



Title
Continuous Quality Improvement Policy and Procedure
Principle
Homekare community services are committed to the promotion of a culture of innovation and continuous improvement in its governance, management practice and service delivery. Homekare community services are committed to implementing an ongoing programme of continuous quality improvement projects.
Objectives
This policy demonstrates Homekare Community Services' approach to Continuous Quality Improvement (our CQI). This policy includes the following: • Demonstrates our consistent compliance with CQC fundamental standards and all relevant governing legislation • Process to identify, assess and manage risks to the quality and safety of our care and support on a continuous process • Shows how we learn from incidents, complaints, feedback and audits and external reviews to drive our measurable improvement • How we involve clients, family members and team member's in our quality cycle • How we provide transparent, evidence-based assurance to clients, families, commissioners and regulators • How we achieve and maintain a CQC rating of Good or above
Scope
This policy applies to the following: • All Homekare Community Service team members • Agency and contract workers who are delivering services on behalf of Homekare Community Services • All regulatory activities carried out under Homekare Community Service CQC registration
Procedure
1 — Policy Statement and Quality Values 1.1 Homekare Community Service's Commitment Homekare Community Care Services is committed to delivering safe, effective, caring, responsive, and well-led care that meets or exceeds the CQC Fundamental

Standards. Quality improvement is not reactive — it is a proactive, data-driven, person-centred process embedded in our organisational culture.

1.2 Our Quality Values

- Person-centred — every quality decision starts with the client's needs, wishes, and outcomes.
- Evidence-based — quality standards are grounded in NICE guidelines, SCIE research, and Skills for Care frameworks.
- Transparent — we are open about our performance, our mistakes, and our improvement plans.
- Learning — every incident, complaint, and audit finding is an opportunity to learn and improve.
- Inclusive — clients, families, and team member's are active partners in quality improvement.
- Proportionate — our governance processes are rigorous but not bureaucratic. They add value, not just paperwork

1.3 CQC Five Domains —Homecare Community Services Quality Framework

CQC Domain	Our Commitment	CQI Methods
Safe	Protected from avoidable harm, abuse, and neglect	Incident monitoring, safeguarding audit, risk assessment reviews, medicines audit, RIDDOR compliance
Effective	Care achieves good outcomes based on evidence	Care plan audits, NICE guideline compliance, training matrix, outcome reviews, supervision records
Caring	Compassion, kindness, dignity, and respect	Client's surveys, dignity audit, observation visits, complaints analysis, compliments tracking
Responsive	Services designed around individual needs	Care plan personalisation audit, complaint trend analysis, access and continuity reviews
Well-Led	Leadership ensures high-quality, person-centred care	Governance reporting cycle, KPI dashboard, policy review schedule, CQC compliance tracker, team member's survey

SECTION 2 — ROLES AND RESPONSIBILITIES

Quality improvement is a shared responsibility. The table below defines accountability at each level.

Role	CQI Responsibilities
Director / Nominated Individual	Holds ultimate accountability for quality and safety. Receives and scrutinises monthly governance report. Approves Quality Improvement Plans. Ensures CQC inspection readiness. Signs off major policy revisions. Holds the Registered Manager to account for KPI performance.
Registered Manager	Leads day-to-day CQI framework. Oversees audit activity and ensures findings are acted upon. Reviews monthly governance report and presents it to the Director. Submits CQC statutory notifications. Leads safeguarding escalation and NSAB liaison. Reviews care plans, supervision records, and training compliance.
HR & Compliance Lead	Leads internal audit programme and produces audit reports with action plans. Maintains policy review schedule. Monitors mandatory training compliance matrix and flags breaches. Tracks regulatory changes and updates compliance documentation. Manages safer recruitment and DBS compliance.
Care Manager	Conducts monthly care plan and MAR chart reviews. Collates service user satisfaction survey results. Tracks complaint progress and action plan completion. Prepares monthly KPI data for governance report. Liaises with families, GPs, and social workers on quality and continuity.
Senior Team	Participates in audit and quality review activity. Contributes reflective learning in supervision. Identifies and raises concerns about care quality promptly. Supports team member's in meeting care plan standards.
Care Team	Delivers care in line with agreed care plan. Records all care visits, observations, and concerns accurately and promptly. Completes mandatory training within required timescales. Engages actively with supervision and appraisal. Raises concerns through whistleblowing or supervision without delay. Completes feedback forms with clients.

