Where a survey had been conducted in 2023 the report, if aligned to the “you said, we did”, poster on the wall and on RADAR is confusing and provides little information that outlines action planning in any detail. The manager states that surveys have been completed but these have not been made available for viewing. **(CR5)** Staff mentioned that the service gave a £15 voucher last year. There were no indications that celebrations to cover different religious or cultures was recognised. There are policies which encompass equality, diversity and inclusivity and these are included in Liaise Life. However, we were unable to find this document despite accessing RADAR it being referenced throughout.

Key Question	Regulations	Quality Statements and Comments
		There had been previous issues with culture amongst the staffing team the manager advised but this had now improved, and people seemed to get along. Staff members did not express concern about feeling unsupported throughout our visit. • This service scored 70 (out of 100) for this area.
SRG RATING: GOOD - This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. **"Characteristics of services the CQC would rate as 'Good' People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity 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 3 Each plans front page has an "about me" section which gives some short signposts that provide information about how people like to be addressed, people who they like to work with, who knows them best, how to express pain and how that person likes to communicate. There are daily notes on file, and these are completed on more than one occasion during the day and night and give an insight into how the day or night has been for that person. They are signed off by staff members, and the managers have oversight of the notes. Tenants have their own diaries on file, and these demonstrate that relevant observations have been undertaken throughout the day, what activities have taken place such as leisure and recreational, and any appointments that there might be to attend such as dentists, GP and other healthcare appointments. The last tenants meeting was in October 2024, and there is no evidence to suggest that people have had an opportunity for group discussions. **(RR1)** There is ample information highlighting likes, dislikes and preferences and it is clear that tenants enjoy a varied lifestyle and have access to community services and engage in a host of different activities. Many care plans are not written in first person formatting, and this gives the wrong impression that people are being spoken for rather than speaking for themselves. Tenants we spoke with, or observed engaging with others, were constantly making decisions about what to do even if aspirational to others. Discussion was entered into around the rights and wrongs of various activities, and tenants made various commentary about what would be unacceptable risk taking for them such as drinking alcohol with medications or entering into unfamiliar areas when out and about. **Care provision, integration, and continuity –** Score 3

Key Question	Regulations	Quality Statements and Comments
		Hospital passports are held in the Blyss system and can be printed off with Medication records and contain a variety of information relevant to good care and support if accessing healthcare services as a matter of urgency including mental health, medical conditions, care and support required to make them feel less anxious. For some tenants who attend hospital, the care provided by Meridian ceases at the point of admission as commissioners generally will not pay for this support as the NHS provides qualified and trained staff. However, considering the support levels required for some tenants this approach may increase vulnerabilities for those who suffer with anxiety or behaviour that challenges. One tenant has apparently been given notice to leave the service, but there is no indication that a transition plan exists in any format or that there has been any concrete discussion held. The tenant is aware of this and is quite anxious about the situation. There is some involvement from social workers according to the tenant, but their contribution is questioned by the tenant. **(RR2)** Outcomes and instructions from healthcare appointments are clearly written in the medical history section of the plan and this details information from all appointments met in the most part, although there was an example were 3 dental appointments for the one person had been highlighted in the diary and there was no evidence of those appointments and what the outcomes were. Letters and documents from professionals are uploaded into the document section of the plan and these indicate how care provision is to be delivered and provides continuity of care in terms of treatment progressions and changes in treatment regimes. Access to appointments is without issue and there were no stated problems from tenants when discussed with them. **Providing information –** Score 3 Accessible versions of information (easy-read and large print) are available, and some tenants have Arabic as a first language, whilst this is acknowledged, there has been no need for an interpreter. An easy read complaints procedure is available in the “communal” lounge. Some tenants prefer to use whiteboard, signs and symbols, tablets or other forms of information technology as their preferred methods of communication.

