

Quality Assurance Policy

Quality Assurance

Introduction

This policy sets out the values, principles and policies underpinning Trusted Hands Care Group's ("**Trusted Hands**" or the "**Group**") approach to Quality Assurance.

Quality Assurance ("**QA**") means raising standards across all parts of the Group and complying with registration and contractual requirements as well as capturing the service user experience.

The QA process deployed by the group will include the following audit against performance standards which will include:

- **The Fundamental Standards, see Appendix 1**
- **The choices and needs of the service user**
- **The requirements of commissioning organisations**
- **All other relevant legislation, attendant legislation and good practice.**

We systematically collect data relating to most of the services daily activities and it measures these to assure families, financiers and authorities of the high-quality services that we offer.

Most of these QA measurement tools are audits which can include the following:

- MAR chart audits
- Care plan and risk assessment audits
- Health and safety audits
- Infection control audits
- Fire risk assessment audits
- Medication audits
- Safeguarding governance audits
- Staff supervision audits
- Personal file audits

- Environmental audits
- COSHH audits
- Dignity in care audits

Quality Assurance (QA) Audit

Our Supervisors and Management will regularly, and randomly, audit the QA measurement tools to ensure they have been completed to the standard required and according to Policies and Procedures, and to verify that residents' needs are being met in a person-centered way.

The QA Audit will follow these steps:

- a task will be identified, and its location (either in the home or in the community) will be recorded
- the auditor(s) will explain what they have observed
- the auditor(s) will identify how the staff member completed the task and record any comments
- the auditor(s) will score against each task:
 - 4 = very good
 - 3 = good
 - 2 = adequate
 - 1 = poor
- the auditor(s) must then discuss the outcome with the appropriate staff member
- where staff are marked '1', management should be informed and appropriate training should be organized, records of the audit will be stored appropriately and any actions taken with a staff member (for example a low score against a task) will be filed in the staff member's locked personnel file (in accordance with Data Protection legislation) the scores retrieved from the QA audit are collated and recorded into a spreadsheet as soon as possible. This spreadsheet then measures each individual's performance and, when collated with all staff performance figures, the home's performance on the whole all data will be collated and made available to CQC and the local Council to demonstrate how our home is meeting the required standards.

Service User Care Plans

Care Plans

A Care Plan is a record of how our services plan to meet the care needs and personal wishes of individual residents, as well as being a store of important information about the service

user and their keyworker. Care planning is a requirement of the Health and Social Care Act 2014 **and that of the 2014 Care Act** and it is the means by which residential homes / services deliver adequate and appropriate care which meets their individual needs.

The Care Plan is comprised of essential documents, including:

- A statement of care (within which the service user confirms consent for their named keyworker to work with / on their behalf)
- A photograph of the service user
- A personal profile of the service user
- A Care Plan (updated every month or sooner if required, with risk assessments included)
- A Monthly Care Plan review (or sooner if required including comments, complaints, compliments by the service user)
- Information from other agencies and/or authorities (such as Behavioral Guidelines)
- Service user's Health Action Plan
- Guidelines for medication
- Audited activities record from external and internal activities.

The Care Plan should be completed within 5 days of a service user moving into the home / service, and then audited as follows:

- During each month, Care Plan Update forms will be completed, considering service user daily notes.
- Internal Reviews will continue Bi -annually, which will be initiated by the manager or Keyworker.

The purpose of these reviews is to ensure that we are continuing to meet the needs of the individual in a manner acceptable to them. If the service user has a social worker, they should be invited, together with any relatives, advocates or friends that the service user wishes to be present. The service user's key worker should also be present. All Care Plans should be monitored to ensure that we are delivering to the service user that which has been mutually agreed, through verbal questioning and feedback, completion of the Care Review form, Care Review meetings and service user meetings. All forms should be signed and dated and held in the service user's personal file. The service user or their representative will be offered a copy of the review document in their preferred format. All Care Plans, their supporting documentation and all other records are to be maintained in line with the group's record maintenance and retention policy.

Care Plan Risk Assessments

The governing principle behind good approaches to choice and risk is that people have the right to live their lives to the full as long as that does not stop others from doing the same. Fear of supporting people to take reasonable risks in their daily lives can prevent them from doing the things that most people take for granted. What needs to be considered in risk assessment is the consequence of an action and the likelihood of any harm from it. By taking account of the benefits in terms of independence, well-being and choice, it should be possible for a person to have a support / care plan which enables them to manage identified risks and to live their lives in ways which best suit them. Risk assessment is an on-going process, forming part of an overall assessment. A risk assessment should be completed each time support is being considered/implemented including assessment and review, and otherwise as considered necessary.

Definitions

Risk assessment – an analysis of what could cause harm, so that precautions can be considered and put in place to prevent harm.

Risk – the likelihood of harm happening and the severity of consequences.

