Scio Healthcare Limited

Highfield House Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The Highfield House Nursing Home is registered to provide accommodation for up to 46 People. The home provides both personal and nursing care support to older people including those living with dementia. The home also provides short term rehabilitation support for up to seven people. At the time of the inspection the home accommodated a total of 45 people.

There was 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.

The inspection was unannounced and was carried out on 11 and 16 May 2016.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided sufficient information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received an induction into the home and appropriate training, professional development and supervision to enable them to meet people's individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

There were suitable systems in place to ensure the safe storage and administration of medicines. Medicines were administered by staff who had received appropriate training and assessments. Healthcare professionals such as chiropodists, opticians, GPs and dentists were involved in people's care when necessary.

Staff followed legislation designed to protect people's rights and ensure decisions were the least restrictive and made in their best interests.

Staff developed caring and positive relationships with people and were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain relationships that were important to them.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people, when necessary in a patient and friendly manner.

People, and where appropriate their families, were involved in discussions about their care planning, which reflected their assessed needs. Each person had an allocated nurse and keyworker, who provided a focal point for that person and maintained contact with the important people in their lives.

There was an opportunity for families to become involved in developing the service and they were encouraged to provide feedback on the service provided both informally and through an annual questionnaire. They were also supported to raise complaints should they wish to.

People's families told us they felt the home was well-led and were positive about the registered manager who understood the responsibilities of their role. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the home.

There were systems in place to monitor quality and safety of the home provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People and their families felt the home was safe and staff were aware of their responsibilities to safeguard people.

The registered manager had assessed individual risks to people and had taken action to minimise the likelihood of harm in the least restrictive way.

Medicines were managed appropriately. People received their medicines at the right time and in the right way to meet their needs.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Staff sought verbal consent from people before providing care and followed legislation designed to protect people's rights.

People were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and on-going training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

Staff understood the importance of respecting people's choices and their privacy.

People were encouraged to maintain friendships and important relationships.

Is the service responsive?

Good

The service was responsive.

Staff were responsive to people's needs.

Care plans and activities were personalised and focused on individual needs and preferences.

People were allocated nurse and a keyworker who provided a focal point for their care and support.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Good

The service was well-led.

The provider's values were clear and understood by staff. The registered manager adopted an open and inclusive style of leadership.

People, their families, health professionals and staff had the opportunity to become involved in developing the service.

There were systems in place to monitor the quality and safety of the service provided and manage the maintenance of the buildings and equipment.

Highfield House 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 checked 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.

The inspection was unannounced and was carried out on 11 and 16 May 2016. The inspection team consisted of two inspectors and a specialist advisor who had clinical experience and knowledge of frail older people and in particular those living with dementia.

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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with the 11 people using the service and with five visitors. We spoke with one health professional and received feedback from seven others. We observed care and support being delivered in communal areas of the home. We carried out pathway tracking of three people using the service, which meant we observed them and how staff interacted with them, looked at their care records and spoke with them and members of their family. We spoke with three members of the care staff, two nurses, a volunteer, the clinical team leader, two activities coordinators, the training manager, the catering manager, the chef, the head house keeper, the registered manager and four directors.

We looked at care plans and associated records for seven people using the service, staff duty records, five staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in August 2014 when no issues were identified.

Good

Is the service safe?

Our findings

People told us and indicated they felt safe. One person said, "I feel very safe and secure". Other comments by people included: "Yes I feel safe, no trouble here", "I get my medication regularly" and "Staffing sometimes not to quick, if I need something they come as quick as they can". A family member told us "I feel mum is safe, always seems to be okay and has got a buzzer to call for help. We've had no concerns." Health professionals told us they did not have any concerns over people's safety.

