GCH (St Katharine's) Limited

St Katharine's House

Inspection report

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09 October 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 4 and 9 October 2018. It was an unannounced inspection.

St Katharine's House is registered to provide accommodation for up to 76 people who require nursing care. At the time of the inspection there were 55 people living at the service.

At the time of the inspection there was no registered manager in post. 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 last carried out an unannounced inspection of St Katharine's House in December 2017. Following our inspection in December 2017 we published a report in which we rated the service as requires improvement. During our December 2017 inspection we found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). This related to incomplete and inaccurate care records. At this inspection we found that the service had failed to address the concerns.

There was not an effective system in place to monitor call bell response times. The provider's procedures to formally assess, review and monitor the quality of the service were not always effective.

Risk assessments were not always accurate, complete or up to date. People were not always protected from risk due to environmental hazards. Medicines prescribed to people were not always held in stock and were not always stored securely.

People were not always protected from the risk of infection. The premises and the equipment were not always clean, and staff did not always follow the provider's infection control policy to prevent and manage potential risks of infection. Equipment was not always maintained in line with manufacturer's guidance.

Records relating to people's care were not always accurate and complete. Care records did not always contain guidance provided by other healthcare professionals.

Where people required special diets, for example, pureed or fortified meals, these were provided by kitchen staff who understood the dietary needs of the people they were catering for. However, people did not always receive person-centred support at mealtimes.

People we spoke with told us there was a constant change in management and that the service was not always well led. Staff had not completed training on planned dates to ensure that their knowledge and practices were up to date.

The service did not always respond effectively to people's changing needs. Care records did not always

capture person centred information about people's backgrounds, hobbies and interest and daily routines.

People had access to activities that included live entertainment. We observed people enjoying some live entertainment. People knew how to make a complaint and information on how to complain was available in the home.

The service supported people in line with the principles of the Mental Capacity Act (2005) and the service followed the correct procedures when depriving people of their liberty.

People and their relatives told us they benefited from caring relationships with the staff who supported them. There was good communication between staff and the people who used the service. Staff received regular supervision, which is a one to one meeting with their manager.

The overall rating for this service is 'Inadequate' and the service is in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel their provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We are taking further action in relation to this provider and full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations have been concluded. In the interim we have asked for and received a plan from the provider telling us how they are going to address these concerns to inform our ongoing monitoring of this service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not always accurate, complete or up to date.

Medicines prescribed to people were not always held in stock and were not always stored securely.

The premises and the equipment were not always clean, and staff did not always follow the provider's infection control policy to prevent and manage potential risks of infection.

Is the service effective?

Requires Improvement

The service was not always effective.

People did not always receive person-centred support at mealtimes.

Staff had not completed training on planned dates to ensure that their knowledge and practices were up to date.

People were supported in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

Staff were kind and respectful and treated people with dignity and respect.

People benefited from caring relationships.

Is the service responsive?

Inadequate

The service was not always responsive.

Records relating to people's care were not always accurate and up to date.

The service was not always responsive to peoples changing needs.

There was a range of activities for people to engage with.

Is the service well-led?

Inadequate

The service was not well led.

People we spoke with told us there was a constant change in management and that the service was not always well led.

The provider did not have effective systems in place to monitor the quality of service.

There was a clear lack of oversight and governance within the service.

St Katharine's House

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 4 and 9 October 2018 and was an unannounced inspection. This inspection was conducted by three inspectors, a specialist advisor, whose specialism was nursing and two Expert by Experiences (ExE). An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications received from the provider. A notification is information about important events, which the provider is required to tell us about by law. This ensured we were aware of any areas of concern.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 12 people, five relatives, five members of the provider's management team, six members of staff, the chef and the administrator We looked at 12 people's care records, six staff files and medicine administration records. We also looked at a range of records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

People's risks were not always managed safely. People's care plans contained risk assessments, which included risks associated with moving and handling, falls, medication and pressure damage. However, risk assessments were not always accurate, complete or up to date. For example, one person required bedrails. We noted that there had been an incident were this person 'was found on the floor next to the bed' and 'had got out at the end of (their) bedrails'. The provider's policy on bedrails dated October 2016 stated, 'risk assessments should be carried out before use and then reviewed and recorded after each significant change in the resident's condition'. The service had failed to ensure that a risk assessment on the use of bedrails after this incident had been carried out for this person.