Key Question	Regulations	Quality Statements and Comments
		All tenants have a communication passport as part of their care planning documentation. These appeared to be detailed. Care plans clearly highlight specific communication needs such as using Makaton, adapted Makaton and key words. The communication plans highlight the need for patience and giving tenants space to speak in their own time. There are also “where pain hurts” charts and these provide several pictures of body parts that the tenant can point to which indicates where pain is sourcing. **Listening to and involving people –** Score 2 Complaints totalled 8 in the last 12 months, and all of these had been subsequently closed. There were no live complaints at the time of the Inspection. There is a complaints policy, and this was last reviewed in July 2025. We were unable to access any of the closed complaints to view the process and documentation/workflow. Surveys, although stated as being undertaken recently, there was no evidence available to support that they have taken place, collated, action planned or feedback to relevant parties apart from one “you said, we did poster” with rather limited information as to what was happening and when. There have been 7 staff meetings from April to December 2025. The most recent staff meeting took place on 12th December 2025. There was indication of action planning follow up evident as the opening business of the meeting. The minutes suggested that there was learning from events being shared amongst the staff team with common themes being isolated such as inadequate care hours and infection control risks. Action plans were also in place to support effective learning. Incidents and support briefings are apparent in the previous meetings and the standing agenda items are useful and relevant as they provide consistency and continuity.

Key Question	Regulations	Quality Statements and Comments
		One family member spoken with said that the standard of care was “astonishing” and that members of the team put in their own time and are very skilled. The person is invited to reviews although not so much the PBS. They also stated that their relative was learning to cope better. **(RR3)** **Equity in access –** Score 3 Two tenants have their own Motability arrangements in place, and these allow for unhindered access to difficult to reach places or when time is of the essence of the task requires a vehicle to carry heavy and bulky items. Access and egress into the service requires the use of a keypad and, staff members generally control who has access to the area. The entrance is blocked by large and imposing metal barred gates. Tenants did not have access to the codes. There are policies relating to equality, diversity and inclusivity. Physical and cultural needs were catered for and specifics are clearly highlighted within the care planning documentation. Several references to cultural and religious identity are noted and there are celebrations of cultural backgrounds and diversity. There is a party every Friday in the communal area which tenants choose whether they would like to attend. This appeared quite popular during our visit on the Friday, and culturally appropriate food to Nigeria was offered around and enjoyed by all. Tenants expressed no issues with accessing the community, attending healthcare appointments or engaging generally in leisure and recreational interests both within the service and externally. Several tenants had higher staffing support ratios to enable them to access their interests safely whilst engaging locally and PBS planning added an additional depth to this. **Equity in experiences and outcomes –** Score 3 There is no indication that there are held, any demographic monitoring reports. We were unable to access complaints pro-forma and there was also no evidence to suggest that incident and complaint analysis was being undertaken with regards to tenants who may have protected characteristics.

Key Question	Regulations	Quality Statements and Comments
		Care plans were noted to tailor to cultural and social needs with photographic evidence demonstrating staff members "going that extra mile" to support tenants with attendance at religious events such as wearing clothing in custom with certain religious celebrations as a way of role modelling for tenants who was just learning to re-establish their cultural identity. Records of community engagement or consultation with diverse groups are also evidenced. **Planning for the future –** Score 2 There are several end-of-life plans in place, but most do not add any detail except to stress that staff should adhere to religious or cultural preferences. Some further detail needs to be incorporated into these although it is appreciated that the age and general health of the tenants is such that these may not be seen as a priority at this time. One plan however has a consent in place which has been signed by the tenant, and this does indicate some personal preferences around the handling of funeral arrangements. We were not made aware of any advance care plan and there does not appear to be any DNAR in place at this time. As stated previously, one person has been asked to leave the service but there is no indication of a transition plan nor concrete discussions around how this will take place. There was no supporting documentation on Blyss to clarify the position regarding this. • This service scored 67 (out of 100) for this area.
SRG RATING: GOOD – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them. **"Characteristics of services the CQC would rate as 'Good' People and communities are always at the centre of how care is planned and delivered.**		

Key Question	Regulations	Quality Statements and Comments
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 A statement of purpose was issued this month, but we were unable to view the document during the inspection. There are several staff meeting minutes available, and these demonstrate that action plans from previous meetings are followed up in the next meeting. We were unable to view a meeting planer for the year so that staff have an aide de memoir. Standing agenda items noted in the minutes as part of the process help with continuity and consistency. We were unable to view any newsletter or staff bulletins and there are none available on RADAR. There did not appear to be easily accessible service strategy information. There were no indications of tenant's meetings being held with the housing association. Induction packs for staff are available, and these are overseen by the management team, we were unable to obtain oversight of this during the Inspection. **Capable, compassionate and inclusive leaders –** Score 3 We requested a copy of the organisation structure and organogram, but this was not available. This would have been useful for tenants and staff alike to fully understand the roles and relationships of people within the organisation. **(WR1)** The last managers walkaround audit observed was in December 2025. There were no other records more recent to indicated that daily checks are being recorded and actioned except for Fire checks. During the visit, the management team were accessible, open and transparent with both staff and tenants. They demonstrated empathy and directed work tasks. Where there were incidents of behaviour