Risk-taking – choosing whether or not to act in relation to the risk that has been identified.

Guidance for Completion of Risk Assessment form

The Risk Assessment / Risk Management form provides a template for staff to evidence their assessment of risk, take into consideration the views of the person and any carers of the risk(s), and where appropriate record any actions needed to manage / mitigate the risk(s). It is intended where possible to be a collaborative process, involving the person with care and support needs and recognizing their expertise in their own life and their personal approach to risk-taking. It should also include the views of others – including any carers (though their views should not take precedence over those of the person with care and support needs, unless there are significant concerns) and other professionals involved.

The risk assessment considers risks in few different areas:

- access to the person's home e.g., mobility difficulties which present a risk to the person safely reaching the door
- in the home e.g., electrical hazard, slips/trips hazards, cluttered environment, pets
- manual handling e.g., lack of equipment, any impact of person's weight on staff' ability to transfer / care for person, risks of falling.
- physical health - risks from any physical condition e.g., stroke, breathing difficulties etc.

- cognitive and behavioral issues e.g., behavior that can pose a risk to the person or others, risks related to wandering, risk of severe self-neglect, risk of suicide
- medication e.g., non-compliance with medication
- everyday activities e.g., risks to the person’s routines, risk of loss of autonomy, risk of social isolation
- safeguarding - risk of abuse

These are shown separately on the Risk Assessment form – staff need only complete relevant sections. Where there is no risk, please leave this section blank. Additionally, it is recognised that not all risks may ‘fit’ into the above categories – there is an additional section for any other risks to be recorded if needed.

Process

For each area of risk identified, you should:

1. Record the risk in as much detail as relevant – this should be the original risk i.e., before any protective measures are put in place e.g., support / services.
2. Consider any factors which increase the risk – these are likely to be personal and/or environmental factors which contribute to the individual’s risk of harm. Clearly differentiate between current and historical factors. Consider if the person is currently in a crisis situation – if so, reflect this at this stage, but it is recommended that staff complete a new risk assessment when the situation has settled.
3. Consider any factors which decrease the risk – these are to be protective factors and could include the individual’s awareness of the risk, informal support networks in place, actions already taken. Staff should not include planned support at this stage – this will be recorded in the Risk Management section.
4. Consider the likelihood – how likely is it that the identified risk could happen – using the following scale:

Low	Do not expect the risk to happen (or recur) but it is possible
Medium	Likely to happen (or recur)
High	Highly likely or almost certain to happen (or recur), possibly frequently

NB: In identifying the likelihood, staff should consider factors such as how long the risk has been occurring for (e.g., is it a one-off), whether there is a pattern, whether other people are at risk (e.g., family/friends, support/care staff, professionals), whether the situation is

monitored and whether any instances of the risk happening are increasing either in frequency or severity.

- Consider the impact of the harm should the identified risk happen - this should be the likely impact on the person, taking into account that this will vary from person to person. Use the following scale:

Low	Minimal impact
Medium	Some impact / harm to anyone
High	Significant / serious impact / harm to anyone

- Using all the above information, record a risk rating using the following scale:

Impact	High	7	8	9
	Medium	4	5	6
	Low	1	2	3
Likelihood		Low	Medium	High

Low apparent risk (1 - 4)	<p>No current indication of risk or risks appear low as a result of likelihood, impact and protective factors in place.</p> <p>ACTION: The necessary level of screening / vigilance will be covered by the person's Care and Support Plan. No additional measures currently necessary.</p> <p>EXAMPLE: person has a falls history, no falls within last 12 months</p> <p>OR: person has had several falls in last 12 months, but equipment and monitoring in place reduces the risk of serious harm</p>
Medium apparent risk (5-8)	Information indicates presence of risk which is considered to be significant at present.

	<p>ACTION: Risk Management plan should be / has been drawn up and implemented.</p> <p>EXAMPLE: person has a falls history, has had several falls in the last 12 months, but has refused any equipment and monitoring. The person is at risk of injury from the falls.</p>
<p>High apparent risk (9)</p>	<p>Information indicates the presence of serious – possibly imminent – risk.</p> <p>ACTION: Risk Management plan needs to be drawn up and implemented immediately and given the highest priority.</p> <p>EXAMPLE: person has falls history, recurrent recent falls resulting in hospital admission / serious injury; in addition, person has cognitive impairment as a result of which they cannot recognise the risks of mobilizing independently – risks are frequent every day.</p>

7. Record the person's own view of the risk – is the person aware of the risk(s)? Are there any capacity issues which may impact on the person's appreciation of the risk? Is this a considered risk that the person wishes to take?
8. Record the view of any family / carer / representative. Is this person aware of the risk? What is their view of the risk? Do they have any concerns that need to be considered / recorded?
9. Having identified and assessed the risk(s), and where indicated by the table above, Risk Management Plan should be recorded and implemented:
 - 9.1. Summarize details of risks/concerns to be addressed by Risk Management Plan (not all risks identified earlier will need Risk Management Plan).
 - 9.2. Record in as much detail as necessary the actions to be taken to manage/mitigate the risk(s). Record also any required timescale and who is to be responsible for each action.