The service provider 'risk assessment form' on bedrail risks dated October 2014, highlighted that is 'the resident is or can become agitated/confused/disorientated' the risk of using bed rails is high. Do not use bedrail, consider use of ultra-low, height adjustable bed if available. This person had recently experienced confusion, agitation and disorientation due to their ongoing medical condition. Despite this the service had proceeded to use bedrails. We asked the provider to demonstrate that other options had been considered such as the use of a low adjustable bed, however they could not evidence that this had been considered or their rationale in not following their own policies and procedures.

We found medicines prescribed to people were not always held in stock. One person was prescribed medicine to prevent them from feeling or being sick. However, this was not in stock. Another person was prescribed medicine to treat or prevent constipation, again this was not in stock. This meant that people were at risk of not receiving their medicines as prescribed. One person had previously been prescribed eye drops by their GP. Following a review of medicines their GP decided to discontinue this treatment. However, this medicine was still being stored on the medicines trolley with the person's current medicine. We also noted that the eye drops were out of date. This meant there was a risk out of date eye drops could be applied to the person putting them at risk of harm.

Medicines were not always stored securely. We observed staff leaving a cabinet which was used to store controlled drugs unlocked and unsupervised (controlled drugs are medicines which are more liable to misuse and therefore need close monitoring). We also noted that the medicines storage room had a key code locked door. The code set by staff to lock the medicine storage room was same as other key coded locks in the home. The impact of these practices meant there was a risk that medicines could be accessed by unauthorised individuals.

People were not always protected from the risk of infection. The premises and the equipment were not always clean, and staff did not always follow the provider's infection control policy to prevent and manage potential risks of infection. For example; in one shower room we observed the grouting for tilling was incomplete and one tile was cracked. This could harbour bacteria and be an infection control risk. In a communal part of the home we found a cup which had mould growing inside it, chairs within the room were stained, when we lifted the cushions on these chairs we found used discarded tissues.

On the floor of another shower room we observed an unsheathed disposable razor the floor. This room was covered in dust and the plughole of the shower was heavily stained with lime scale. This showed us this room had not been cleaned for some time. Lime scale staining was also found in communal wash basins, toilets, baths and showers on the nursing unit. We noted that in one bathroom, there was no hand basin available for people to wash their hands after using the toilet. The toilet brush was visibly stained with faeces. Records of cleaning regimes were located within bathrooms, this enabled the provider to ensure that bathrooms were being continually cleaned. However, in one room we found there was no cleaning record.

In one communal bathroom the ceiling was damaged by water ingress and there was a hole in the ceiling. In another communal toilet we observed rust on pipe work and a substance extended along pipework. The toilet bowl in this bathroom was heavily stained. We brought this to the attention of the provider and they told us they would take this toilet out of commission for the foreseeable time. However, when we checked later in the day we found the room was still open. On the second day of our inspection we noted that work had been carried out to address our concerns. However this was not in place on the first day of our inspection.

Equipment was not always maintained in line with manufacturer's guidance. We noted that a hoist scale used to support people with moving and handling tasks was not recorded as neither having been serviced or calibrated. These checks are important to ensure the equipment is working correctly. When we raised this with the provider they informed us that this was a recording issue and that the hoist scale had received a service. However, on the second day of our inspection we were shown an email which confirmed they had not been serviced or calibrated. The impact of this was that people were at risk of using ineffective equipment.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Although the service was not always safe, people told us they felt safe. One person told us, "I feel safe". Another person said, "I absolutely feel safe and able to be independent". A third person told us, "I feel safe, everybody cares for me"".

Staff were aware of how to safeguard people from avoidable harm and were knowledgeable about signs of potential abuse. Staff were able to describe the process for reporting concerns both within the service and externally, if required. One staff member told us, "I would report my concerns to my manager and [provider]. If I did not feel anything was being done that I would contact CQC (Care Quality Commission)".