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. All of the staff and the registered manager had received appropriate training in safeguarding. Staff knew how to raise observed concerns and to apply the provider's policy. One member of staff told us "If I had a concern I know I can go to safeguarding but I would go to [the registered manager] first. Management are very hot on safeguarding and reporting incidents". A senior member of staff told us "Staff follow procedures and if concerned will tell me straight away, and I would always make sure the resident is safe first. Then I would inform the deputy or manager who was on duty, then write a report and start an investigation. The manager will inform safeguarding and if they didn't I would". The registered manager explained the action they would take when a safeguarding concern was raised with her and the records confirmed this action had been taken when a safeguarding concern had been identified. The registered manager had reported any safeguarding concerns to the appropriate authority in a timely manner.

People were protected from individual risks in a way that supported them and respected their independence. The registered manager had assessed the risks associated with providing care to each individual; these were recorded along with actions identified to reduce those risks. They were personalised and written in enough detail to protect people from harm, whilst promoting their independence. For example, one person was at risk of choking. A risk assessment had been completed and detailed the action that staff should take to reduce the risk while supporting them to eat. This included not speaking to them while they were chewing their food. We observed staff supporting this person at lunchtime and saw staff following the risk assessment and speaking with them after they had swallowed their food. For people who were at risk of skin damage special cushions and mattress were used to reduce the risk of damage to their skin. Staff told us, a system was in place to check people who required a pressure mattress on their beds were set at the right pressure. The registered manager had also identified risks relating to the environment, such as the use of oxygen, slips and trips on stairways, the use of electrical appliances and activities in the garden.

Staff were able to explain the risks relating to people and the action they would take to help reduce the risks from occurring. Moving and handling assessments clearly set out the way to move each person and correlated to descriptions given by care staff. Staff had been trained to support people to move safely and we observed equipment, such as hoists, being used in accordance with best practice guidance. Where an incident or accident had occurred, there was a clear record of this and an analysis of how the event had occurred and what action could be taken to prevent a recurrence. People's care records and risk assessments were updated when they had be subject of a fall or other incident.

There were enough staff to meet people's needs. The provider told us that staffing levels were based on the needs of people using the service. They explained they had assessed staffing in line with a national guidance produced by a specialist company, who are an independent organisation providing information and market intelligence to the independent health and community care sectors. For homes, such as Highfield House Nursing Home, providing nursing care the suggested benchmarks is 38 hours per person per week, inclusive of both care and nursing provision. The provider was able to demonstrate the home was consistently providing staffing in excess of the benchmarked hours. There was a duty roster system, which detailed the planned cover for the service, with short term absences being managed through the use of overtime or staff from one of the other homes owned by the provider. The registered manager was also available to provide support when appropriate. People and their families provided mixed feedback in respect of staffing levels and identified times when staff appeared to be "very busy" and on occasions they had to wait longer for call bells to be answered. We pointed people's concerns out to the providers who undertook to review their deployment strategy.

The provider had a safe and effective recruitment process in place to help ensure that staff who were recruited were suitable to work with the people they supported. All of the appropriate checks, including Disclosure and Barring Service (DBS) checks were completed on all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

People received their medicines safely. Staff had received appropriate training and their competency to administer medicines had been assessed to ensure their practice was safe. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. There was a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions and a process for the ordering of repeat prescriptions and disposal of unwanted medicines. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

There were arrangements in place to deal with foreseeable emergencies. There was also a fire safety plan for the home. Staff were aware of the plan and were able to tell us the action they would take to protect people if the fire alarm went off.

Good

Is the service effective?

Our findings

People and their families told us they felt the service was effective and that staff understood people's needs and had the skills to meet them. One person said, "It's all very good". A family member said the staff were, "very good overall". Another family member told us their relative was, "well looked after". Health professionals told us the staff were knowledgeable about the people they supported and they did not have any concerns about the staff's ability to look after people effectively.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. The provider had clear policies, procedures and recording systems for when people were not able to make decisions about their care or support. We saw staff followed these by consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. For example, a best interest decision had been made in respect of people who required bedrails to be fitted to their bed to protect them from falling out.

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 are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS applications had been made to the supervisory body with the relevant authority for all of the people using the service. The registered manager carried out a review of the applications on a regular basis to ensure they were still required. Staff had been trained in MCA and DoLS; they were aware of the people that these restrictions applied to and the support they needed as a consequence. People's families and other representatives had been consulted when decisions were made to ensure that they were made in people's best interests and the least restrictive option.