NB: Regardless of whether the Risk Management Plan is completed or not, some additional information is required at the end of the form:

- Staff should record all sources of information / parties to the Risk Assessment by ticking the relevant boxes.
- Staff should record all copies which are to be distributed / filed by ticking the relevant boxes. Staff should consider sending a copy to the person with care and support needs

- this is particularly important where the person has contributed to the Risk Assessment / Risk Management Plan.

When the form is printed out, Staff should read and sign / date as you usually would and, where possible and appropriate, ask the service user to sign and date the form also.

Service user involvement

The QA process must include the involvement of service users in the auditing and monitoring of the service. This engagement includes supporting service users to assess the quality of their service during individual service reviews. During the care planning process, the service user will have defined their Key Performance Indicators (KPIs) to define those outcomes that they want their service to deliver. The service will deploy individual service reviews with the support of any member of the service user's circle of support as required to support the service user to identify areas of improvement or changes to their individual service due to changes in their presentation and or preferences. The outcomes from these reviews can include changes to the individualized service. The QA process therefore requires to be person centered to the needs and choices of the individual service for example involving the service user to engage in quality circles to assess the quality of service area domains. QA audit tools can also include service user surveys to capture the customer experience as well as surveys of the views of relatives and staff.

Record Keeping

Records

As described in Section 1, numerous forms are completed on a daily basis as part of Quality Assurance. Each of these forms can be found in the Forms folder in the office or in the folders directory of the home / service e-filing system.

Further record keeping maintained by the home includes:

- Diary of Appointments.
- ABC forms and BIR records.
- Accident and Incident Report Forms
- Service user daily records.
- Notification Forms, such as CQC and DoLS.
- Visitors' Book.
- Service user finances.
- Statutory Body Reports, such as Inspection Reports, Health and Safety Reports, Food

and Hygiene Reports, Fire Service Reports, Electrical and Gas Reports.

- Staff records, such as Application, References, appraisals, supervisions, emergency contact, etc.
- Service user Forms, such as health records, minutes of service user meetings, activity records, etc.

All reports must be written in a clear manner. Any subject reported must be followed up until the matter has concluded, e.g., if a service user is reported to have injured themselves, the report must ultimately show what was done to remedy the situation, up until that individual was healthy again.

All incidents and unusual occurrences, including movements of service user, must be reported in the service user daily records.

The QA process also captures personal data for example names and dates of birth of service users, data which has originally been used to deliver the service. The QA process is therefore mandated to be compliant with the 2018 Data Protection Act and the GDPR which requires companies to provide a reasonable level of protection for personal data. The processing of that data must be carried out in a manner that is lawful, fair and transparent and only for specified, explicit and legitimate purposes. For the purposes of the Regulation, processing means any operation or operations that are performed on personal data whether or not by automated means, such as collection, recording, organisation, structuring and storage. Personal data includes that included in employee and non-employee records such as name, job title, home address, email address and phone number — anything that could allow the identification of the person. The personal data collected should be relevant, adequate, limited to what is necessary and kept up to date. The Regulation requires that the data should be kept in such a manner and with such management to protect the data against unlawful or unauthorized processing or accidental loss or destruction.

Reporting and recording confidential information

Daily records

- Staff must first record all information into an individual(s) personal note.
- If further records need to be completed then staff must ensure that the type of forms used are noted down with the information that has been recorded in the individual's personal notes.
- If staff record that management has been informed, they MUST state the time, the date, and to whom.

Complete an Incident Report Form and safeguarding alert where required:

- An individual was to display behaviors that adversely affected others, such as physical or emotional abuse.
- An individual was to have an accident and sustain an injury
- Accusations are made against any other individual.

Send a notification to CQC if:

- An individual was to display behaviors that adversely affected others such as physical or emotional abuse.
- An individual has an accident with a sustained injury.
- There is a serious complaint.

Complete the ABC chart if:

- Any behaviors occur.
- An individual was to display behaviors within themselves which did not affect others.
- An individual was to display behaviors that adversely affected others such as physical or emotional abuse.

Complete an Accident Form if:

- Any accident occurs to an individual, whether or not there is an injury.

Complete a Near Miss Form if:

- A near miss occurs and actions need to be taken and recorded with regard to minimizing the risk to ensure it does not happen again, e.g., someone trips over a raised carpet but does not suffer any injury – the next person to trip on the raised carpet may not be so lucky and could suffer a serious injury.

Complete the Epilepsy Record if:

- Any service user has an epileptic seizure, any number.

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