We observed, and staffing rotas confirmed, there were sufficient staff to meet people's needs. The provider used a 'dependency tool' when carrying out assessments on people's care needs. This enabled the provider to calculate the right ratio of staff against people's needs. On occasions where staffing levels had not been achieved the provider had taken appropriate action to access additional staffing. One person we spoke with told us, "There are enough staff and they always help you".

Staff holding professional qualifications had their registration checked regularly to ensure they remained appropriately registered and legally entitled to practice. For example, registered nurses were checked against the register held by the Nursing and Midwifery Council (NMC).

Safe and effective recruitment practices were followed to help make sure that all staff were of good character and suitable for the roles they were employed for. We checked the recruitment records of five staff

and found that all the required pre-employment checks had been completed prior to staff commencing their employment. This included a completed application form, two written references and disclosure and barring check (DBS). The DBS check helps employers make safe recruitment decisions and prevents unsuitable potential employees from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People who were assessed as being at risk of malnutrition had 'Malnutrition Universal Screening Tools' (MUST) in place. MUST is a five-step screening tool used to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. Monthly weight charts were kept for people who were a risk of malnutrition or who needed to reduce their weight. Monthly weight charts were kept. Where staff were concerned about people's weight or appetite health professionals were contacted for advice and support.

However, records were not always accurate or complete. For example, one person's care records contained two separate monthly weight charts both dated June 2018. Both documents recorded two separate Body Mass Index (BMI) recordings and two separate weight recordings. We asked staff which document was the accurate record, however staff were unable to do this. The person's care records documented that since their admission to the service they had lost 6.8kg in weight. In the absence of up to date and accurate records we could not be satisfied that the service was taking the appropriate action to effectively and safely manage this person's care needs.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

We observed the midday meal experience on the unit supporting people living with dementia and the unit supporting people with nursing needs. The meal time experience across the two units were different. For example, on the dementia unit, we observed people waiting for long periods of time without having their meal served. One person waited seated for thirty minutes for their meal. The person then became angry and left the dining room without having their meal when another resident who arrived in the dining room was served immediately. Two more people, having waited for over 30 minutes, stood up and left the dining room.

A fifth person was walking with purpose between their bedroom and a lounge area. Walking with purpose describes how some people living with dementia can walk between different points within their living environment and can indicate a specific underlying need. Staff were unaware that this person was not in the dining area at lunch time until it was pointed out to them by a member of the inspection team.

We noted that people in the nursing unit appeared to enjoy their lunch and were supported to eat and drink at an appropriate pace. Staff encouraged people to eat independently, stepping in to support them and prompt where needed. People spoke positively about the food. Comments included; "It's home cooking, well balanced, always a choice", "It's very good, as you'd have at home", "The food is brilliant" and "I enjoy the food, you can choose from the menus".

People's needs were assessed prior to their admission to ensure their individual care needs could be met. People's care records contained information about their health and social care needs. They gave guidance to staff on how best to support people. However, the information obtained during the assessment process

was not always used to develop effective care plans. For example, one person had developed a pressure ulcer prior to admission with the service. This had been identified during the assessment process. As a result the service made a referral to the tissue viability team, following the referral the person's care records had been updated and staff were to 'follow wound care management as prescribed wound dressing / recommended by TVN'. However, the person's care records did not contain detailed information on the guidance from the skin tissue viability team.

People were supported by staff who had completed training to ensure they had the skills and knowledge to carry out their roles effectively. However, training records and the provider confirmed that staff had not completed training on planned dates to ensure that their knowledge and practices were up to date. We noted that 15 separate staff members were not up to date with safeguarding and moving and handling training. This meant that staff were not always updated on important information to support people effectively.

We raised this with the provider who demonstrated that although planned training dates had not been attended by staff they could evidence that staff had their competencies checked through supervisions and spot checks. Following the inspection, the provider sent confirmation that training had been arranged to ensure staff were up to date with the providers mandatory training.

Newly appointed care staff went through an induction period which reflected the Care Certificate. The Care Certificate is a set of standards that social care workers are required to work to. It ensures care workers have the skills, knowledge and behaviours to provide compassionate, safe and high-quality care and support. This included training for their role, shadowing an experienced member of staff and having their competencies assessed prior to working independently with people.