Key Question	Regulations	Quality Statements and Comments
		that challenges both managers were responsive and engaged with the process supporting both the tenant and the staff members directly involved. Staff members spoke respectfully of the management team and expressed their concerns that the current peripatetic manager was leaving, as they felt there had been a lot of turnovers in management which had led to inconsistency. **Freedom to speak up –** Score 2 A bullying and harassment policy was developed in 2022 with no set review date. The policy is vague and gives no contact numbers for employee assistance programmes or the human resources department. In all cases the policy signpost everyone to "HR". This requires firming up with a flow chart and a natural adaptation of this would be to have a "freedom to speak up" policy. **(WR2)** There is no evidence to suggest that the policy details have been actioned by staff members. Staff were slow to respond to some requests such as going to monitor the Friday party and general requests. At times it appeared to take a while in coming to fruition such as staff being willing to walk around the service to show how everything is. Staff upstairs were quiet and engrossed in mobile phones and didn't really communicate much. Staff felt that managers were approachable and they would be able to speak with them about any concerns, observation of interaction with the management team supported this. During private conversations staff stood behind the tenants, which appeared to be a little dissuasive when encouraging the tenants to speak about the service. **(WR3)** **Workforce equality, diversity and inclusion –** Score 3 Equality and diversity policies are available through RADAR.

Key Question	Regulations	Quality Statements and Comments
		Staff spoken with expressed no issues with equality and the diversity of the home appeared to add a richer cultural experience with tied into the cultural background and heritage of some tenants residing within the service. Workforce demographic data (by ethnicity, gender, disability) was not available to view although the quality manager suggested that the information my be collated within the service overall. Recruitment policies are available through RADAR. Whilst application data was available through the screen sharing of the operational manager, the information was difficult to navigate as this was being done remotely through a third person although it appeared that the basic information required was there. A second reference was added to the file of one recruited staff member which had not been included during the initial examination of the records. All personnel records are maintained remotely. There are no recent staff surveys (within the last 12 months) to view although these apparently do exist somewhere within the system so the formatting and questioning and as to whether this highlighted inclusion or diversity is yet unknown. Equality and diversity policies as with many others are referenced to Liaise Life, which we were not able to view so cannot comment on the contents of this. Training records (mandatory EDI training) indicate compliance in this area. There was some difficulty on RADAR to see the policy Liaise Life which we were told encompasses several policies. We could not find this on the system during the Inspection. **Governance, management and sustainability –** Score 2 Governance at a local level requires some attention. There was no evidence of any governance meetings held within the service and although this is a provision encompassing supported living, there are several tenants within that service who have relatively complex physical and mental health support issues.

Key Question	Regulations	Quality Statements and Comments
		Managers state that previous GP services have been poor prior to the new GP coming on board and that things are beginning to improve with their input. However, there would be benefits from having a monthly clinical/risk register meeting, that discusses issues such as mental health states, infections, challenging behaviour issues, weight loss/gain, nutrition and hydration, individual medical conditions, medicines to name but a few. This information could be entered into RADAR as part of the analysis trends to demonstrate oversight. Whilst this is a part of governance, other information as part of that governance process does not appear to be available such as commissioning visits or any statutory inspections. There are several action plans on RADAR which mentions a Service Improvement Plan (SIP) as a link within the plans, but we could not view the SIP as a stand-alone document. From a quality perspective, there are several audits planned at varying times during the calendar year. Medicines are both weekly and monthly, the system indicates that some weekly medicine audits are overdue and the auditing schedule appears to commence from around January. Finding much evidence over a rolling 12-month period was difficult. An Operations Manager medicines audit in January 2026 highlighted 20 points within the audit that required actioning of various priorities. Of the 20 identified, there are still 11 to be completed with 5 being overdue. The audit is detailed and provided clear and concise information which identifies the issues and demonstrates good oversight. The audit rated management of medicines at this audit as inadequate. Weekly audits of the laundry area are insufficient and take no account of cleaning schedules, cleanliness of the environments, usability of the area, equipment conditions. DoLS events are recorded accurately, and this highlights which applications are overdue for action and others pending. From the evidence seen, the service has made attempts to contact the Local Authority to request updates, but these are yet to be responded to.

