Wood Green Nursing Home Limited

Wood Green Nursing Home

Inspection report

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Date of inspection visit:
15 June 2016

Date of publication:
12 August 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This unannounced inspection took place on 15 June 2016. At our last comprehensive inspection in January 2015 we found the provider was in breach of the regulations as they had failed to report to the Care Quality Commission (CQC) incidents that had resulted in, or had the potential to result in harm to a person using the service. On this our most recent inspection we found that improvements had been made.

Wood Green Nursing Home is registered to provide accommodation, nursing and/or personal care for up to 40 older people. At the time of our inspection 29 people were using the service.

The manager was registered with us as is required by law. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found that medicines management within the service was not robust and checks being completed were not always effective in identifying issues, omissions or errors.

Staff were trained in how to protect people from abuse and harm; they knew how to recognise signs of abuse and how to raise an alert if they had any concerns. Risks to people were assessed and included measures to reduce identified risks and guidance for staff to follow or make sure people were protected from harm. The recruitment process was robust and the provider was as sure, as possible, that staff employed at were suitable and safe to work with people who were cared for by the service. We found that there were a suitable amount of staff on duty.

Formal staff supervision was not always regularly undertaken and in line with the contract agreed with its employees; however staff told us they could access the support they needed when they needed it. Staff attended regular training in areas that were relevant to the needs of people using the service. However, training and updates in relation to end of life care was lacking. People enjoyed their meals and were supported by staff to eat and drink enough to keep them healthy. People were supported to access input from health care professionals as and when they needed it. Evidence of any support provided whilst people waited to be seen by healthcare professionals was not consistently demonstrated.

Staff interacted with people in a positive and caring manner. People were satisfied with the way staff communicated with them and the information they were provided with. We found that staff were respectful and maintained their privacy and dignity whilst supporting them. People were encouraged to remain as independent as possible by staff. Information for staff and people in relation to how to access advocacy services needed to be sourced.

Activities available within the service were limited and not always centred on people's interests. People were clear about how to make their views known and information was displayed about how to make a complaint.

People described to us how staff supported them to maintain relationships with their friends and families.

People were positive about the leadership of the service and had confidence in the registered manager. The provider's quality assurance systems were not always effective in identifying issues or demonstrating how improvements to the effectiveness and safety of the service would be actioned. Peoples' feedback in relation to the quality of the service and complaints were acted upon and improvements made as a result.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines management within the service was not robust and checks being completed were not always effective in identifying issues, omissions or errors.

People were cared for by staff that had the skills and knowledge to protect them from harm.

Recruitment practices were effective and protected the people using the service.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Specialist training and updates for staff in relation to the needs of people at the end of life was lacking.

Staff formal supervisions were overdue, however staff told us they felt well supported in their role and could access support when they needed it.

People's human and civil rights were upheld and staff took appropriate action if people did not have capacity to make decisions.

Is the service caring?

Good

The service was caring.

People were satisfied with the way staff communicated with them and the information they were provided with.

People spoke positively about the caring and kind nature of the staff.

People were treated with dignity and staff respected people's right to privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities available within the service were limited and not always centred on people's interests.

People were clear about how to make their views known and information was displayed about how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People and staff spoke positively about the approachability of the registered manager.

The provider's audits and checks were not all comprehensive and some lacked effective analysis of their findings.

Feedback from people was actively sought both formally and informally and was acted upon by the provider.

Wood Green Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 15 June 2016 and was unannounced. The inspection was undertaken by one inspector and an Expert by Experience. An Expert of Experience is someone who has personal experience of using or caring for a user of this type of care service.

We reviewed the information we held about the service. Providers are required by law to notify us about events and incidents that occur; we refer to these as notifications. We looked at notifications that the provider had sent to us. The provider completed a Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about their service, how it is meeting the five questions, and what improvements they plan to make. We used the information we had gathered to plan what areas we were going to focus on during our inspection.

