Quality Assessment Compliance Guide

Senior Responsible Officer:	Lara Gillman, Senior Commissioning Manager, Integrated Adults Commissioning Hub		
Lead Author	Jess Breeden, Quality Investigations Officer, Disabilities Quality Assurance Team		
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Contents

Introduction

Purpose of the quality assessment compliance guide:

- The guide has been developed by the Gloucestershire County Council Integrated Commissioning team in partnership with experts by experience, health and social care colleagues, and local care providers (see Appendix 1 – list of contributors).
- The guide has been created to give direction to both Assessors and Providers during the Quality Assessment Process. Quality visits are conducted using the Provider Assessment and Market Management Solutions (PAMMS) QA module. More information on the tool and how visits are conducted can be found on the Disability Quality Assurance Team web page. A full provider guide is supplied ahead of any quality visit.
- The guide aims to clarify what good practice looks like, ensuring that this is in line with framework agreements, legislation and regulation where possible. It has considered the differences between care settings and sets out expectations accordingly.
- The guide aims to ensure consistent quality of care delivery amongst care providers, as well as consistency in how assessments are completed by the Quality Assurance team.
- The guide is publicly available on the GCC website and will be regularly updated in line to changes in the care sector and/or assessment process.
- The guide has been set out into 7 compliance areas for easy reference. Please note that there will be some natural overlap and therefore repetition between areas due the nature of the content.

Key terminology and codes used:

ALL services	Includes day services, respite services, supporting living, residential care and all need categories.	**CHC**	Continuing Healthcare
CLDT	Community Learning Disability Team	**CPD**	Continuing Professional Development
CQC	Care Quality Commission	**DNACPR**	Do not attempt Cardiopulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards	**ECM**	Electronic Call Monitoring

FORENSIC	Forensic mental health care services	**GSAB**	Gloucestershire Safeguarding Adults Board
IHOT	Intensive Hospital Outreach Team	**IPC**	Infection Prevention Control
KLOE	Key Lines of Enquiry (CQC)	**LD**	Learning Disability
LDISS	Learning Disability Intensive Support Service	**MAR**	Medication Administration Record
MCA	Mental Capacity Assessment	**MDT**	Multi-Disciplinary Team
MH	Mental Health	**MUST**	Malnutrition Universal Screening Tool
NEWS2	National Early Warning Score Tool	**NICE**	National Institute for Health and Care Excellence
PBS	Positive Behaviour Support	**PEEP**	Personal Emergency Evacuation Plan
PPE	Personal Protective Equipment	**PRN**	'As required' medication
RES	Residential service	**ReSPECT**	Recommended Summary Plan for Emergency Care and Treatment
RESTORE2	Recognising early soft signs, take observations, respond, escalate Tool	**SBARD**	Situation, background, Assessment, Recommendation Tool
SL	Supported Living service	**STOMP**	Stopping over medication of people with a learning disability, autism (or both) using psychotropic medication

Compliance Areas:
Section 1 - Daily Support

Applies to	Support Planning	PAMMS standard
All	• Support plans are person centred. Likes and dislikes are clear. Pertinent historical information is referenced. • Plans are non-discriminatory, and are tailored to individuals' preferences and identity e.g. religious beliefs or sexual orientation. • Individuals, family, and the right professionals are involved in support planning. Information is shared appropriately with professionals and family. • Support plans are accessible to the individual where possible and using communication guidelines (e.g., easy read, pictorial, braille). • Minimal reliance on support i.e., Doing with (not doing for or doing to) can be seen. • 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 are readily accessible and charged. Aids are understood by staff and use is promoted. Communication books, objects of reference or equivalent are accessible and personalised. • Transitions are well planned for through care and support pathways. • It is clearly documented where other care providers or stakeholders are involved, what their remits are, how information is effectively and appropriately shared, and that collaborative working is encouraged e.g., between the care provider and a day service, educator, regular health service (such as dialysis) or employer. • They are often reviewed and seen by the staff team (read and signs) and signed by the individuals where appropriate. • Routines, structure, and consistency are in place for those who benefit from this approach. • One page 'snapshot' in place. Pertinent information such as allergies, PBS, or medical conditions are clearly highlighted. • 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. Individuals get the support they are supposed to.	**3**

Forensic	• Support is structured in a way which reflects a recovery focused model. • Individuals are supported to follow Community Treatment Orders.	**3**
Exceeding compliance	• Provider can show they have gone the extra mile to create a personalised approach to support planning e.g. video support plans, use of talking matts	**3**
Applies to	**Activities**	PAMMS standard
All	• Activities are varied and are relevant to individual interest. • Choices are given in a suitable format. • Participation is encouraged appropriately. Refusals are documented and alternatives are offered. Individuals are given the opportunity to opt out of activities. • Individuals are supported to engage in sensory activities. A range of resources are available within the service. • New experiences are encouraged with positive risk taking considered. • Activity planners are in place and frequently reviewed with the individuals. • Charges for activities are appropriately managed. • Individuals have access to vehicles and/or bus passes as relevant to need and service. • A missing person protocol/profile is in place including a photo of the individual, key information, and actions to take, if right for individuals.	**1**
Res, SL	• Activity coordinators may be in place (larger services). • Where possible or appropriate there is a designated in-house activity area with planned activities. • Individuals can access a range of local groups.	**1**
Res, SL, Forensic	• Individuals are supported to go on holiday if they wish to do so. • Individuals are encouraged to access activities during evenings and weekends and are encouraged to socialise. E.g. pub trips, attending discos, theatres, cinema, themed nights and gigs. • Provider is aware of or accesses local services that can offer support e.g. Gloucestershire Gig Buddies • Independent living is encouraged, and development of daily living skills are promoted in both the home and the community.	**1**