SECTION 3 — THE CONTINUOUS QUALITY IMPROVEMENT CYCLE

3.1 The Plan-Do-Study-Act (PDSA) Model

Homekare Community Service's uses the Plan-Do-Study-Act (PDSA) cycle as the foundation of its quality improvement approach. This is consistent with NHS and social care improvement methodology and is recognised by NICE and SCIE as best practice:

Stage	Action	What We Do
PLAN	Identify what to improve and how	Analyse audit findings, complaints, incidents, and feedback. Set measurable improvement targets. Write Quality Improvement Action Plans with named owners and timescales.
DO	Implement the improvement	Carry out the planned change — update procedures, deliver training, change practices, communicate with team member's and client's.
STUDY	Review what happened	Evaluate whether the change achieved the desired outcome. Re-audit to measure impact. Review through the monthly governance report.
ACT	Embed or revise	If the change worked, embed it in practice and policy. If not, revise the approach and repeat the cycle. Share learning with the whole team.

3.2 Triggers for Quality Improvement Activity

CQI activity is triggered by any of the following:

- A finding from the internal audit programme
- A complaint or pattern of complaints
- A serious incident or near-miss
- A safeguarding concern or referral
- A CQC inspection finding or regulatory concern
- Negative client or team member's feedback
- A new or updated NICE guideline, SCIE resource, or CQC guidance document
- A Safeguarding Adults Review (SAR) published by NSAB
- A change in legislation or commissioning requirements
- A team member's suggestion or observation during supervision

SECTION 4 — QUALITY AUDIT PROGRAMME

4.1 Overview

Homekare Community Service operates a rolling quality audit programme covering all regulated activities. Audits are the primary mechanism for identifying compliance gaps, risks, and improvement opportunities. All audit findings must result in an action plan with a named owner and target date within 10 working days.

4.2 Audit Schedule

Audit Area	Frequency	Lead	Aligned Standard
Care Plan & Risk Assessment Audit	Monthly (100% active service users)	Care Manager	CQC Reg 9, NICE NG97
MAR Chart & Medicines Audit	Monthly	Care Manager	CQC Reg 12, NICE NG67
Safeguarding Referral & Compliance Audit	Monthly	Registered Manager	CQC Reg 13, NSAB Procedures
Dignity & Person-Centred Care Audit	Quarterly	HR & Compliance Lead	CQC Reg 10, SCIE Dignity in Care
Health & Safety Audit (incl. risk assessments)	Quarterly	HR & Compliance Lead	HSWA 1974, Management Regs 1999
Training Compliance Audit	Monthly	HR & Compliance Lead	CQC Reg 18, Skills for Care
Supervision & Appraisal Compliance Audit	Monthly	HR & Compliance Lead	CQC Reg 18, SCIE Supervision Guidance
Complaint & Incident Trend Analysis	Monthly	Registered Manager	CQC Reg 16, Reg 17
Safer Recruitment & DBS Compliance Audit	Quarterly	HR & Compliance Lead	CQC Reg 19, Skills for Care Safer Recruitment
MCA & DoLS Compliance Audit	Quarterly	Registered Manager	Mental Capacity Act 2005
Equality & Diversity Impact Audit	Annually	HR & Compliance Lead	Equality Act 2010, SCIE Co-production
Annual Quality Review	Annually	Registered Manager	CQC Reg 17, Skills for Care Annual Report

4.3 Audit Methodology

Each audit must:

- use a pre-designed, standardised audit tool aligned to the relevant regulatory standard;
- sample a minimum of 25% of records per month (or 100% where specified above);
- be completed within the first 10 working days of each month for monthly audits;
- be signed off by the Registered Manager before results are entered into the governance report; and
- generate a written action plan where any finding falls below the required standard.