We liaised with the local authority and Clinical Commissioning Group (CCG) to identify areas we may wish to focus upon in the planning of this inspection. The CCG and local authority are responsible for buying local healthcare/ social care services and checking that services are delivering the best possible care to meet the needs of people.

During our inspection we spoke with nine people who used the service, four relatives, the cook, six members of staff, the registered manager, the quality manager and a director. We observed care and support provided. Not all the people using the service were able to communicate with us so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records about people's care and how the service was managed. These included reviewing three people's care records, two staff recruitment records, one staff disciplinary record, six people's medication records and a variety of other records used for the management of the service;

including staff duty rotas and records used for auditing the quality of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they were happy with how they were supported with their medicines. A person said, "I get my medicine on time". A relative said, "They (staff) seem to know what they are doing with (relative) medication". We reviewed how medicines were being managed within the service. We looked at six medicine administration records (MAR) in depth. We found discrepancies in the levels of medicines in stock for two people and staff were unable to evidence to us that the medicines had been administered as outlined in the MAR. The provider's policy was displayed on the folders containing MAR, stating that 'all boxed medicines must be counted on every medication round', however our findings were that this was not being adhered to by staff. One record where discrepancies were found showed that no count of the boxed medicines had occurred on 19 out of the 21 days that medicines had been supplied to that person. One record we reviewed for a person who had recently been discharged from hospital was unclear in terms of whether the person should be receiving pain relief on a regular basis. Nursing staff told us that they had not given this medicine. However, we found that no pain assessments had been conducted for this person as was the providers' policy to support this clinical decision to determine pain levels. A call was made during our visit to the persons GP to ask for an immediate review of their medicines and need for pain relief. This meant people may be at risk of becoming unwell due to not taking their medicines as prescribed by their doctor.

We saw that one person prescribed a medicinal skin patch for pain relief was having this provided at the correct intervals. However the patch was being alternated between two places on the body and this was not in line with the manufacturer's guidance, which could result in unnecessary side effects. This issue was raised with the registered manager and they agreed to ensure staff were made aware so that future practice was safe. Medicines were audited weekly by staff and a fuller audit was completed monthly by the registered manager. The audits we reviewed were not comprehensive and failed to identify the issues we found. Staff received training in relation to medicines management and periodically competency checks were completed in relation to safe administration of medicines. We found that the guidance for staff in relation to the administration of 'as required' medicines was in place. The ordering and storage of medicines was found to effective.

People told us that they felt the service was safe. People told us, "Yes I feel safe here" and "I feel safe, they (staff) watch me when I am walking to make sure I am okay". A relative told us, "I know (relative's name) feels safe". Staff were clear about their responsibilities for keeping people safe and protecting them from avoidable harm. They were able to describe to us the different kinds of abuse people may be exposed to and what action they would take if they suspected someone was at risk, including the reporting procedures. A staff member said, "It makes a real difference to people when you make them feel safe and secure". Another staff member said, "If I witnessed abuse I would report it to someone senior here, I know it would be acted upon and I know I could tell the local authority too". We saw that staff had attended training in a variety of areas that improved their skills in identifying and protecting people from harm, for example, moving and handling techniques and infection control.

Potential risks to people were effectively assessed in relation to their individual health and support needs.

Staff were able to describe peoples' individual risks and how these were minimised by their interventions, for example, providing regular pressure relief to minimise any skin damage. Records we reviewed detailed how people's health risks should be managed to maintain their safety and wellbeing. Records were updated as required and reviewed periodically. We observed people being supported to use equipment provided to them to assist them to mobilise, for example, walking frames; we observed that staff understood how to support people safely to use their equipment.

Staff were able to describe how they would deal with, report and document any incidents or accidents that occurred. We saw that incident forms were completed in a timely manner, with a brief outline of the immediate actions taken. Staff said they were made aware of any changes to practice or learning from incidents that occurred at handover and/or recorded on the handover sheet.

There was a fire safety risk assessment in place with clear procedures in the event of an emergency evacuation. Staff understood what the evacuation procedures were in the event of an emergency. Tests of the fire safety equipment were carried out regularly to make sure it was in good working order and fire exits were clearly sign posted. Regular checks and audits of the safety of the environment were routinely undertaken.

