Location:					**Provider:**			
Overview of Service:	• • •							
Overview of quality intelligence	CQC			Reported areas of concern	• • •			
	Quality Compass							
	Inclusion Glos							
Quality Reviewer completing form and job role:				**Provider Contact facilitating Quality Assessment and Job Role:**				
Other Service staff who contributed to assessment:				**Service Users who contributed to assessment:**				
Date initial evidence requested:				**Date of Quality Appointment:**				
Date action plan sent:				**Predicted completion date:**				
Areas of assessment	The home and environment		Rota and Staff support/Management presence		Behaviour, Incidents and deterioration			
	Closed cultures		Capacity and restriction, DOLS and MCA		Daily activities, routines, and personalised support			
	Health, Deteriorating health, working with medical professionals		Medication		Audits			
Action plan key:	Unless otherwise stipulated: Red actions – evidence to be provided within 1 week Amber actions – evidence to be provided within 4 weeks Green actions – evidence to be provided within 6 weeks							

The home and environment	
What we look at	**What we expect to see**
- *welcome and visual inspection* - *evidence of IPC/PPE protocols* - *access and restrictions* - *is the home and garden safe and well maintained?* - *(SL) tenancy agreements and arrangements. Consider who provides accommodation and support.* - *service users consultation* - *appropriate certification, such as employment liability*	• ID is checked • A record is kept of any visitors should this be appropriate at the location. • IPC/PPE processes are followed in line with COVID guidance - cleaning schedules are in place, Visitors policy in place and restrictions are minimised, health questionnaires and testing regimes are completed as advised. • The home is safe, clean and free from hazard, and appears welcoming and homely according to the individuals. • There are sufficient toilets/sinks/bathrooms for the size and purpose of the service. • Appropriate fire equipment for the location e.g. extinguisher, fire blanket, tested and working fire alarms. • The environment meets the physical, sensory, and therapeutic needs of the individuals. • Décor is well presented and in good state of repair. Any issues are addressed via maintenance process. Evidence shows that individuals are involved in décor choices in both private and communal areas. • Individuals have full access to the property, and any restrictions imposed are fully supported by MCA/Best interest/DoLS processes as appropriate. Door are unlocked, keys provided to allow free access where possible. Garden in good state and accessible. Food, drink, and healthy snacks are accessible. • (SL) Tenancy agreements are supplied in an accessible format (easy read or alternative). Provider has considered how individuals are supported to agree, the service charge is fair, and there are no unfair restrictions and notice periods. Utilities are fair and appropriately managed. Agreement for 5 yearly redecorations in place. Where possible, provider and landlord should be separate entities to allow the individual to move and keep the same provider, or stay and change provider. • There is regular consultation and individuals are involved in decision making where possible and appropriate. House meetings take place. (SL) Individuals' are consulted when an individual moves in, and compatibility is considered. • Employer's liability £10m Public Liability £5m, Professional Liability or Indemnity £2m. Contents insurance has been discussed with tenants where required
Any actions:	
Evidenced requested:	

Rota and Staff support/Management presence	
What we look at	**What we expect to see**
- *Rotas and overview of staffing and service requirements.* - *(forensic/complex) adjustments to working conditions.* - *Management/ senior staff presence including weekends* - *On-call system in place* - *(SL) ECM data* - *Team meetings records* - *supervisions and appraisals records* - *staff training matrix* - *policies and procedures library* - *Sample of recruitment, induction and probation paperwork*	• There is a senior/experienced member of staff on each shift and evidence of good managerial presence at the service. Managers are knowledgeable about individuals at the location. • Rotas are created a minimum of 4 weeks in advance. There are adequate staff to keep people safe and/or in line with commissioned support. Rotas are in an accessible format for people supported. Rota is well balanced with skill level, male and female staff etc (as appropriate to the needs of the service). Rotas are skill matched to individuals. (SL) Individuals choose their support times and support staff. • Staff turnover is low and exit interviews are completed. Agency used at a minimum, with continuity - same staff used where possible. Evidence of agency induction/ checklist of service. • There are no concerns regarding days/hours worked without a break (or evidence of agreement to opt out of WTR). Staff are well supported and appropriately trained. Risk of 'burnout' is minimal. • (Forensic and Complex needs) The complexity of needs at the service is reflected in the hourly rate, length of shift, and annual leave entitlement of the staff team. Rotas allow for longer handovers, and there is increased managerial presence and supervisions. • On call are available and responsive. On call have experience and understanding of service to offer appropriate support and guidance. On call contact is recorded and actions are followed through. • (SL) ECM used with only 10% and under of remote/ software logs. Visits have not been missed. • Team meetings are held frequently and capture relevant issues. Actions are taken and all staff have read minutes. Where appropriate, communication books are well utilised with appropriate information, and handovers are completed. • Staff receive a minimum of 4 supervisions per year and an annual appraisal. Processes are constructive. Issues are brought forward, CPD is encouraged, poor practise is challenged, actions are created and reviewed. Supervisors should be trained. • Training matrix should be clear and well populated with method of training and period of renewal stated. All mandatory training is identified. There is additional training relevant to role, service, and specific need. Training is in date. Competency observations completed. Continual Professional Development is encouraged. Care certificates have been completed Core and mandatory training (skillsforcare.org.uk) Where applicable due to support required and size of staff team, individuals staff have training specialisms. There are dignity champions. • (Forensic) training and knowledge of the criminal justice system, public protection, and ensure compliance with relevant legislation and guidance (Mental Health Act, Sexual Offences Act, MAPPA, MARAC, PREVENT etc) • Policies are in place and staff have access to policies and procedures at all times • Interview questions are appropriate, recruitments checks are completed. Visa and right to work paperwork is in place. References are verified for authenticity. Satisfactory DBS check completed. Where there is a disclosure, information should be gathered and a risk assessment complete. Individuals are actively involved in recruitment.