Exceeding compliance	• Providers champion interests and needs, considering positive risk taking and advocating for involvement. • Activities are bespoke to the service and individual needs and available 24/7. • Alternative in house and external options are sourced where individuals like an activity, but do not wish to engage in groups. Sufficient time is allowed for activities to be enriching. Individuals with lived experience describe this as having activities that feed the soul. • Provider seeks community involvement in in house activities – festivals and fetes etc. • Education opportunities are promoted.	**1**
Applies to	**Respect and Inclusion**	PAMMS Standard
All	• Staff are seen to be interacting with individuals in a positive, respectful, and non-discriminatory manner. Staff are LGBTQI aware. • Dignity and respect is maintained through all support tasks. Staff explain what they are doing prior to and during tasks. • Assumptions are not made about an individual based on appearance, condition, lifestyle choice or otherwise. Individuals are not infantilised. People are treated as individuals and labels are not used. • Staff are seen offering choice appropriately i.e. tailored to individual interests, following their communication style, and time is given for a response. • Dignity champions may be in place (larger services). • Faith and individual cultural needs are respected and followed. Provider considers adjustments required to meet cultural needs in all environments and supports individual to to an active member of their faith community. • Community inclusion and social value is promoted. Individuals are encouraged to be independent in the service and in the community through robust risk assessments and independence training. • Individuals are encouraged to pursue employment, volunteering, and training opportunities. • Positive risk taking is encouraged. Appropriate equipment should be in place. Obstacles to community access should be explored. • There is a hate crime policy, staff understand hate crime and how to report experiences of hate crime.	**1**
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.	**1**

Exceeding compliance	• Individuals with lived experience describe best practice as seeing that staff really care about the individual through observation, discussion and action. Staff advocate and challenge when necessary. Support is not generalised to the service, and staff respect individuals' adulthood and specific preferences and ensure this is reflected in communication approaches.	**1**
Applies to	**Risk**	PAMMS standard
All	• A balanced, service specific, individualised approach is taken to policy and risk assessing. • Risk assessments are signed by staff and reviewed annually as a minimum, or as needs change. Review measures and what has changed need to be clear. • Actions are in place to minimise all identified risks. • There is a clarity and consistency between needs, risk and capacity documents. Where mental capacity is considered, it is supported by relevant paperwork and processes (see MCA section). • Positive risk taking is always encouraged and the least restrictive approaches are considered. • Risks to the individual, public and others are well managed.	**3**
Exceeding Compliance	• Provider takes a proactive approach to risk management, considering future risks that may present and planning for them well, based on knowledge of the individual, service and market.	**3, 16**
Applies to	**Choice**	PAMMS standard
All	• Sufficient time is given for daily choices to be offered and decisions to be made, with all communication styles and aids in place. • Goals and wishes are pursued and reviewed. Goals are broken into small achievable steps and are created in appropriate formats that are meaningful to the individual. • All meetings are held in a suitable format. Attendance is recorded. Notes are taken and shared appropriately. Easy read notes may be in place. Actions are timebound and followed up. • Individuals can have meals and rest when they want to.	**1**
Res, SL, Forensic	• Individuals can get up/go to bed and eat meals when they want to. • Individuals are supported to make choices about their clothing and appearance. Suitable clothing choices may be encouraged, but right to make unwise choices where capacity is held in this area is respected.	**1**

	• How an individual is supported to access mail, emails and house/personal phone is documented, and privacy is encouraged where possible. • Individuals are consulted when an individual moves in, and compatibility is considered. • Individuals are consulted with via keyworker monthly and via house meetings on a regular basis, depending on nature and size of service. Processes are adapted to suit individual need e.g. alternative to formalised meetings. Individuals can opt out of these processes if they wish to.	
Exceeding Compliance	• Individuals with lived experience describe best practice as ensuring assumptions are not made and that specific likes are considered when buying clothes, and toiletries for example. Care is given to clothes during the laundry process. • Individuals with lived experience describe best practice as support workers being ambitious when goal setting. Looking outside of preconceived goals and considering what would improve their life and supporting little steps towards this. Being honest where goals cannot be met and ensuring individuals are well informed. Creating experiences that perhaps individuals haven't thought of that are enriching. • Keyworker is active in completing any assigned tasks.	**1**
Applies to	**Relationships**	PAMMS standard
All	• Individuals are provided with training and literature relevant to their needs to support safe internet use as needed. • Where relevant, a visitor's policy and risk assessment are in place. All measures are taken to safely facilitate visitation both within and outside of the service. No unnecessary restrictions are imposed. Individuals have access to private space to meet visitors. Any safeguarding concerns are responded to appropriately. • Individuals have privacy and are supported to engage safely in relationships. Informed choices around sexual relationships and desires are supported.	**1**
SL, Day, Forensic	• Contact with friends and family is kept and relationships are fostered, and different methods of contact are utilised where needed. • Gatherings and parties are encouraged.	**1**
Exceeding Compliance	• Individuals with lived experience describe best practice as giving support to both attend and have full involvement at large personal events, supporting reconciliation, and supporting where individuals are bereaved. Staff have an awareness of who is important to individuals within the community, take time to broaden links, and ensure these links they can be maintained even when staff change. Friendships are fostered.	**1**