Overall people told us there were sufficient staff available to support them. People said, "There is a buzzer (the nurse call system) you can press, but you have to wait a little while if they (staff) are busy" and "When they (staff) are busy they will say 'give me five minutes". A relative told us, "They could always do with more staff, I sometimes have to wait for them to open the main door to me". No one we spoke with described having to wait for more than a few minutes during busy times for support from staff. We observed that there were enough staff available to meet people's needs. The registered manager told us that staffing levels were currently reviewed based upon peoples' needs and level of complexity or as more admissions were taken, but that no specific tool was being utilised to determine these numbers. The rotas we reviewed demonstrated that the service was consistently staffed at the levels described by the registered manager. The registered manager told us that they were currently recruiting into a night nurse vacancy and had used agency nurses as an interim measure; however the agency nurses used were mainly the same ones to ensure some consistency and familiarity of staff for people. We observed that the majority of people who chose to stay in their room or had health needs that meant they were nursed in bed. We saw staff periodically checked on these people and spent time ensuring they were happy and that they received the care they needed. The registered manager told us, "Staffing is good at present". Staff spoken with were satisfied that there were sufficient staff available throughout the day and night to provide the support people needed.

We reviewed the processes for recruitment within the service and found these to be effective. Staff confirmed that they had to provide satisfactory evidence in relation to their character, skills, qualifications, work and personal history before commencing in their role. We reviewed the recruitment files for two staff members and found no gaps in their employment history and that appropriate references had been sought. Disclosure and barring service (DBS) checks had also been undertaken for these employees; this helped to ensure that staff were safe to work with people who used the service. Disciplinary records we reviewed demonstrated that the provider had followed their own procedures and policy.

Requires Improvement

Is the service effective?

Our findings

People told us that they felt well looked after and that staff were competent. A person said, "Staff look after me well". A relative said, "Staff appear to know how to look after people". Staff told us that they received training that developed their skills in order to meet people's needs effectively. They said the training they received was a mixture of some online and classroom taught sessions. Staff said, "I think management are supportive when it comes to improving your knowledge with training" and "We get regular opportunities to do training and updates".

Records showed that a variety of training was on offer to staff including their basic training. The provider had taken on contracts with the local authority to provide end of life care for people since our last inspection. At the time of our inspection there were several people who had end of life needs or had life limiting conditions. Some of the staff we spoke with told us that some years ago they had received training in end of life care; others told us they had never received any training. We asked staff if they felt competent to support people with such care needs, they said, "I did a course a long time ago, it would be good to refresh my knowledge", "In terms of end of life care I could do with a brush up on my skills" and "No I have never had any formal training". We spoke with the registered manager who confirmed no specific training was currently being provided; they agreed that this was a potential training gap for a number of staff and agreed to look into training packages.

Staff told us they received formal supervision periodically and that they could access support they needed at any time. Staff said, "I had supervision a few months ago" and "I haven't had any supervision recently, it's overdue". Staff were provided with a copy of the supervision policy and asked to sign a supervision contract upon joining the service, which set out that the provider would provide formal supervision to them at least every eight weeks. We found that staff supervisions were between six to 12 months overdue. We asked the registered manager about this and they agreed that supervisions had fallen behind and told us that a plan was in place to remedy this over the next few weeks.

Staff were provided with an induction when they started working at the service. The service had implemented the care certificate which sets fundamental standards for the induction of adult social care workers. Staff told us they were provided with an opportunity to shadow more senior staff for their first few shifts and were supervised closely during their induction period. A staff member stated, "I got chance to get used to peoples' routines, likes and dislikes. The staff and manager checked in with me regularly to make sure I was okay". Staff told us their induction had made them feel confident when commencing in their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. People told us and we observed that people were not restricted and that their consent was actively sought by staff before assisting or supporting them. A person told us, "I can do what I want when I want". Staff had received training and updates in relation to the MCA and the DoLS. They were able to demonstrate an understanding of the need to consider people's ability to give consent and what may be considered as a restriction of their liberty. One person was subject to a DoLS authorisation at the time of our inspection and staff knew how to support the person in line with this.