Staff received regular supervision, which is a one to one meeting with their manager. Staff told us they felt supported by the registered manager and the provider. One staff member told us, "I get regular supervision". Another staff member said, "We have supervision and we get to talk about what's working and what's not".

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report our findings. The 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. We saw that people were supported in line with the principles of the MCA.

Staff had a clear understanding of their responsibilities in relation to the MCA. One staff member told us, "Assume capacity until proven otherwise". Another staff member said, "It's about people's ability to make safe decisions". Where people were assessed as lacking capacity to make a decision, there were records identifying that a best interest decision had been made. For example, one person had been assessed as lacking capacity to consent to personal care. The person's care plan evidenced how the service had discussed this with the persons family members and acted in the persons best interest.

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 found the home was meeting the requirements of DoLS.

We observed parts of the service had reminiscence areas, which were set up with items from past years. This followed good practice guidance for helping people living with dementia to be stimulated. This is because talking about the past can bring up happy memories and good feelings, and is proven to particularly support people who may be feeling down. Rooms we observed had been personalised and made to look homely.

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Good

Is the service caring?

Our findings

People and their relatives told us they benefited from caring relationships with the staff who supported them. One person told us, "The staff are very kind which is vital. They are very patient and always stop to listen". Another person said, "The staff are compassionate and kind". A relative told us, "The carers are competent, kind and compassionate".

During the day of the inspection, we noted there was good communication between staff and the people who used the service. People were treated with kindness and respect by staff, who understood their individual needs. For example, one person had difficulties communicating. This person's care records gave guidance for staff to recognise and respond to the person's communication needs. During our inspection, we observed staff communicating effectively with this person. Staff gave the person the time they needed to explain what they were asking or discussing. This demonstrated that staff knew and respected the people they were supporting.

Staff showed concern for people's wellbeing in a caring and meaningful way. For example, one person on the dementia unit became upset. Staff spoke with this person and gave them reassurance and held the person's hand. As a result, the person became settled and their mood improved. Throughout the interaction staff knelt to the same level as the person and spoke in a warm and gentle manner.

Throughout our visit we saw people were treated in a caring and kind way. The staff were friendly, polite and respectful when providing support to people. Staff took time to speak with people and reassure them, always making sure people were comfortable and had everything they needed before moving away. For example, one person wanted to move to a different area of the service. Staff knelt down to this person's eye level and asked them which area they would like to move to. The staff member then supported the person with moving to another seated area, during the move the staff member asked the person if they wanted a cup of tea. The person declined and staff respected the person's wishes.

Staff spoke with people with respect using the people's preferred names. When staff spoke about people to us or amongst themselves they demonstrated compassion and respect. During our inspection we noted that staff were always respectful in the way they addressed people. We observed staff knocking on people's doors and where people had their doors open staff still knocked and waited to be invited in.

Staff told us they respected people's privacy and dignity. One staff member said, "We always make sure doors and windows are closed, but dignity is also about keeping people informed about what's happening before you start delivering their care". Another staff member told us, "We make sure people are covered up, but more importantly it's about giving people choices".

Care records highlighted what people could do for themselves in order to remain independent. This included aspects of personal care, mobility and getting dressed. Were the need to promote independence had been highlighted, there was guidance for staff on how to prompt and support people effectively. Staff told us how they supported people to do as much as they could for themselves and recognised the

importance of promoting people's independence. One staff member we spoke with told us, "Supporting independence allows people to carry on doing what they can for themselves and it helps to keep people stimulated".

Staff understood and respected confidentiality. Records were kept in locked cabinets and only accessible to staff.

Inadequate

Is the service responsive?

Our findings

People were at risk of not being supported appropriately as records relating to people's care were not always accurate and up to date. For example, one person's care records contained a document that stated the person had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision in place. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. The person's care records stated that they were not to be resuscitated in the event of cardiac arrest or the person becoming unresponsive. We requested evidence that the instruction to DNACPR for this person had been agreed in line with national guidance. However, the provider was unable to provide this information and as a result we requested that the provider took the appropriate action to ensure that the instruction to DNACPR was accurate. We were informed that the information in the person's care records was inaccurate and the person did not have a DNACPR decision in place.