Applies to	**Records**	PAMMS standard
All	• Daily logs are factual, respectful, legible, signed for, and stored securely. Logs are completed in real time wherever possible, not retrospectively. • They provide a good overall picture of an individual's day and mood, activities undertaken, and show choices offered, progress towards goals, along with personal care given or meal and medication support as per identified support needs. A clear record of appointments is kept. • Nature of delivered support is clear including time taken, staffing ratio, location, task/activity, • Information is shared through a handover process. • Provider is using (or intends to use) electronic care records.	**3**
Exceeding Compliance	• Written notes are supplemented with picture and video records. • With consent gained, a system is in place to share information regularly with family, such as access to electronic care records. • Individuals with lived experience describe best practice as recording being purposeful. Daily records are analysed, and any findings are considered, and actions are taken i.e. trying to understand why an individual hasn't engaged in activities. Daily notes are accessible should an individual request to see them. Records kept are pertinent to the individual. • Individuals have been involved in writing their own notes, with agreement sought that their day is accurately recorded.	**3**
Applies to	**Nutrition and Exercise**	PAMMS standard
All	• Healthy eating is encouraged, as appropriate to needs and health conditions (see NHS eat well plate). • Individuals are consulted on for menu planning. • SALT, cultural, and dietary guidelines are adhered to. Any restrictions are clearly documented. Staff are suitably trained to prepare meals and support at mealtimes (i.e. Dysphagia, see also environment), • Individuals are encouraged to be active and partake in exercise in the service and the community.	**4**
Res, SL, Forensic	• Individuals are involved in shopping, and where possible in meal preparation tasks. Individuals have choice over where and when they eat their meals. • Alternatives to the daily menu are possible. Pictorial food menus are available if needed.	**4**

Exceeding compliance	• Hosting themed nights, taster opportunities, sharing cultural meal experiences, and ensuring mealtimes are pleasurable would show best practise.	**4**
Applies to	**Behaviour and safeguarding**	PAMMS standard
All	• All staff are trained in, and can prove a good understanding of PBS, proactive, and least restrictive approaches. • For individuals requiring a PBS plan, plans are in date, reviewed annually, and clear to follow with a focus on preventative strategies. Plans are 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. • Where required, staff are trained in BILD ACT accredited physical intervention package (to only use training in restrictive practices that is certified as following the Restraint Reduction Network training standards from April 2021). Any restrictive practises are clearly outlined (the specific intervention and when to use) in individuals PBS plans and risk assessments and used as a last resort and reported appropriately. https://bildact.org.uk/certified-organisations/ • Incidents are responded to appropriately. Incidents are clearly recorded. Records of any incident must include date, time, persons involved, detailed ABC reporting (antecedents, behaviour, consequences), lessons learnt/actions taken. A GCC ABC guide is available. Debriefs should always be offered and should also be recorded. Where restrictive practices are used, what approach and why it was utilised, and time taken should be clearly defined. • Incidents are analysed for triggers, patterns and learning curves and plans are adapted as a result. Advice is sought from CLDT, LDISS, PBS team, PBS clinic or others as required. Advice given is followed. • There are no punitive responses to the behaviour of individuals. • GCC Safeguarding processes is followed. GSAB, CQC, DBS, police (as applicable) are informed promptly. • Safeguarding is transparent, reported appropriately. All staff to be aware of the escalation process/ how to raise and report a safeguarding/whistle blow. Staff can explain how they safeguard individuals. • Designated Safeguarding and Deputy Safeguarding Leads are present in the organisation. • There is a clear safeguarding process, where possible this is available in an easy read format. Individuals supported to understand how to report any safeguarding concerns. Individuals have access to a private space to have a sensitive conversation/phone call. • At least one member of staff within the management team is level 3 trained.	**3, 6**

Forensic	• 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 sect ion 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. • (ATU) seclusion/segregation process in place and used appropriately - types, records, MDT agreement sought, who are where are reports sent.	**3, 6**
Exceeding compliance	• Quarterly or annual auditing of safeguarding and incident logs ensure lessons learnt over time. • Providers actively involve those raising safeguarding concerns when seeking resolution and lessons learnt.	**6, 14**