	• Staff handbook in place. Induction to service with evidence of shadow shifts. Evidence that staff have read and understood policies and procedures of the service. Buddy/ Mentor system for new starters. Staff do not commence working in the location until all adequate checks are completed. • Processes as set out in the framework are followed regarding suspension of services due to planned and unplanned absences, hospitalisations, and psychiatric admissions
Any actions:	
Evidenced requested:	

Behaviour, Incidents and deterioration	
What we look at	**What we expect to see**
- *staff have undertaken relevant training* - *how PBS is used and how risks are reduced* - *quality of recording and reporting* - *how/when are professionals involved* - *safeguarding log – nature and frequency* - *(ATU) seclusion/segregation* - *staff knowledge of whistleblowing, safeguarding, and PBS.*	• Staff are trained in safeguarding levels 1-3 as appropriate to role. Staff are trained in proactive and least restrictive approaches (to only use training in restrictive practices that is certified as complying with the Restraint Reduction Network training standards from April 2021) The Restraint Reduction Network Training Standards - Restraint Reduction Network • Individuals have a PBS plan, in date and clear to follow with a focus on preventative strategies. Created from a functional analysis. Reactive strategies should follow a gradient approach. PBS plan is reflected in Risk assessment documents and support plans. Where possible, individuals co created their PBS plan. • Advice is sought from CLDT, LDISS, PBS team PBS clinic or others as required. Advice given is followed. • (Forensic) Risks to the individual, general public and others are well managed. Offending behaviour is reduced and where possible admission to secure care is avoided. Compliance with any Ministry of Justice restrictions (such as exclusion zones or conditions under a section 17(a) Mental Health Act 1983 community treatment order) and in addition, is required to increase its monitoring of care plans and risk assessments, promptly liaise with the relevant Purchaser to identify any breaches of conditions and proactively / creatively support positive risk taking within a structured care planning / risk assessment framework. • The report provides evidence of the assessment having been conducted in a manner consistent with the Mental Capacity Act • (Complex), staff are trained in PBM. Used as a last resort and reported appropriately. • There are no punitive responses to the behaviour of individuals • Incidents are responded to appropriately. Incidents are clearly recorded. Adult help desk and/or GSAB, CQC, DBS, police are informed in a timely manner as applicable • Incident forms and ABC forms are used effectively. Incidents are analysed for triggers, patterns and learning curves and plans are adapted as a result. • Incidents have evidence of a debrief for staff and individuals • (ATU) seclusion/segregation – process in place and used appropriately - types, records, MDT agreement sought,

	who are where are reports sent • Staff demonstrate good understanding of PBS at the service. • Safeguarding is transparent, reported appropriately. All staff to be aware of the escalation process/ how to raise and report a safeguarding/whistleblow • Designated Safeguarding and Deputy Safeguarding Officers are present in the organisation. • There is a clear safeguarding process, where possible this is available in an easy read format.
Any actions:	
Evidenced requested:	