People we spoke with told us, "The food is good here", "They (staff) always ask you what you want" and "I like the food here". A relative said, "(Relatives name) tells me she likes the food here". People told us and we observed that staff went to each person telling them what was on offer for lunch and supported them to make a choice; there was no menu available for people to visually see through pictures or to read what was on offer. The cook said they would consider creating one for people to refer to more easily. They told us that where the food on the menu was not acceptable to the person, alternatives were offered. People told us they had plenty of choice and felt they could always ask for something different without issue. We observed that the food on offer was homemade, smelt and looked appetising and was adequate in terms of nutrition. We observed lunch to be well-organised; with those people needing assistance or in their rooms receiving their meal and being assisted if necessary in good time. We saw that people had drinks within their reach throughout the day.

The chef was knowledgeable about people's individual dietary requirements, preparing soft diet food or pureed meals when people had difficulties with swallowing. Staff demonstrated they knew those people who needed additional support and monitoring to ensure their nutritional needs were met. We saw that people's weight was regularly monitored and nutritional assessments were completed and appropriate care plans outlining how these needs should be met were in place. Where the need for specialist dietary advice was required; we saw that referrals had been made to the appropriate external health care professionals. We saw that people were asked regularly for their opinion and thoughts on the menu content at meetings that were held by the deputy manager.

People told us staff met and understood their healthcare needs. A person said, "They (staff) will get me the doctor" and "Staff look after me with appointments and seeing the doctor". A relative said, "I am taking (relatives name) for an appointment that's been organised for her". Records we reviewed contained information for staff in relation to managing peoples' health conditions day to day for example, the potential adverse symptoms that may be experienced by people with diabetes. Staff we spoke with understood people's health care needs and conditions and demonstrated they knew how to support them should they become unwell. We saw that referrals were made to external healthcare professionals on behalf of people, for example to community mental health teams.

Good

Is the service caring?

Our findings

People we spoke with told us that overall staff were caring. One person told us, "Staff look after me", "Some are better than others" and "All the staff are friendly". We saw that people were relaxed around staff and were responded to with warmth and friendliness. A relative said, "The staff appear kind when they look after people" and "You often see staff having friendly banter with people". We saw staff check on people's well-being by asking them if they were comfortable or if they needed anything. They spoke with people kindness and demonstrated their understanding when supporting them.

People were encouraged to express their views and be involved as much as possible in making decisions about support needs. A relative said, "I feel involved and informed". We observed people being supported to make a variety of decisions about a number of aspects of daily living during our inspection, for example what activities they wanted to do. Staff told us they took the opportunity to chat and get to know people and speak with their family members or visitors for any additional information. A staff member described how one person liked to be addressed formally by their full name, and how another liked to be hugged when greeted, as this made them happy.

People, their relatives and visitors told us they were happy with how they were communicated with and the information they received. Each person was provided with a 'service user guide' when they were admitted which outlined what they could expect from the service. We saw that care plans described how best people should be communicated with. Our observations highlighted that staff were patient and took the time to ensure that people understood what was said to them.

A staff member stated, "Advocacy? No I wouldn't know how to go about it". Staff we spoke with were uncertain how they may be able to access independent advice and support for people. The registered manager told us that people would be supported to access advocacy services if they required this. They told us they would source more information re local services and would share and display this with people and staff. No one on the day had the need to access advocacy services.

People told us the care they received was delivered in a respectful and dignified manner. People said, "Staff are respectful to me" and "They (staff) always knock my door and wait to be asked to come in". We observed that staff were respectful towards people and where possible encouraged them to try to do as much for themselves as possible. We observed that people who required support to use the toilet were spoken to discreetly in communal areas and guided carefully by staff to maintain their dignity. Staff were seen to communicate with people using respectful language and supporting them in a dignified manner. Staff members stated, "I always ask people what they want, not just assume and get on with it" and "I help people the way they like and want, whilst making sure they are kept dignified, like shutting curtains, making sure they are covered in between washing with a towel to keep them warm and not exposed". We saw that people's care plans described people abilities and any limitations or their choices about how they wished to be supported.