Key Question	Regulations	Quality Statements and Comments
		Data protection and certification are available on the office wall. We had requested to see an organisational structure and/or organogram, but these were not available during the visit. Active monitoring of quality, safety, and risk do appear to be ongoing, although in some areas such as medication audits there are a number overdue. Records of regular audits and improvement actions are held within the audit scheduling on RADAR but the system itself is rather difficult to work with and finding evidence is a somewhat laborious process requiring constantly accessing and backtracking which is very time consuming and leads to evidence being overlooked potentially. Evidence of leadership responding to risks and underperformance was evidenced during the visit such as when staff member was becoming frustrated and argumentative with a tenant over the telephone in the managers office. The manager and deputy acted immediately both the Inspector, and a Team Leader advised them of what had happened. The issue was raised with the Operations Manager which was reassuring. We had a discussion with the Quality Manager about systems and processes, and it was evident that auditing and oversight where in place with action planning and information exchanges ongoing with a monthly away day to discuss organisation performances and that of individual services. **(WR4)** **Partnerships and communities –** Score 3 The service works well with local healthcare providers and there is consistency in relation to oversight of medical conditions and other health and welfare support. This is evidenced within the professional notes on Blyss and the care planning notes. Appointments are clearly identified within the diary aspect

Key Question	Regulations	Quality Statements and Comments
		of the individuals care plan, although at times appointments within the diary have no supporting evidence applied that proves an appointment took place and one example is cited earlier in this report around a visit to a dental practice. There were no healthcare providers to speak with during the visit, nor is there any evidence of a healthcare provider survey being undertaken. Many of the tenants appear to engage frequently in community-based activities whether these be leisure, recreational or educational. Access to these activities is excellent with regular bus routes, easy walking distances or other tenants who have their own Motability vehicles. Tenants make it clear how much they enjoy attending various activities and these are highlighted in their activity planners and planning documentation. Detailed PBS documentation ensures that tenants who have behaviour that challenges can still participate in community activities with decreased risk of harm to themselves and others as the plans contain good information as to when and how to react in given situations, de-escalation techniques and good communication information. **Learning, improving and innovation –** Score 3 Quality improvement plans and service improvement plans are present although we did not see a SIP, following discussions with the Quality Manager we were provided with assurance that this document exists, along with the action planning which we saw during the visit, and the information contained therein is detailed and has timelines for completion with clear and achievable objectives. Records of audits, complaints, and incident investigations are available and although we could not view the complaints log, the manager was able to provide examples during discussions.

Key Question	Regulations	Quality Statements and Comments
		Evidence of implementing learning from feedback was evidenced in 7 staff meetings seen in which there are action follow ups and standing agenda items to ensure consistency. Training matrices showing 96% compliance and the areas of non-compliance have been mentioned within this report. We were not provided with any evidence that suggest further ongoing training and development which was not of a mandatory nature. Evidence of learning from mistakes, complaints, and incidents is apparent from the perspective of incidents and learning outcomes are clearly identified on incident reporting formats. Staff were encouraged to contribute to service improvement through team meetings, supervision and appraisal. The audit schedule list on RADAR highlighted audits being undertaken at various periods and we able to view audits on a weekly basis for finances, some medication audits, out of hours visits, Ops manager quarterly visits an IPC quarterly audit and several others. Some targets for audits had been missed such as weekly medication audits, but the medicine audits completed by the Ops manager/delegated person was detailed and identified clear action planning. A number of these remained outstanding. **Environmental sustainability – sustainable development –** Score 2 The service has an Environmental Policy which was developed in 2022. The policy encourages staff and tenants alike to consider environmental impact as part of daily living. Waste recycling is undertaken in line with local authority waste disposal requirements. There is no evidence seen to support tenants engaging in recycling or environmental activities. **(WR5)** • This service scored 62 (out of 100) for this area.

Key Question	Regulations	Quality Statements and Comments
SRG RATING: REQUIRES IMPROVEMENT - This service does 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' 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	Evidence closure of outstanding incident investigation	Show updates for each incident and focus on closure of overdue incidents.					