People and their families told us that staff asked for their consent when they were supporting them. Staff sought people's consent before providing care or support, such as offering to provide support to help them mobilise. One member of staff told us, "Upstairs where people have capacity I say is it okay if [to do personal care] or do you want to get up yet. Downstairs [The dementia specialist wing where people lack capacity] we work to their routines. I explain what I am doing, for example personal care and make a best interest decision. I keep talking with them and explain what I am doing even if they don't respond". We saw staff checking with people and seeking consent before supporting them. Daily records of care showed that where people declined care this was respected.

There were arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on the principles of the care certificate

which is a set of standards that health and social care workers adhere to in their daily working life. Each new member of staff was allocated a mentor to provide on going support, advice and guidance. They spent time shadowing more experienced staff, working alongside them until they are competent and confident to work independently. The training manager provided oversight of the training across of the provider's services and was able to draw on issues identified and lessons learnt and feed them into the providers' training programme. They also worked with other organisations to ensure that training opportunities were maximised.

The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as, fire safety, infection control, manual handling and safeguarding vulnerable adults. Staff had access to other training focused on the specific needs of people using the service, such as, dementia awareness, diabetes awareness and palliative care. Staff were also supported to achieve a vocational qualification in care. One member of staff told us, "I get regular training on Wednesday I am doing my mandatory training and I have recently completed my manual handling training, which was very good. They make you hoist people, not just talk about it. You get to experience it yourself [being hoisted]". Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example how they supported people who were living with a cognitive impairment to make choices and maintain a level of independence.

Staff members had access to supervision an annual appraisal. However, for some staff these were sporadic. Supervisions and appraisals provided an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. Staff said they felt supported, and the registered manager had an open door policy and they could raise any concerns straight away. During our inspection we observed staff regularly going into the registered manager's office for an informal chat. We raised this with the provider's representative who took action to ensure supervisions were completed in a structured way.

People were supported to have enough to eat and drink. People told us they enjoyed their meals. One person said, "The food is excellent, the cook is very good it's very good food". Another person told us staff "bring me in a hot drink at night; we get lots of choices for food and drinks. If I didn't like anything on the menu staff might suggest an omelette". Other comments included "I go downstairs for my main meal, and have sandwiches in my room"; "good food" and "We have a choice of food and choose the menu the day before". A family member said, ""The foods ok, I've eaten here"

The catering manager provided a link between the nursing staff and the kitchen staff. They told us people's dietary needs were assessed before admission or by the nursing staff and then monitored. When appropriate, guidance was obtained from the Speech and Language Therapy Team (SALT). The catering manager had recently put in place a new system to monitor people's nutritional and hydration needs, which provided the opportunity to put in place additional interventions when nutritional or hydration issues were identified.

The chef and kitchen staff were aware of people's likes and dislikes, allergies, preferences and special dietary requirements. Both the catering manager and the cook were aware of the new regulations in respect of the management of food allergens. These regulations require organisations to display information about the top 14 food allergens, such as nuts or wheat, and list any menu items which may contain any of those allergens. Menus were planned weekly, and people were given a choice of two hot options the day before, or they could have a jacket potato, salad and cold meat or an omelette.

People told us they could choose where to eat, either in the dining room or in their room. People were

encouraged to eat well and staff provided one to one support where needed. Staff closely monitored the food and fluid intakes of people at risk of malnutrition or dehydration and took appropriate action where required. The new food and fluid charts were completed for people who required this. However, these were not always completed correctly for some people. We raised this with the registered manager and the catering manager who felt it was because staff were still in the process of getting familiar with the forms.

Meals were appropriately spaced and flexible to meet people's needs. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner. Staff were aware of people's needs and offered support when appropriate. A member of staff told us, "We try to encourage people to eat their meals downstairs in the dining room so it is a social occasion, where people can meet and chat to each other. It is also especially important for people on the rehab programme to help with their independence."