4.4 Root Cause Analysis

Where an audit identifies a significant or repeated failing, the Registered Manager must conduct a Root Cause Analysis (RCA) within 5 working days. The RCA must:

- identify the immediate cause, contributing factors, and underlying root cause;
- involve the relevant members of Team member (without blame attribution);
- result in a documented improvement action with SMART targets; and
- be reviewed at the next governance meeting to confirm actions are progressing.

SECTION 5 — GOVERNANCE REPORTING CYCLE

5.1 Monthly Governance Report

The Registered Manager produces a monthly governance report reviewed at the monthly management meeting and submitted to the Director / Nominated Individual. It must include data across all of the following domains:

Domain	Data Included	KPI Target
Service User Safety	Incidents, accidents, near-misses; RIDDOR; safeguarding referrals	Zero preventable incidents; 100% RIDDOR on time
Care Quality	Care plan audit completion; outstanding actions; unplanned care changes	100% active client audited monthly
Medicines	MAR audit completion; medication errors; training compliance	100% audit completion; zero un-investigated errors
Safeguarding	Referrals made; response times; NSAB feedback; outstanding actions	100% referrals within 24 hours of concern identified

Workforce	Training compliance; supervision compliance; vacancies; agency usage	≥95% training compliance; ≥90% supervision on time
Complaints & Feedback	Complaints received; response times; outcomes; compliments	100% acknowledged 2 working days; resolved 20 working days
Health & Safety	H&S audit findings; outstanding risk assessments; PPE; COSHH	100% risk assessments current; zero overdue RIDDOR
Quality Improvement	Progress on previous action plans; new improvement actions identified	All action plans progressed with owner and target date

5.2 Quality Improvement Action Plans

Every audit finding, complaint, incident, or feedback item that identifies a gap must result in a documented Quality Improvement Action Plan. The action plan must include:

- a clear description of the finding or concern;
- the root cause (where identifiable);
- the specific action(s) required;
- the named owner of each action;
- a target completion date;
- the regulatory standard or KPI the action will address; and
- evidence of completion, reviewed and signed off by the Registered Manager before closure.

5.3 Annual Quality Review

The Registered Manager conducts a comprehensive Annual Quality Review. This must:

- analyse 12-month trend data across all governance domains;
- compare performance against sector benchmarks (Skills for Care national data, CQC national statistics);
- review the effectiveness of quality improvement actions implemented during the year;
- identify strategic quality priorities for the coming year;
- include analysis of client's satisfaction survey results and complaint trends;
- assess workforce stability, training outcomes, and supervision quality; and
- be presented to the Director / Nominated Individual and used to update the organisational quality strategy.

SECTION 6 — SERVICE USER AND FAMILY INVOLVEMENT

6.1 Annual Satisfaction Survey

Homekare Community Service conducts an annual client's satisfaction survey aligned with SCIE co-production principles. The survey must be accessible (plain English, large print, and easy-read formats available) and must assess:

- dignity and respect — whether client's feel treated with kindness and respect;
- person-centred care — whether care reflects their individual choices and goals;
- communication — whether they are kept informed and involved in their care;
- continuity — whether they see consistent team member's who know them well;
- safety — whether they feel safe with their team member's; and
- overall — whether they would recommend Homekare Community Service's to others.
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A minimum 60% response rate is the target. All negative feedback or scores below threshold must generate a Quality Improvement Action Plan.

6.2 Complaints as a Quality Improvement Tool

Every complaint is a quality improvement opportunity. The Registered Manager must:

- acknowledge all complaints within 2 working days;
- resolve all complaints within 20 working days;
- analyse complaint trends monthly in the governance report;
- refer any complaint that identifies a safeguarding concern to NSAB without delay; and
- ensure every upheld complaint generates a Quality Improvement Action Plan.

6.3 Client Involvement in Quality Review

In line with SCIE co-production guidance, Homekare Community Service will seek to involve clients and their representatives in:

- reviewing survey results and identifying priorities for improvement;
- commenting on proposed changes to care and support delivery; and
- participating in annual quality review discussions where they wish to do so.

SECTION 7 — INCIDENT, ACCIDENT AND NEAR-MISS MANAGEMENT

7.1 Reporting

All incidents, accidents, and near-misses must be reported to the Registered Manager on the same working day they occur or are identified. The Registered Manager logs each event in the incident register and begins an initial review within 24 hours.