Closed cultures	
What we look at	**What we expect to see**
- *Professional boundaries - overview of service dynamics, rotas and training* - *how is independence and inclusion promoted?* - *how is dignity and respect promoted?* - *explore compliments and complaints* - *explore safeguarding* - *team meeting records and communication book entries* - *whistleblowing processes*	• Management and staffing is stable. Managers are knowledgeable and present. • Professional boundaries are maintained. Consideration regarding family members working at the same service. • minimal reliance on support i.e. Doing with (not doing for or doing to) can be seen • Relevant mandatory training, including Care certificate, equality and diversity, and Dignity and respect training during induction period. • Complaints procedure is accessible to staff and service users in the location in an accessible formal (easy read or alternative). • A record of compliments and complaints is held. Complaints have been acted upon accordingly. They have been responded to swiftly, with thorough investigation and actions taken as a result have been appropriate to the nature of the complaint. Lessons are learnt. • Appropriate reporting of Safeguarding. No punitive response to individuals. • Whistleblowing policy is readily available and staff feel confident to whistle blow should it be required. Duty of Candour. Open and transparent culture. Anonymity is protected. • Feedback on service delivery is sought from a variety of sources, analysed and actioned. Positive working relationships with stakeholders.
Any actions:	
Evidenced requested:	

Capacity and restriction, DOLS and MCA	
What we look at	**What we expect to see**
- *MCA and DoLS processes.* - *consider any restrictions imposed* - *record keeping and review* - *access to advocacy* - *staff understand the principles involved.* - *(forensic) security*	• Capacity is always assumed. Independence, freedoms and positive risk taking is promoted. Mental capacity assessments evidenced - MCA1 and 2 and details outcome achieved. Appropriate and number of people evidenced as undertaking assessment, (min of 2). MCA reviewed annually. MDT involvements. • Any additional restrictions pertaining to COVID 19 are sufficiently explored (vaccination, self isolation) • Record kept of Best Interest meetings held. • Restrictions are prevented altogether or are minimal, reasonable and appropriate. Reasonable adjustments to environment, advice sought. Restrictions are not punitive to behaviours exhibited. • Where in place, DoLS are authorised. MDT involvement is reflected. DoLS conditions are well considered. Reviewed annually. Impact on others considered. (RES - ADASS application, outcomes and conditions. (SL – discussions with SW etc court of protection application if required). • MCA and DoLS decisions are reflected in related support plans and risk assessments (e.g. covert medication administration, DOSH involvement, appointeeship). • Individuals have accessible (easy read or alternative) information regarding advocacy services and are supported to access services where required. • MCA and DoLS training is undertaken; level of training undertaken is relevant to role. • (forensic) Security measures are the least restrictive without over reliance on physical security, whilst ensuring safety of the public and others. Procedures are clear. • (ATU) access to S17 leave, legal support, powers of the nearest relative, decisions when not MH related when capacity is doubted, last MH act Tribunal- yearly to review the persons section. Managers meeting 6 monthly to review section status. Monthly rights read to a person if staying in hospital, contest a section, regular MDT, access to IMHA, accessible format
Any actions:	
Evidenced requested:	

Daily activities and routines and personalised support	
What we look at	**What we expect to see**
- *Daily routines and choices* - *Support plans and risk assessments* - *Activities and planning* - *Healthy lifestyles, meal choices and planning*	• Rota indicates adequate staffing to meet support needs. There is flexibility in how support hours are used and rota planning to best support the individual • Support plans are person centred. Individuals, family and professionals are involved in support planning. They are accessible to the individual (e.g. easy read, pictoral, braille). Routines, structure and consistency are in place for those who benefit from this approach. (MH) The support is structured in a way which reflects a recovery focused model.