Section 2 - Capacity & Restriction, DoLS & MCA

Applies to	Capacity & Restriction, DoLS & MCA	PAMMS standard
All	• MCA and DoLS training are undertaken; level of training undertaken is relevant to role. At least one manager to have undertaken GCC's L3 MCA training, bookable via Learn Pro. Recommend all assessing staff complete L2 training. • Capacity is always assumed. Independence, freedoms, and positive risk taking is promoted. Individuals can make unwise decisions should they choose to and have the capacity. • Impulsivity, disinhibited behaviours, and fluctuating capacity are well considered. • Whilst general environmental factors do not need to be recorded, any adjustments made to enable the most effective capacity assessment for each individual needs to be well reflected. This includes specificities around time of day, assessor, and place. • MCAs should be clear and detailed. It should be possible to determine what decision is being considered and how the decision was achieved. There should be evidence of the assessment having been conducted in a manner consistent with the principles of the Mental Capacity Act 2005. • Where required, mental capacity assessments are decision specific. MCA1 (for daily decisions) and MCA 2 (for significant decisions) are present, and detail outcome achieved. • MCAs are reviewed annually, indicated by sign and date. Reassessment required if needs change. MDT involvements as appropriate. • Best Interest decisions evidenced, including any records of Best Interest meetings held. Where appropriate, family involvement is sought. All those involved in deciding are listed, ideally signed for. BI decisions always include prescribing professional if medication related decision. • Consent is sought wherever possible for receiving personal care, taking photographs, storing and sharing of information, care and treatment (not an exhaustive list). • Individuals have accessible (easy read or alternative) information about advocacy services and are supported to access services where needed. • Restrictions are prevented altogether or are minimal, reasonable, and appropriate. Always the least restrictive option. Reasonable adjustments to environment are made and advice sought. Restrictions are not punitive to behaviours shown.	**2**

	• Where in place, DoLS are authorised, or have been requested to funding body – DoLS tracker to evidence this. MDT involvement is reflected. DoLS conditions are well considered. Provider clearly states risk factors. Reviewed annually. Impact on others considered.	
Res, SL, Forensic	• MCA and DoLS decisions are reflected in related support plans and risk assessments (e.g., covert medication administration, Dosh involvement, appointeeship). • Power of Attorney / Deputyship / Appointee is clearly documented, and evidence towards this is provided • Any other restrictions are explored sufficiently (e.g. during COVID 19 pandemic - vaccination, self-isolation decisions) • Any Advanced Decisions are recorded. • RES - ADASS application, outcomes, and conditions. • For restrictions within supported living settings, discussions had with funding body on Community DoLs	**2**
Forensic	• Providers should have clear procedures in place to accommodate any period of s17 leave and provide wrap around support as required. Providers should also ensure that all information is relayed in an accessible format and that individuals have access to independent mental health advocacy support as needed. • Security measures are the least restrictive without over reliance on physical security, whilst ensuring safety of the public and others. Procedures are clear.	**2**
Exceeding compliance	• It would be best practise to have individual MCAs for each decision • It would be best practise for MCAs to be standalone documents but linked to any related care plans and risk assessments.	**2**

Section 3 - Health Needs

Applies to	Staff knowledge and support services	PAMMS standard
All	• Staff receive the right training to support specific heath needs at the service (i.e., rescue medications, injections, PEG, epilepsy, diabetes, schizophrenia, addiction, dementia etc. Not an exhaustive list) • Staff have completed learning disability and autism training. Oliver McGowan training is preferable. • Staff show knowledge of contributing factors to increased health risks e.g. epilepsy, mobility needs, LD. • Staff show knowledge of health inequalities (e.g. for BAME community) and consider support of reasonable adjustments, advocacy, and promotion of health messages. • Staff are knowledgeable about relevant conditions at the service and confident with equipment supporting health needed such as CPAP machines, bed sensors etc. • Appropriate and timely professional involvement is sought - Behaviour, mental health, physical health, CLDT input, LDISS, IHOT, MH professionals (not exhaustive list). Records are kept of meetings and outcomes are actioned.	**3, 13**
Forensic	• Any outcomes set focus on mental health recovery, drug/alcohol dependence recovery, stopping/reducing undesirable behaviours, and better understanding of conditions to make life plans and stay physically and mentally healthy. • 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. • The provider has an awareness of local services including the Complex Emotional Needs Team, and Change Grow Live. Use of existing networks and community links. Where accessed, advice is used appropriately.	
Exceeding compliance	• Individuals with lived experience describe best practice as seeing that staff really care about the individual through observation, discussion and action. Health needs are evidently well supported, and staff are adaptable, proactive and responsive.	**1, 3**
Applies to	**Support plans and Record keeping**	PAMMS standard

All	• Records kept are relevant to need and signs of any change are monitored and acted upon swiftly (weights, fluid, bowel, behaviour, seizure activity, skin integrity etc). Food and Fluid Charts are in place for those who have a poor diet, who may be at risk of malnutrition. Body Maps are in place where needed. • MUST, Waterlow, Turn/Repositioning charts are in place where needed and updated and information analysed, and actions taken. • Staff understand how to monitor for the soft signs of deterioration. This could include RESTORE2 training use of SBARD, NEWS2 or DisDAT tools. Records are audited to support this monitoring.	**3, 13**
Res, SL, Forensic	• Appointments are clearly recorded, and logs show provider has been proactive in supporting health related needs. Providers advocate for their individuals and encourage reasonable adjustments. Individuals are encouraged to have available vaccinations (winter flu, COVID-19 booster etc) and attend relevant health screening appointments (breast cancer, smear tests etc). • Individuals are provided with information to better understand health topics and support informed decision making. E.g. Screening videos • All individuals are registered with a GP surgery. Individuals are supported with regular health consultations including Annual Health Checks (LD, Autism), annual Serious Mental Illness checks, annual 'Well Man' and 'Well Woman' checks, Podiatry, Dentistry, etc. as appropriate to need. A list of key contacts is kept. • Outcomes of AHC's are recorded and reviewed. Medication is often reviewed with STOMP applied and a view to reduction. • Good oral health is promoted. Ensuring consistency and that dental routines are person centred. • HAP holds all relevant information to acknowledge and support individuals' 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. • Health Passports are in place, are relevant (i.e. are considerate of how care could look in a hospital setting) and are reviewed. This information is easily accessible for a hospital visit, such as using orange folders or ICB red grab bags). • ReSPECT forms are promoted, and where possible are in place and signed by a clinician. If in place, a process has been followed including MCA / Best Interest and appropriate health professionals/family/carers/advocacy have been involved in the decision-making process. There is consideration of wants and wishes for deteriorating health needs.	**3, 5**