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail.

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. One person told us, "I like being here, I am looked after very well, staff are very kind". Another person said, "The staff are lovely, lovely girls". Other comments from people included, "Staff are polite and cheerful" and "[Named member of staff] is very nice and very caring". A family member told us, "Staff are very nice, [my relative] seems to get on well with them". Health professionals were positive about how staff cared for people.

People were cared for with dignity and respect. Staff spoke to them with kindness and warmth and were observed laughing and joking with them. One person told us staff, "maintain my privacy and dignity" and added "staff will knock on my door". People had a specific care plan related to dignity, which focused on how they wanted to be supported in areas, such as with their personal care. The registered manager had identified a member of staff to be a 'dignity champion' who was responsible linking in with the community and identifying best practice in respect of supporting people's dignity.

Staff had good knowledge of the individual likes and dislikes of people and understood the importance of respecting people's choice, and privacy. They spoke with us about how they cared for people and we observed that personal care was provided in a discreet and private way. One member of staff said, "I love working here, it's a pleasure to come to work". Staff knocked on people's doors and waited before entering. A member of staff told us that when supporting people, "We have do not disturb signs on the door. I make sure the curtains are closed; door shut and put a towel over their lap. I explain what I am doing; if they can do it themselves I encourage them". Staff were very respectful of people's privacy and were able to speak with people privately. There were also rooms available for people to meet privately with friends and family should they wish. The movement of the people at the home was unrestricted and they were able to choose where they spent their time. We spoke with some people who chose to spend their time in their own rooms. They said the staff respected this and offered them opportunities to join others if they wished.

People and when appropriate, people's families were involved in discussions about developing their care plans. The care plans were in the process of being upgraded to ensure the care provided was centred on the person as an individual. We saw that people's new care plans contained a 'Life diary's' which include information on people's family, education, schools and how they like to bath in the morning as well as how they like to have their hair and what toiletries they like. What people like to wear their religious beliefs and the people who were important to them. They also included information such as 'I can get confused and anxious when people try to rush me'. Staff used the information contained in people's care plans to ensure they were aware of people's needs and their likes and dislikes.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. This identifies people who are important to the person. All of the families we spoke with confirmed that the registered manager and staff supported their relatives to maintain their relationships. People's bedrooms were personalised with photographs, pictures and other possessions of the person's choosing.

Information regarding confidentiality formed a key part of staff's induction training for all care staff. Confidential information, such as care records, was kept securely within the office and only accessed by staff authorised to view it. Any information which was kept on the computer was also secure and password protected.

Good

Is the service responsive?

Our findings

People and their families told us they felt staff were responsive to their needs. One person said, "I think the home is very good and staff are brilliant". A family member told us, "We are happy with the home. Been in and out of several homes, so far this is one of the best". Health professionals told us that staff were responsive to people's needs.

People experienced care and support from staff who were knowledgeable about their needs and the things that were important to them in their lives. Staff's understanding of the care people required was enhanced through the use of care plans, which detailed people's preferences, backgrounds, medical conditions and behaviours. These plans were detailed and reviewed on a regular basis. They also included areas such as, maintaining a safe environment, personal hygiene, behaviour, communication and mobility. The care plans were in the process of being upgraded to ensure the care provided was centred on the person as an individual.

People and when appropriate their families, were involved in discussions about their care planning, which reflected their assessed needs. People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Handover meetings were held at the start of every shift, these focused on issues and actions affecting people, which provided the opportunity for staff to be made aware of any changes to the needs of the people they were supporting.

Each person had an allocated nurse and a keyworker. A member of staff explained, "Everyone has a named nurse who will complete their care plans and risk assessments. They also have a keyworker or buddy who will work closely with them. We tend to keep the same people, as the more you know about people the more you can provide special care and go above and beyond". The key worker's role was to provide a focal point for that person and maintain contact with the important people in the person's circle of support. They also supported them with their shopping, managing their clothes and maintaining their room.