- *Communication needs are met* - *How is contact with friends/family being maintained? Consider COVID status.* - *How are independent living skills promoted?* - *Consultation* - *How is community inclusion and social value promoted?* - *Transitions*	• Activities are varied and are relevant to individual interest. Refusals documented and alternatives are offered. Choices are given in a suitable format and new experiences are encouraged. Activity planners are in place and frequently reviewed with the individuals. Individuals are supported to go on holiday if they wish to do so. Activity coordinators may be in place. Where possible or appropriate there is a designated in house activity area with planned activities. • Individuals can get up/go to bed and have meals when they want to. Individuals are supported to make choices about their clothing and appearance. How an individual is supported to access and understand their mail is documented. • A balanced, service specific, individualised approach is taken to policy and risk assessing. Capacity is considered, supported by relevant paperwork. The least restrictive approaches are considered. Risks to the individual, general public and others are well managed. • Healthy eating is encouraged. SALT and dietary guidelines are adhered to. Individuals are involved in meal planning. Individuals are encouraged to be active and partake in exercise in the service and the community. • Daily logs are accurate, legible and stored securely. They provide a good overall picture of an individuals day and demonstrate choices offered, progress towards goals, along with personal care given or meal and medication support. • Communication profiles are in place and followed by staff. Staff are trained as relevant to need e.g. Makaton, sensory impairment, Intensive Interaction. Assistive technologies in place are understood by staff and use is promoted. • Contact with friends and family is maintained and relationships are fostered, and different methods of contact are utilised where needed. Gatherings and parties are encouraged. How an individual is supported to access emails and house/personal phone is documented, and privacy is encouraged where possible. There is a COVID 19 visitors policy and risk assessment in place and in line with government guidance. All measures are taken to safely facilitate visitation both within and outside of the service in line with latest guidance. No unnecessary restrictions are imposed. Individuals have privacy and are supported to engage safely in relationships. • Individuals are encouraged to be independent in the service and in the community. Positive risk taking is encouraged. Washing and cooking facilities should be accessible and risk assessed. • Individuals are consulted with via keyworker and house meetings. Goals and wishes are pursued and reviewed. Goals are broken into small achievable steps. • Individuals are encouraged to be part of the community. Individuals have access to vehicles and/or bus passes as relevant to need and service. Individuals access a range of local groups. • Individuals are encouraged to pursue employment, volunteering and training opportunities. • (Forensic) individuals will be supported to integrate safely into the local community and achieve a sustainable, socially included lifestyle through new opportunities and experiences, which assists in reducing the individuals risk profile. Individuals are supported to follow CTOs. • Transitions are well planned for through care and support pathways.

Any actions:	
Evidenced requested:	

Health, Deteriorating health, working with medical professionals	
What we look at	**What we expect to see**
- *Training* - *Health records – appointments records, Annual Health Check records, health screening, Health Action Plans,* - *signs of any deterioration and monitoring in place* - *input of CLDT, LDISS, IHOT* - *(Forensic) Recovery support and crisis planning* - *planning and processes for hospital admission and discharge.* - *Appropriate use of DNACPR* - *Appropriate life planning* - *Suitability of equipment and environment* - *Knowledge of COVID 19 risk factors*	• Staff receive appropriate training to support specific heath needs at the service (i.e. rescue medications, injections, epilepsy, diabetes, schizophrenia, addiction, dementia etc.) RESTORE2 training encouraged in all services. • Individual is supported with regular health consultations including AHC's, as appropriate to need. Outcomes of AHC's are recorded and monitored. STOMP (psychotropic medication) is frequently reviewed with a view to reduction. Good oral health is promoted. • Appointments are clearly recorded and logs identify provider has been proactive in supporting health needs, • HAP contains all relevant information to acknowledge and maintain service user health, including actions required and a record of professionals involved. • HAP and specific support plans are frequently reviewed in consultation with health professionals. Support plans are reflective of needs identified in HAP. • Records kept are relevant to need and signs of any deterioration are monitored and acted upon swiftly (weights, fluid, bowel, behaviour, seizure activity, skin integrity etc) • Appropriate and timely professional involvement is sought - Behaviour, mental health, physical health, CLDT input, LDISS, IHOT, GHC, MH professionals. Records are kept of meetings and outcomes are actioned. • (Forensic) any outcomes set focus on mental health recovery, drug/alcohol dependence recovery, stopping/reducing undesirable behaviours, and better understanding of conditions in order to make life plans and stay physically and mentally healthy. • (Forensic) A crisis plan must be in place in consultation with relevant professionals and include how to recognise signs of crisis or relapse and prevention techniques. It should be regularly reviewed. • Hospital passport (My Health Passport) in place, is relevant and reviewed. • If DNACPR in place, it followed a process including MCA / BI and appropriate professionals / advocacy • Where hospitalised, appropriate admission / discharge from hospital including discharge planning and updated support docs • Use of purple ReSPECT forms and consideration of wants and wishes. If in place, followed a process including MCA / BI and appropriate health professionals / advocacy • staff demonstrate knowledge of contributing factors to increased risk of COVID 19 eg epilepsy, mobility needs, LD, symptoms can be masked such as coughing.
Any actions:	
Evidenced requested:	