	If an individual or their representative does not wish to the engage in the ReSPECT or End of Life process, this is documented, and the conversation should be pursued at appropriate intervals over time. • Any DNACPR listed in the ReSPECT form is clear to its purpose and is reflective of wishes. • Where hospitalised, proper admission / discharge from hospital including discharge planning documentation is available and providers advocate for this. Any changes in an individual's health related needs, is reflected and updated in the support plans. • Processes as set out in the framework are followed regarding suspension of services due to planned and unplanned absences, hospitalisations, and psychiatric admissions.	
Exceeds compliance	• Provider is proactive in supporting health needs at all times. This is demonstrated through conversation, as well as records being easy to navigate with a clear thread between recognised conditions, support required, accessing health services, and any action taken to resolve or minimise health issues.	

Section 4 - Medication management

Applies to	Medication management	PAMMS standard
All	• Where medication is in use, robust management is necessary to minimise risks including a sufficient auditing system. Scale of auditing is proportionate to size of service and/or amount of medication present. Lessons are learnt with efforts made to improve systems as needed. Any areas identified as non-compliant are added to an action plan, with clear timescales for completion and identification of the lead person responsible. A guide to frequency of audits is as indicated below. • A clear and comprehensive medication policy is in place is reviewed and signed by staff (audit monthly). • Medications are in date (audit monthly). • Medication is signed in and out of service by x2 staff and stored securely in a locked cabinet following NICE guidelines. Keys/codes are stored securely (audit weekly). • Medication required to be with an individual for community activities such as allergy and epilepsy medication remain with staff at all times, and with a MAR and all guidelines. • Temperatures are checked daily if necessary. Refrigerated medication needs to be stored securely and not in contact with any food products. Medications are stored in line with NICE guidelines. If there are medicines which need to be stored in a refrigerator, ideally a specific lockable medication fridge will be available. If this is not practical medication may be stored in a lockable box in a fridge. In either case the fridge temperature must be recorded daily using a maximum/minimum thermometer. Providers to note some thermometers require regular calibration. Staff must understand how to reset this after each reading. (audit weekly). • Patient information leaflets are available at the service. • Monitored dose systems include a descriptor of what each medication looks like (audit monthly). • All liquids/ointments to clearly indicate open and use by date (audit weekly). • MAR is printed (or eMAR in place), clear, all fields are complete (no gaps/missed signatures), and codes are followed (audit weekly). • Double signatures identify changes and handwritten entries. Backs of MARs are well utilised with time and reason for administration changes (audit weekly). • A record is kept of all staff signatures within MAR file (audit monthly - unless using eMAR system).	**3, 8, 13, 14**

	• Staff have completed safe handling of medication training and training is in date. Sufficient staff (core team as minimum) have completed training for individual needs such as insulin and rescue medication training (audit monthly). • All trained staff are checked for competency with theory and practical assessments. Competency is checked as a minimum annually (audit monthly). • Refusals, gaps in administration and incidents (e.g. dropped tablet) are responded to promptly an appropriately to ensure safety of individuals (audit weekly). • Errors are minimal. All errors are recorded and sufficiently investigated. All medication errors and near misses should be logged and reported to GCC to allow learning and protocol changed if required. GCC and CQC guidance to be followed (audit weekly). • Medication trained staff who have been identified as making regular medication errors are removed from medication administration, re-trained and medication competencies revisited. • There are clear profiles for individualised administration (audit monthly). • There are systems in place to enable individuals to manage medications as self-sufficiently and safely as possible. Self-administration medication risk assessments are in place. Staff need to be vigilant in recognising any changes in presentation that indicate medications are not being taken as prescribed, and there should be a clear process to manage this. This will be particularly relevant where mental health is fluctuating. Self-medication pathways should be reviewed regularly (audit monthly). • Covert pathways are clearly shown and supported by MCA and best interest paperwork with appropriate health professional involvement. There is evidence, that a covert medication protocol is in place and signed by a GP and Pharmacist (audit monthly). • Health related policy and protocols are clear, relevant and in line with NICE guidelines (e.g. epilepsy, PEG). Protocols are personalised and include health needs and purpose of medication, clear instructions of how to respond, and when to seek further medical assistance (audit monthly). • PRNs are used minimally. PRN protocols are in place and clearly state when the medication should be given, and when to seek further medical support. PRN medication that becomes regular use medication, is reviewed by the GP. All used of PRN is recorded (audit monthly). • Location specific policies and risk assessments may include invasive medication technique, insulin protocols for high/low and training, safe practise with harmful/dangerous items (e.g., oxygen, paraffin based) and rescue medications (audit monthly).	