7.2 Investigation

The Registered Manager investigates all incidents proportionate to severity:

- Minor incidents — supervisor review with reflective discussion within 5 working days.
- Significant incidents — full investigation with Root Cause Analysis within 10 working days.
- Serious incidents (e.g. unexpected death, serious injury, safeguarding) — immediate escalation to Director; CQC statutory notification within required timeframes; NSAB notification where safeguarding thresholds are met.

7.3 Learning and Improvement

Every investigated incident must produce a documented learning outcome. The Registered Manager ensures:

- learning is shared with relevant team member's through supervision, team meetings, or briefings;
- procedural or care plan changes are made where indicated;
- the incident and learning are referenced in the monthly governance report; and
- trends in incident type or location are escalated to the Director/ Nominated Individual if patterns emerge.

7.4 Duty of Candour (Regulation 20)

Where a notifiable safety incident occurs, Homekare Community Service must notify the client or their representative as soon as reasonably practicable, provide an honest account of what happened, offer an apology, advise what further enquiries will be undertaken, and provide a written record of the notification. The Duty of Candour cannot be delegated. The Registered Manager is responsible for compliance.

SECTION 8 — WORKFORCE QUALITY

8.1 Training Compliance

Training compliance is a core quality indicator aligned with the Skills for Care workforce framework. The mandatory training matrix (maintained by the HR & Compliance Lead) tracks completion of all required training across the workforce. Standards:

- training compliance rate of ≥95% for all mandatory modules at all times;
- 100% of new team member's complete the Care Certificate within 12 weeks of start date; and
- any compliance breach below 95% triggers an immediate Quality Improvement Action Plan.

8.2 Supervision

Regular, structured supervision is both a quality assurance tool and a team member's development mechanism. Minimum supervision frequency:

- new team member's — monthly for the first 6 months;
- all team member's — minimum every 6 weeks;
- Care Manager/ Senior — minimum every 6 weeks; and
- Registered Manager — minimum every 6 weeks, conducted by the Director / Nominated Individual.

Supervision records must be retained in each team member's Individual team file. Supervision compliance is reported in the monthly governance report. Supervision must include reflective practice — not just task review.

8.3 Appraisal

All team member's receive an annual appraisal aligned to the Homekare Community Service Aims, KPIs & Appraisal Framework. The appraisal reviews performance against role competencies, identifies training needs, sets improvement goals, and acknowledges achievement. Appraisal completion rate $\geq 90\%$ is the CQI target.

8.4 Safer Recruitment

Safer recruitment is a fundamental quality safeguard. CQI oversight includes:

- Enhanced DBS checks completed and renewed on schedule for all team members;
- right-to-work verification documented for all team members;
- employment history verified and all gaps explained;
- two satisfactory references obtained before start date; and
- Fit and Proper Person assessment completed for Director/ Nominated Individual and Registered Manager.

SECTION 9 — HEALTH AND SAFETY GOVERNANCE

9.1 H&S Management

Health and safety governance is a component of Homekare Community Service's CQI framework. The HR & Compliance leads the H&S audit programme. The following are monitored monthly:

- Risk assessment currency — all client's and workplace risk assessments reviewed on schedule;
- Manual handling assessments — person-specific and reviewed when needs change;
- COSHH assessments — completed for all substances in use;
- PPE provision — adequate stock maintained and recorded;
- RIDDOR compliance — all reportable incidents submitted to HSE within required timeframes; and
- Accident/incident log — reviewed monthly and included in the governance report.

9.2 Lone Working

All team members operating in the community must be covered by a lone working risk assessment and procedure. The Registered Manager ensures lone working check-in systems are in place, tested regularly, and that all team member's are trained in lone working safety. Lone working incidents are reviewed monthly.

9.3 Infection Prevention and Control

Infection Prevention and Control (IPC) is audited quarterly. The audit covers: PPE use and availability, hand hygiene compliance, COSHH assessment currency, and staff training compliance. Any IPC concern is escalated immediately to the Registered Manager.