Medication	
What we look at	**What we expect to see**
- *Medication profiles* - *Review of MARs and medications* - *Audits and records of investigations* - *Medication policies and protocols (rescue medication, PRNs, invasive procedures, insulin management, returns, disposals etc)* - *Read and signs and staff signature list* - *Training and competency record* - *Homely remedy consent forms* - *Annual medication review* - *Controlled drugs, returns meds logs.*	• Clear profiles for individualised administration. Covert pathways are clearly identified and supported by MCA and best interest paperwork and appropriate health professionals. • When meds are supported by staff: Medications are in date, ordered appropriately, signed in, stored securely in a locked cabinet and temperatures are checked daily if necessary. Patient information leaflets are available. Keys/codes are stored securely. Topical and oral meds are kept separately. • MAR is printed, clear, all fields are complete, and key is followed. Double signatures identify changes and handwritten entries, there are clear systems for daily counting. Process for social leave such as signing out sheet. • Errors are minimal. Audits are completed monthly at a minimum. All errors are recorded and sufficiently investigated. Lessons are learnt with efforts made to improve systems as required. Refusals are responded to. • Policy and protocols are clear, relevant and in line with national guidance (NICE). PRNs are used minimally. Location specific policies and risk assessments may include; invasive medication technique, insulin protocols for high low and training, safe practise with harmful/dangerous items (eg oxygen, paraffin based) and rescue medications. • All staff administering medications to have read policies and a record is kept of all staff signatures with MAR file. • Staff have completed safe handling of medication training and training is in date. All trained staff are checked for competency with theory and practical assessments. Competency is checked 6 monthly. Sufficient staff (core team as minimum) have completed training for individual needs such as insulin and rescue medication training. • Homely remedy list in place and signed by a GP or a pharmacist • Evidence of annual medication review and any correspondence/rationale concerning changes to drug regimes. Regular blood work for lithium, clozapine etc. STOMP (psychotropic medication) is reviewed. • Controlled drug book and returns book in place. Returned meds to be locked until return. • There are systems in place to enable individuals to manage medications as self-sufficiently as possible. Self-medication pathways should be reviewed regularly.
Any actions:	
Evidenced requested:	

Audits	
What we look at	**What we expect to see**
- Finances (including petty cash and shared monies) - File audits - Health, safety and the environment - Fire safety - Safeguarding log	• Financial systems in place are supported in risk assessments and support plans. Appointee, MCA and Best interest decisions are reflected as necessary, and the least restrictive approach is used. Where monies are held, balance checks are completed daily by 2 staff. There should be a clear audit trail for income and expenditure and linked receipts. Monies should be stored in a locked safe, ideally in the individuals bedroom. Audits should take place weekly/monthly and consider all the above, along with whether spending is fair and appropriate, including shared expenditure. All discrepancies are investigated and measures taken to prevent reoccurrence. • Service user and staff files should be reviewed annually to ensure contents are relevant, up to date, and well ordered. Daily records should be audited monthly to ensure individuals are receiving support in line with their funding, support plans, and goals and capturing a reflection and a good overall picture of an individuals day • All measures are taken surrounding equipment and environment to ensure service is safe. Environmental risk assessments are in place and reviewed annually. M&H equipment is checked. Vehicles are checked, along with mileage records. Cleaning schedules are in place, well populated, and identify frequency and nature of task. Enhanced IPC recommendations in relation to COVID 19 are followed. Health and safety audits are completed monthly. All identified issues are addressed through an action plan. Risks are minimised. Lessons are learnt (RES – weekly water flushes, water temps, legionnaires) Certificates are in date - PAT (annual), gas safety (annual), electrical wiring (5 years), vehicle insurance (annual). • Fire risk assessment in place, relevant and reviewed. Evacuation plan is clear to follow. Fire drills take place and a record is kept with actions taken where required. Equipment is tested and placed appropriately. Carbon monoxide indicator in place. Exits are free from obstruction. PEEPS in place and reviewed. Adaptions are made as required to equipment to support those with sensory needs or impairments. • Incidents are responded to appropriately. Incidents are clearly recorded. Adult help desk, GSAB, and/or CQC and police are informed in a timely manner. • Business continuity plan including Information management and data security, event of a flood, power cut, gas leak, pandemic etc although not an exhaustive list. • Fire drills involve difference scenarios (staffing, time of day). A designated fire officer in place. • There is oversight/analysis of auditing systems to ensure systems are working effectively. Where possible and appropriate, there are cross service quality audit systems in place, such as service user auditing.
Any actions:	
Evidenced requested:	

	Anything additional
-Details of discussion	
Any actions:	
Evidenced requested:	

Date published and sent to provider	
Action plan progress visit date	