	• Schedule 2 and some Schedule 3 controlled drugs are stored appropriately either in a separate cupboard or a separate lockable section of the main medicine cabinet. Controlled drugs cupboards must meet requirements of legislation. Controlled drug book and returns book in place (audit weekly). • Sharps process is clear and followed (audit monthly).	
Res, SL, Forensic	• Medication is ordered appropriately i.e. cycles are synchronised where possible, no shortage of supply of cyclical medication (audit monthly). • External medicines (creams etc) are stored separately with date of opening recorded and with a topical cream chart in place and body map to identify where the creams should be applied (audit weekly) • Oral meds are kept separately (audit monthly). • There is a clear and consistent process for counting medications. All medications should be counted at the time of administration. In addition to this, higher risk medication such as controlled drugs should be counted daily. Lower risk medication should be counted weekly. Count processes should be risk assessed, taking into consideration the medication form (i.e tablet, liquid), risk of misuse, and the amount of medication in circulation. Any inaccuracies during counts must be acted upon swiftly. • A sample of medications should also be recounted during a medication audit to determine accuracy of checks (monthly). • Process for social leave such as signing out sheet (audit monthly). • Risk assessments are in place for specific medications/interventions such as blood thinning medication (Anticoagulant e.g., Warfarin, Rivaroxaban), administration via PEG, or presence of Oxygen (audit monthly). • Homely remedy list in place where used. It is advised that homely remedy lists are reviewed by a GP or Pharmacist to check for contraindications, particularly if routine medications change (audit monthly). • Medications are disposed appropriately though the returns process. Returned medication to be locked until returned (audit monthly). • 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. Antipsychotics prescribed for dementia should be reviewed every 6-12 weeks.	**8**
Exceeding compliance	• 6 monthly medication competencies would be best practise. • PRN protocols signed by a GP or a pharmacist and reviewed annually or when a medication changes (audit monthly).	**8, 13**

Section 5 - Environment

Applies to	Environment	PAMMS standard
All	• Visitor ID is checked upon arrival and a record is kept of any visitors should this be right at the location. • There are sufficient toilets, sinks and bathrooms for the size and purpose of the service. Hand soap and paper towels are supplied. • The service is safe, clean, and free from hazard. Exits are free from obstruction. • 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 promptly via maintenance process. • IPC/PPE processes are followed with cleaning schedules in place. • Staff are seen wearing and disposing of PPE correctly, as appropriate to the task. • There are sufficient and appropriate bins at the service. General and clinical waste is managed effectively and safely. • Current HCPA guidelines are followed in the event of an outbreak/pandemic e.g. Scabies, COVID 19 • Individuals have full access to the property, and any restrictions imposed are fully supported by MCA/Best interest/DoLS processes and/or robust risk assessment processes. • Doors are unlocked, and keys supplied to allow free access where possible. • Outdoor areas are in good state and accessible. • Staff are suitably trained to prepare meals and support at mealtimes (Food hygiene, basic First aid and depending on service type - use of Safer Food Better Business, location being Food Hygiene rated). • Safeguarding and Complaints procedure is readily available for staff and individuals in appropriate formats. • Insurances are in line with current minimum standards (Employer's liability, Public Liability, Professional Liability or Indemnity).	**7, 9, 10**
Res	• Fridge, freezer, and meal temperatures are recorded daily. Food is clearly labelled with opened/use by dates. • Legionella risk assessment and appropriate flushing and temperature check or control system in place following HSE guidance.	**9, 14**
Res, SL, Forensic	• Food, drink, and healthy snacks are accessible. • The service appears welcoming and homely according to the individuals' requirements and tastes. • Evidence shows that individuals are involved in décor choices in both private and communal areas.	**1, 4, 9**

	• There is regular consultation, and individuals are involved in decision making about their home where possible and appropriate. House meetings take place with individuals, where appropriate.	
SL, Forensic	• 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. • 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. • Contents insurance has been discussed with tenants where required.	**9**
Exceeding Compliance	• Environmental barriers have been considered wherever possible. For example, automatic doors throughout the service to allow safe and free access. • It would be best practice for all services to keep a record of fridge and freezer temperatures as part of effective food management. • There is consideration of how to minimise day to day noises in the service.	**2, 9**