Another person's care records stated that they were at risk of 'wandering' which is a term no longer used to describe a person with dementia who walks with purpose. The records also stated the person was a 'domestic risk (falling, unsafe use of appliances, fire risk)'. However, following a change in the person's care needs the person was no longer mobile and was cared for in bed. Despite this change in need staff had recorded that there was no 'care plan change required'.

A third person required food and fluid charts to monitor their nutritional input. Food record charts can provide important information that supports a nutritional assessment of a person's treatment and care needs. Although staff had recorded what the person had eaten they had not reviewed the person's intake to determine whether it was satisfactory or not. The document used asked staff if 'food intake satisfactory Yes/No?' There was also an example of how to complete this person's chart in their care records. However, staff had failed to complete the records accurately. This meant that the system designed to monitor a person's ongoing wellbeing was not being used effectively.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The service did not always respond effectively to peoples changing needs. For example, one person's needs changed and as a result they were admitted to hospital for catheterisation. The person's care plan showed the person had a catheter put in place and that it required replacing every 12 weeks. There was no record to show the catheter had been changed at the appropriate intervals. We spoke to a member of staff and the provider's management team who confirmed that the person's catheter had not been changed for over three months. We raised this with the provider and they took action to address this. However, this was not in place on the first day of our inspection.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

Care plans captured people's preferences, likes and dislikes. However, care records did not always capture person centred information about people's backgrounds, hobbies and daily routines. For example, all the staff we spoke with told us how people liked to spend their time and what was important to them. However, the information shared with us by the staff members was not contained within people's care plans. This meant that new staff or agency staff may not easily obtain the person-centred information to support people effectively.

People had access to activities that included live entertainment. We observed people enjoying some live entertainment. People told us they enjoyed the activities at St Katharine's House. One person told us, "There is plenty to keep us busy, you can do as much or as little as you want to". Another person said, "I like the games, I am a champion at one of them". A relative told us "He thinks (activities) are brilliant".

People's individual, diverse needs were respected by staff who understood equality and diversity. One staff member we spoke with told us "We must treat people as individuals".

People knew how to make a complaint and information on how to complain was available in the home. One person told us, "I would just go straight to the senior person in charge". Records showed that where complaints had been made they had been dealt with in line with the provider's complaints policy.

Inadequate

Is the service well-led?

Our findings

At our previous inspection on 13 December 2017 we raised concerns in relation to the oversight and governance of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. Following our inspection in December 2017 the provider submitted an action plan dated 2 March 2018. The action plan clearly stated that improvements would be made in relation to the good governance of the service. We found these improvements had not been made. Therefore, the provider had failed to assess and improve the quality of the service.

At this inspection we found that the systems in place at St Katharine's House designed to monitor and assess the ongoing quality of the service were still ineffective in that they had not identified the issues relating to the safety and wellbeing of people using the service, found during the inspection. For example, the risks associated with bedrails, safe maintenance of equipment, inaccurate information relating to DNACPR instructions and people's care records not being accurate and complete.

The provider carried out audits, however, these audits were not effective. For example, we saw evidence that medicine audits were conducted on a regular basis yet the audits had not identified the risks relating to medicines management we found during our inspection.

This is a continuous breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014.

There was not a registered manager in post. 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 were informed that a new manager had been hired a few days after the former manager left and that she had begun the application process for becoming the registered manager.

People we spoke with told us there was a constant change in management and that the service was not always well led. Comments included; "I could do a far better job than them", "Management do not introduce themselves, so we don't always know there's been a change. I think it's a bit rude", "I wouldn't say the staff here are all happy, it's clear some are not", "It's all in a muddle and they continual change staff", "The leadership here is uncertain", "The fixed boarding school type routine irritates me. There are problems because there isn't a manager who stays long enough. We need stability". A relative we spoke with told us, "I wonder if the people at the Gold Care office understand the job on the ground". Another relative said, "They couldn't run a bath".

The service encouraged open communication between the staff team. A staff member told us, "We have regular meetings". Team meeting minutes showed that staff regularly met to discuss the day to day running of the service. The home sought people's views and opinions through satisfaction surveys.

Staff understood the whistleblowing policy and procedures. Staff told us they felt confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice. One staff member told us, "I would whistle blow if I had to".

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of reportable events.