Requires Improvement

Is the service responsive?

Our findings

We found that attempts were made to review the care provided to people with them and/or their representative's involvement where possible. A relative said, "They (staff) contact me about any changes and let me know if any meeting or checks are coming up". Care plans contained some basic details of people's likes, dislikes and preferences. Staff were able to discuss people's likes and dislikes with us, for example when supporting them with their personal care or dietary needs.

People told us that they enjoyed some of the activities timetabled, such as the visiting vocalist. They were asked their thoughts about the activities available to them, "I'd like to do more", "I'm bored sometimes" and "'I would like more trips out". A relative said, "There are no activities here they (people) sit in a chair all day". Some people spoke about their past hobbies or interests with us and also talked about the activities they used to enjoy. These included, dancing and gardening yet they told us no activities of this type were available to them. An activity timetable was displayed in the front corridor but there were no personalised activities included on the timetable.
The service has no dedicated activity co-ordinator so care staff were expected to organise these as part of their role. During the morning we did not see people engaged in any purposeful activity. In the afternoon we saw periods of time when staff were less busy supporting people but saw little effort was made by them to engage people in meaningful activity or in conversation.

The service had a dining area that had been creatively designed to give the appearance of a coffee shop/cafe for people to enjoy and socialise in. We observed that this was only utilised by one person at lunch time and no activities were offered to people during the day in this purposefully created space. We spoke to staff about activities, they said, "It's hard to fit them in, we do some nail painting and hand massage when we can" and "Lots of people don't like to join in activities; they are not specific to each person, some days are better than others in getting people to do activities". People and staff told us that no access to the local community was planned or took place. This meant that activities on offer failed to support people to follow their interests, as they were limited in choice and relied on the availability of care staff.

People's cultural and spiritual needs were considered as part of their assessment. One person said, "I asked for a taxi to take me to church and they (staff) were very supportive with this". Staff encouraged and supported people to personalise their rooms and display items that were of sentimental value or of interest to them. We saw that each bedroom had a picture and the name of person on the front door which supported people to correctly identify their own room.

People described to us how staff supported them to maintain relationships with their friends and families in a number of ways, including taking telephone messages for them when they were not available and being welcoming towards their relatives and visitors. We saw that visitors could access a hot drink and we saw a number of visitors taking advantage of this facility.

A staff member told us, "We have daily handovers and a written sheet which details changes that have

occurred and what we need to know about". We saw that when changes to people's health or support needs occurred, this was communicated through a verbal handover between shifts and also recorded on the newly developed 'handover sheet'. This document contained information about the person's individual health needs, their room number and a photograph for easy identification for all staff. Our observations throughout the day showed that people were responded to appropriately when they wanted or requested support.

We reviewed how the provider dealt with complaints. People we spoke with knew how to make a complaint. People told us, "I would make a complaint to the manager if I needed too", "I would tell a nurse if I had a concern" and "I would tell the manager if I had any complaints". The people we spoke with and relatives visiting said they knew how to raise issues and confirmed if they requested anything it was done. The service had a complaints procedure clearly displayed which gave people the guidance they needed about how to make a complaint and whom they should contact. Information about how to make a complaint was also included in the 'service user guide' people were given. We found that overall the provider acknowledged, investigated and responded to each complaint received in a timely manner and in line with their own policy. Staff knew how to direct and support people to make a complaint. A staff member said, "I would report it to my senior and get them to take the details to pass it on to the manager, or send them to the manager straight away if they were available". We saw that learning was adopted from complaints made; for example, we saw that new signage had been purchased and erected on the car park following a complaint made about safety and the potential risk of an accident occurring.

Requires Improvement

Is the service well-led?