Section 6 - Staff team and staff support

Applies to	Recruitment, induction and training	PAMMS standard
All	• Recruitments checks are completed, to include - an application form with full history (checking gaps in employment history and explanations for gaps, interview questions and responses, job description. • Check status of staff subject to immigration. Right to work in UK/ Photographic Identification birth cert/passport/visa, satisfactory DBS check completed. Where there is a disclosure, information should be gathered, and a risk assessment completed. DBS monitoring over time in place. • Correct procedures in line with government guidance have been followed for any sponsored staff. Sponsored staff are well supported and there are no unfair terms and conditions of their employment. • Ensure 2 written references are in place, references should include the previous employer, are not from family members and are not testimonials. Delays and gaps on reference are fully explored and where not provided, risk assessments are in place to allow safe working. • There is no evidence of discriminatory practise during or after recruitment. provider is LGBTQI aware. Provider is aware of racial prejudice. Provider is a Disability Confident employer. Training and support is available for staff where English is an additional language. • 2 interviewers present. Interview questions are value based and personalised to the provider and role. Interviewers should have received safer recruitment training. • Staff turnover is low or average (see skills for care) and exit interviews are offered, and ideally completed and feedback taken on board. • Changes to staffing team, including managers and above, are shared with staff, individuals and families where appropriate. • Staff handbook in place. • Induction to service, to cover relevant areas, mandatory training, along with evidence of shadow shifts. Buddy/ Mentor system for new starters. • Evidence that staff have read and understood policies and procedures of the service. • Evidence of agency induction/ checklist of service and assurance of skills from agency profiles, to include listing training completed and dates ensuring courses are up to date. Evidence from Agency conforming DBS has been sought DBS numbers and dates are to be reflected on agency profiles. Determine immigration status	**11, 12, 13**

	• Training matrix should be clear and well populated with method of training and period of renewal stated. All mandatory or optional training is clearly shown. • All staff have completed mandatory training as advised by Skills for Care relevant to service and individual need. Evidence of a manager undertaking GCC's MCA and Safeguarding level 3 training. Training is in date. • Any training time is reflected on rota to evidence staff presence (or lack thereof) or paid if taken outside of working hours. • Training is not solely e-learning and face to face training is accessed where possible. • Additional training relevant to role, service, and specific need is available and encouraged • Where applicable due to support required and size of staff team, individuals' staff have training specialisms and there are identified champions (IPC, dignity, safeguarding) • Care certificates have been completed. NVQ and Diplomas are encouraged through CPD. It would be best practise that service or registered managers have completed or are working towards a Level 5 Diploma or above.	**11, 13**
Exceeding compliance	• Individuals to be actively involved in recruitment. This can be through engagement in writing interview questions or joining the interview panel. • Evidence that during induction staff, supervisor, and individuals being supported are happy that staff are competent. Competency observations completed with practical and theory knowledge explored. Confidence of staff is assessed, and feedback is sought from individuals they have supported. • Training knowledge is assessed via an ad hoc competency check through supervisions and staff meetings. • Training is available to regular agency staff where this is required.	**11**
Applies to	**Daily running and support**	PAMMS standard
All	• 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. • Rota is well balanced with skill level, male and female staff etc (as appropriate to the needs of the service). • 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. • There are no concerns regarding days/hours worked without a break (or evidence of agreement to opt out of Working Time Regulations). Increased monitoring may be needed for staff working longer hours.	**3, 6, 12, 13, 14, 15**

	• The complexity of needs at the service is reflected in the hourly rate, length of shift, handover period, staff support, and annual leave entitlement of the staff team. There should be a clear process for accruing and using annual leave and flexi time for both all staff. • Rotas are in an accessible format for people supported. • Staff receive a minimum of 4 1:1 supervisions per year, including 1 annual appraisal. Supervisions are made available to all staff and alternatives to in person meetings are considered where needed such as phone calls or grouped supervisions. • Processes are constructive. Issues are brought forward, CPD is encouraged, poor practise is challenged, knowledge is checked through 'hot topic' questions or equivalent, actions are created and reviewed. • Staff are well supported and appropriately trained. Risk of 'burnout' is minimal. • Supervising staff receive training for role. • Staff wellbeing is continually supported. A wellbeing service may be accessible through the provider or staff are signposted to The Wellbeing Line. • There is recognition of skilled staff and achievements are praised. • The provider has robust mechanisms in place to manage both expected and unexpected changes in the service to ensure safe, effective and consistent care (for example to cover sickness, vacancies, absences and emergencies). • Management and staffing are stable. Managers are knowledgeable and present. • Professional boundaries are maintained. Consideration regarding family members working at the same service e.g., no direct line management, ensure on opposite shifts. Professional Boundaries policy in place. • 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 right information, and handovers are completed. • Complaints and safeguarding procedures are accessible to staff and individuals in the location in an accessible format (easy read or alternative). • Safeguarding concerns are reported promptly through proper avenues, these are recorded, along with actions taken and reconciled. Incident forms to be fully populated also, including debriefs with staff and individuals. Analysis of these take place. • Whistleblowing policy is readily available, and staff feel confident to whistle blow should it be needed. • Duty of Candour. Open and transparent culture. Anonymity is protected.	