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR2	Pre-admission and admission documentation should be available for analysis and auditing	Upload pre-admission and admission documentation into Blyssful or Nourish when it comes on-line					
SR3	Harvest view and opinions for healthcare professionals	Send out a survey to relevant professionals seeking feedback to demonstrate learning and development					
SR4	Clarify safeguarding referral thresholds with various commissioning authorities	Contact commissioners and ask for most up to date safeguarding policies from each and keep a hard copy					
SR5	Safeguarding reporting needs to be more accessible for tenants.	Easy reading documents to be provided to each tenant that demonstrates how to report concerns.					
SR6	More tenants to have direct control of their personal finances.	Meet with tenants and or their families to discuss financial control and how more autonomy can be safely given to tenants so that they have more meaningful control over their personal monies. Care plans to emphasis MCA around these. Explore policy documents around this.					
SR7	Appointment details to be entered into care planning documents.	Check appointments made have been met and what outcomes there are.					
SR8	Tenants have more room to express themselves freely.	Unless requested by tenant or required according to the care plan, tenants should be given the opportunity to speak without hinderance by the presence of staff standing over them during what should be private conversations.					

CQC Key Question - SAFE **By safe, we mean people are protected from abuse and avoidable harm.**							
SR9	Environments should be conducive to comfortable living and if a communal area should be clean.	Kitchenette is dirty and tired, would benefit from a replacement although white goods appear to be okay. Communal areas, if that is what tenants want, should be clean, decorated (water stains and marks removed) and furnished in such a way as to make the experience a good one.					
SR10	Reduce the risk of IPC issues	Deep cleaning would be suggested in communal area and all rubbish removed from other rooms such as maintenance rooms and other unused rooms. Purchasing a skip would be a good start					

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 admission documentation is uploaded and used as the basis for care planning and support needs	Upload the relevant documents and cross reference in planning					
ER2	More effective communication and fact finding required from all associated with the service. This will help with improvements and planning.	Send out surveys and record outcomes. Provide all tenants and staff with the relevant "you said, we did" format although these need to be clearer in what they are saying. The current poster has no reference to anything concrete.					
ER3	The decision-making process which requires MCA and consent need to demonstrate more involvement from significant others.	MCA and consent documents on Blyssful need to show greater involvement from others. All forms seen have very little evidence that family members have been consulted					

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	Tenants have goals and objectives in their plans but progress seems to be limited over fairly long periods of time.	Keyworkers should be concentrating on the goals and objectives for people in their plans. I think 30% was about the maximum achievement from all goals seen.					
CR2	Tenants generally do not have a copy of their Tenancy agreement.	Speak with housing association.					
CR3	Some concern around who is signing on behalf of tenants and do they have the legal authority to do so.	Check out "Co-worker" and signature mentioned within the report.					
CR4	Care planning narratives	Try to ensure that planning narratives are in the first-person as this removes the feeling of having things provided rather than people making choices and decisions.					
CR5	Staff surveys to be completed	Undertake sweep of staffing to ascertain feelings with regards to ED&I and other operational issues.					

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	Tenants' meetings to be held	Speak with tenants as the housing association presumably hold tenants meetings and so the opportunity	Management Team				

		should be available for tenants to attend.					
RR2	Transition plans to be formalised	Ensure that all records relating to the process of serving notice and support whilst this is happening are uploaded onto file to show that due process has been followed and that the tenant continues to receive support to make that transition.	Managment Team				
RR3	Harvest information from all sources and demonstrate learning.	Perhaps produce a monthly newsletter for staff and tenants in appropriate formatting to exchange information as tenants don't appear to be aware of organizational change or strategy.	Management Team				

CQC Key Question - WELL-LED

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

Reference Point	Recommendation Made	Action to be taken	Who By	Date to Complete by	Evidence of Completion	RAG Status	Comment
WR1	Understanding roles of people within the organisation better.	Make available organigram.	Management Team				

WR2	Bullying and harassment policy documentation firming up.	Review this policy to support staff in being equipped to speak up.	Management Team				
WR3	Tenants should be able to speak without being overheard.	Provide tenants with more personal space for private discussion with others.	Team Leaders				
WR4	Improve evidence of local governance oversight.	Hold monthly governance meeting for this service and discuss in greater detail audit action plans and delegate tasks. Demonstrate evidence of clinical risk management. Introduce a policy of the month and use stop and tell to check for embedding.	Management Team				
WR5	Contribution to environmental sustainability	Perhaps introduce an educational session for tenants to be aware of waste management and environmental footprints.	All				