SECTION 10 — SAFEGUARDING QUALITY GOVERNANCE

10.1 Safeguarding as a Quality Domain

Safeguarding governance is fully integrated into Homekare Community Service CQI framework. The Registered Manager is responsible for safeguarding quality oversight. All safeguarding activity must align with Nottinghamshire Safeguarding Adults Board (NSAB) multi-agency procedures.

10.2 Making Safeguarding Personal

Consistent with NSAB's Making Safeguarding Personal (MSP) approach, all safeguarding activity at Homekare Community Service must be:

- person-centred — the views, wishes, and outcomes of the person at risk are central to all decisions;
- outcome-focused — what does the person want to happen? Are those outcomes achieved?
- proportionate — responses are appropriate to the level of risk and the person's wishes; and
- documented — MSP conversations and outcome reviews are recorded in the safeguarding file.

10.3 Safeguarding CQI Metrics

Metric	Standard
Safeguarding referral timeliness	100% of concerns referred to NSAB within 24 hours of identification
Section 42 enquiry cooperation	100% full cooperation with all local authority s.42 enquiries; documentation available within 48 hours
Staff safeguarding training	100% of staff hold current safeguarding adults training (Level 1 & 2 for care staff; Level 3 for manager)

MSP documentation	100% of safeguarding records include MSP conversation and desired outcomes recorded
SAR learning	All relevant SARs reviewed and learning embedded within 3 months of NSAB publication
CQC safeguarding notifications	100% of CQC-notifiable safeguarding events submitted within required timeframes

SECTION 11 — KEY PERFORMANCE INDICATORS

The following KPIs are reported monthly in the governance report and used in the annual quality review.

KPI	Standard	Reported By
Care plan audit completion rate	100% of active service users monthly	Care Manager
Mandatory training compliance	≥95% all modules at all times	HR & Compliance Lead
Care Certificate completion	100% within 12 weeks of start date	HR & Compliance Lead
Supervision compliance	≥90% team member's within required frequency	HR & Compliance Lead
Annual appraisal completion	≥90% of eligible team member	HR & Compliance Lead
Complaint acknowledgement	100% within 2 working days	Care Manager
Complaint resolution	100% within 20 working days	Registered Manager
Safeguarding referral timeliness	100% within 24 hours of concern identified	Registered Manager
CQC notification compliance	100% within required timeframes	Registered Manager
RIDDOR compliance	Zero overdue RIDDOR submissions	HR & Compliance Lead
Client satisfaction	≥90% would recommend Homekare Community Service (annual)	Care Manager
Team Member satisfaction	≥80% feel supported and valued (annual)	HR & Compliance Lead

Internal audit completion	100% of scheduled audits on time with action plans	HR & Compliance Lead
CQC rating	Good or above maintained at all inspections	Registered Manager

SECTION 11 — CQC INSPECTION READINESS

Homekare Community Service's operates on the principle of being inspection-ready at all times. The Registered Manager ensures the following evidence set is current, accessible, and well-organised:

- Client's Records — care plans, risk assessments, consent forms, MAR charts, care delivery records
- Individual team file records — Individual team files with DBS, right to work, references, training certificates, supervision, and appraisals
- Governance Reports — last 12 months of monthly governance reports with evidence of director review
- Audit Reports — all completed audit reports with action plans and evidence of completion
- Incident and Complaint Records — all incident reports, RCAs, complaint files, CQC notifications, RIDDOR submissions
- Policy Suite — all current policies, dated, version-controlled, with sign-off evidence
- Training Matrix — current compliance matrix showing all team member's and all modules
- Safeguarding Records — all referrals, outcomes, and NSAB correspondence
- Health & Safety File — risk assessments, H&S audit reports, COSHH, PPE records, accident log
- Quality Improvement Plans — all active and recently completed improvement plans with evidence of progress

SECTION 12 — POLICY REVIEW AND VERSION CONTROL

This policy is reviewed annually or sooner following: any change in CQC guidance or legislation; new or updated NICE or SCIE guidance; NSAB procedural updates; or following a serious quality or safety event. All material changes are approved by the Director / Nominated Individual before implementation.

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