	• Feedback on service delivery is sought from a variety of sources, analysed and actioned (meetings, forums and anonymous surveys), to include individuals, families / friends, staff and external professional views. Feedback on outcomes is given. • There is a positive working relationship with stakeholders.	
SL, Forensic	• ECM used with only 10% and under of remote/ software logs. Visits have not been missed.	**3, 12**
Res, SL, Forensic	• On call process is clear, to include on call policy. • On call have experience and understanding of service to offer proper support and guidance. They are available and responsive. Fair share of on call duties. • On call contact is recorded and actions are followed through.	**12**
Exceeding compliance	• Rotas enable admin time, so there is minimal impact to support hours. • It would be best practice for individuals choose their support times and support staff. • Rotas are skill matched to individuals. • It would be best practice that staff who are returning to service after a period of absence (permanent, bank or agency are given sufficient time at the start of the first shift back to fully catch up any changes at the service and competence and confidence is ascertained. • It would be best practise to ensure agency staff who have been at the service for over 6 months and who work there on a regular basis are offered supervisory support.	**12**

Section 7 - Governance

Applies to	Finances	PAMMS standard
All	• A robust financial policy should be in place for any service handling money, be that for the individual or the service, such as petty cash. Staff expenditure is clearly defined. • Financial systems in place are supported in risk assessments and support plans. Plans should clearly say who has access to what and why. For example, any cash/cards being stored in the office, and PIN being known, agreed processes for accessing and using bank cards. Any limits/agreements around expenditure are clearly described. • 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 individual's bedroom if living at the service. • There should be a robust audit system to minimise any risk of financial abuse. 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 by a suitable person, and measures taken to prevent reoccurrence.	**6, 16**
Res, SL, Forensic	• Where individual lacks capacity, financial responsibility is managed by a third party, for example Client Affairs. Appointee, MCA, and best interest decisions are reflected as necessary, and the least restrictive approach is used. • Any contributions (such as to events, activities, house kitty etc) are clearly identified and managed in line with individuals' financial situations. • Where possible, individuals are supported with monetary management skills and independence is encouraged. Budgets are agreed and reviewed.	**2, 14, 16**
Exceeding compliance	• Individuals are involved in their balance checks.	**1**
Applies to	**Audits and checks**	PAMMS standard
All	• Staff and individuals' 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 individual's day.	**14, 16**

	• It is recommended that services use (or are progressing towards the use of) digital recording systems. Measures need to be in place to ensure devices are secure and used appropriately. Providers should make use of the benefits of these systems in auditing and analysis.	
	• Where vehicles are present, a suitable record should be kept of mileage and vehicle walkaround safety checks should be completed weekly, or prior to each journey depending on usage. Vehicle concerns should be addressed before use. • Any mileage paid to to/from staff or individuals meets HMRC recommended rates. Mileage and destination should be recorded. • A vehicle use policy is in place and driving licence information is held • Cleaning schedules are in place, well populated, and show frequency and nature of task. • Enhanced IPC recommendations in relation to outbreaks (e.g. COVID-19, Scabies) are followed.	**7, 16**
	• All measures are taken surrounding equipment and environment to ensure service is safe. • Environmental risk assessments are in place and reviewed annually. • Moving and Handling equipment is checked. • Health and safety audits are completed monthly. All identified issues are addressed through an action plan. Risks are minimised. Lessons are learnt • Certificates are in date – electrical appliance checks (annual), gas safety (annual), electrical wiring (5 years), vehicle insurance (annual). • Audits evidence weekly water flushes, water temperatures, legionnaires checks (residential only)	**9, 10, 16**
	• 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 issues arise. Fire drills involve difference scenarios (staffing, time of day). A designated fire officer in place. • Equipment is tested and placed appropriately. Carbon monoxide indicator in place. • PEEPS in place where required and reviewed. Fire grab bag in a suitable location.	**3, 9, 16**
	• Incidents are responded to appropriately. Incidents are clearly recorded. Adult help desk, GSAB, and/or CQC and police are informed promptly. Lessons are learnt. • 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.	**6, 15, 16**

	• Business continuity plan in place, service specific, and reviewed annually. Includes: measures for environmental emergencies, staffing shortages, Information management and data security breaches, pandemic, cyber-attacks etc (although not an exhaustive list). • Provider has completed the Data Protection Toolkit and cyber essentials training. • There is oversight/analysis of auditing systems to ensure systems are working effectively. • Environmental, social, and financial sustainability is embedded into approaches. This could include but is not limited to use of digital care records and working towards being paper free, capturing of meaningful social activities, minimal wastage and effective recycling and reusing systems, opting for sustainable transport alternatives, robust recruitment and ongoing support offers to minimise turnover	
Exceeding Compliance	• Quarterly or annual auditing of complaints ensure lessons learnt over time. Providers actively involve those raising complaints when seeking resolution. • Where possible and appropriate, there are cross service quality audit systems in place, such as peer led auditing, or use of external auditors.	**16**

Appendices

Appendix 1 – list of contributors

Name	Organisation	Role
Jess Breeden Steph Hunt, Tanya Beres, Pamela Gallagher Willis	GCC Integrated Commissioning	Quality Investigation Officer, Lead Author Quality Review Officers
Amie Wilson, Naomi Carley	GCC Commissioning	Commissioning Managers
Emma Miles	GCC LD Ops	Deputy Social Care Manager
Terri Howe and Jane Reid	CHC	Commissioning Support Officers
Chris Gifkins	Gloucestershire ICB	Senior Care Homes Clinical Pharmacist
Dave Evans, Denise Holder, Alisha Willams	Inclusion Gloucestershire	Quality Checkers with lived experiences
Becci Hopton Becky Evans Tony Lafford, Cathy Andrews, Liz Watkins Sally Ann Martin Julie Reader-Sullivan	Saracen Care Prosperity Care and Well being Orchard Trust Voyage Care Headway Gloucestershire	Care provider service managers and quality leads