Our findings

At our inspection in January 2015 we found that the provider was in breach of the regulations as we identified a number of incidents had occurred within the service, which had not been reported to the appropriate external agencies and professional bodies by the provider. The incidents related to allegations of abuse and injury in relation to people who used the service, the provider had a legal responsibility to report these. On this our most recent inspection we found that the provider was reporting incidents effectively and had made the necessary improvements.

Systems in place for the registered manager and provider to monitor the quality of care and potential risks within the service did not consistently identify the issues we identified with medicines management. For example, in the April 2016 monthly medicine audit a discrepancy was noted in the quantity of one person's medicines, but no evidence was noted or recorded of what action had been taken. We also found that the information contained within the incident forms we reviewed was not detailed or consistently clear about what action had been taken to minimise further reoccurrence. Other details such as whether the incident was witnessed by staff or not was not always included. Analysis of incidents completed by the registered manager failed to clearly outline any learning and improvements made. We saw that an alarm mat to monitor someone's movement and minimise their risk of future falls after an incident was not mentioned, but had been put in place. Some monthly analysis was being undertaken by the registered manager to check for trends and patterns in incidents, but no records were available for April or May 2016 as there had been a delay in these being completed. Records of audits and checks being completed that we reviewed varied in the quality of their analysis and evidence of actions taken. This meant that some aspects of the provider's quality assurance process of the service were not robust.

People we spoke with told us they knew who the registered manager was and were positive about their leadership of the service. People said, "He's a new manager and I know I could talk to him" and "He's nice and helps us as well". Relatives told us, "Things have improved since he came; carers are working harder and doing more since he started" and "He's very helpful". The service had a registered manager in post that was registered with the Care Quality Commission. We saw they were available to people and staff throughout the inspection. Staff told us that there was an open culture in the home and they felt comfortable to raise any issues with the registered manager. They said the registered manager was supportive and available to them when they needed support. A staff member said, "I like (registered manager's name), he sorts things out when we go to him and things seem more settled here". Another staff member said, "(Registered manager's name) is a good manager". The registered manager told us they were well supported by the provider and we found that they had good understanding of their responsibilities for notifying us of certain incidents and events.

Staff told us they felt supported in their role through meetings and supervisions. We saw that a range of systems of communication were in place within the home, for example handovers. We found these were effective at ensuring staff had the information they required to provide people with the care and support they required. Staff told us they were clear about their role and what was expected from them and they were encouraged to express their views and make any suggestions which could improve the quality of the service.

The deputy manager performed daily 'walk abouts' and records of these were made available to us; they outlined actions taken if any issues were identified. These included a number of environmental observations for example cleanliness and peoples' access to call bells. These checks included the deputy manager observing staff competency and safe use of moving and handling equipment, when supporting people. However, we did identify from the training records that the deputy manager was significantly overdue an update in current safe moving and handling practice. We raised this with the registered manager who said they would ensure that this was undertaken as soon as possible by the deputy manager.

Peoples' feedback was sought in meetings undertaken by the deputy manager. The provider also sent out satisfaction surveys to ensure people and their relatives were able to provide feedback. A relative told us, "They (provider) organise meetings but I couldn't get to the last one". We saw that the provider had analysed the findings from the surveys and outlined to people how they intended to act on their feedback. For example, feedback about the accessibility of the 'service user guide' was responded to by the provider ensuring a copy was available in each bedroom, in the lobby and copies could be collected from the office as necessary. This demonstrated that stakeholders had a variety of ways to share their experiences and opinions about the service and the provider made change's based on their feedback.

Staff described how they would report any concerns they had if they learnt of or witnessed bad practice. One staff member said, "I would know how to whistle blow and could do this by contacting you (Care Quality Commission) or social services". The provider had a whistle blowing policy, for staff to refer to and was they were also given a copy of this when joining the provider's employment; this detailed how staff could report any concerns about the service and included the contact details of external agencies. Staff were aware of the process for reporting accident and incidents. Staff told us that learning or changes to practice following incidents were cascaded to them in daily handovers or was contained in the handover sheet.