Staff were knowledgeable about people's right to choose the types of activities they liked to do, and respected their choice. People had access to activities that were important to them. The home had two activities coordinators who provided both group activities, such as arts and crafts, quizzes and live music, and one to one sessions for people who preferred to stay in their rooms. People told us they enjoyed the activities provided. One person said staff provided, "good activities, people [coming in to perform], quizzes and bingo trying to keep us active. We had Brownies here on Saturday in garden planting and singing songs. [The activities coordinator] came round putting sun cream on everyone so we didn't burn". Another person told us, "I go to activities most days, they are okay".

People and their relatives were encouraged to provide feedback and were supported to raise concerns if they were dissatisfied with the service provided at the home. One person said, "I went to a resident meeting and we asked about having a mini bus for trips out, like they do at the [another home owned by the provider], we are still waiting to hear". We looked at the minutes of previous meetings and where concerns and requests were raised we saw that these had been actioned and responded to.

The registered manager sought feedback from people and their families on an informal basis when they met with them at the home or during telephone contact. They also sought formal feedback through the use of quality assurance survey questionnaires sent to people. We looked at the feedback from the latest survey, from April 2016, which was all positive in respect of the care people received, comments included 'The home is excellent, very fit for purpose' and 'the family and I are truly grateful for the love and care given to [my relative]. Thank you'. Everyone who had completed the survey confirmed they would recommend the home to others. There was also two compliment cards from relatives displayed on the reception counter for staff to read.

One of the directors of the home had recently held an open door day, which provided an opportunity for people, their relatives and staff to speak with him on an informal basis to provide feedback and raise any concerns. We saw these interactions were documented and where concerns were raised action points were made and followed up.

The provider had a policy and arrangements in place to deal with complaints. They provided detailed information on the action people could take if they were not satisfied with the service being provided; this information was available in the foyer and in the service user guides given to people and their families. People and their relatives told us they knew how to complain but had not needed to do so. The registered manager told us they had not received any complaints since the home was last inspected and was able to explain the action that would be taken to investigate a complaint if one was received.

Good

Is the service well-led?

Our findings

People and relatives told us they felt the service was well-led. One person said, "I've seen the registered manager, she's very nice". A family member told us, "The manager being very supportive" with regards to their relative. Another family member said, "[The registered manager] is marvellous". The health professionals were positive about the leadership at the home.

The providers were fully engaged in running the service and their vision and values were set out in the 'service user's guide'. There were posters reinforcing the provider's expectations with regard to people's experiences of the care displayed in the home. There was a clear management structure with a registered manager, heads of departments, nursing staff, care staff and administration staff. Staff understood the role each person played within this structure. There was the opportunity for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities, such as monthly resident meetings, the providers open door day and the feedback survey. Positive feedback was also recorded through a compliments file.

Staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the potential for the management team to engage with staff and reinforce the provider's value and vision. They also provided the opportunity for staff to provide feedback and become involved in developing the culture of the service. There was an opportunity for staff to engage with the management team on a one to one basis through informal conversations and supervisions, although for some staff these were sporadic. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They said that they enjoyed their jobs and described management as supportive. Staff confirmed they were able to raise issues and make suggestions about the way the service was provided in one to one or staff meetings and these were taken seriously and discussed. One member of staff said there was, "very good management here and I feel part of a team" they added "Of all the homes I've worked in this is the best; love it". Another member of staff told us they felt, "supported by the manager".

The provider had suitable arrangements in place to support the registered manager, for example regular meetings, which also formed part of their quality assurance process. There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. These included regular audits of medicines, staff files, infection control, environmental health and safety, and fire safety. The registered manager also carried out an informal inspection of the home during a daily walk round. The provider carried out their own quality assurance process and provided documentary feedback of their findings to the registered manager. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes.

The providers were responsive to new ideas and had developed links with external organisations and professionals to enhance the staff's and their own knowledge of best practice and drive forward improvements. For example one of the providers was a member of the local authority safeguarding board and the chairman of the Isle of Wight Registered Nursing Homes association.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

Although, the provider and the registered the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration.