Alliance Care (Dales Homes) Limited

Mill House

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 27 July 2017 and was unannounced.

Mill House is a care home registered to provide care for up to 43 people. At the time of our visit there were 33 elderly people living at the service, all of whom required nursing and personal care. The accommodation was arranged on two levels of the service's building.

There was a registered manager in post, who was a regional support manager with the provider. The service was being managed on a day to day basis by a new manager who had been in post since February 2017 and was supported by the registered manager. The new manager was planning to apply to become the registered manager. 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.
Staff were clear about the action they would take to keep people safe from abuse. People and staff were confident they could raise any concerns and these would be dealt with properly.

The provider had a 'traffic light system' in place to alert and guide staff. However, that system was not always used effectively. Most of the risks to people's health were identified and plans were in place to manage the risks. These had been kept under review and were relevant to the care being provided.

Medicines were administered in line with recognised good practice, which significantly reduced the risk of people being subject to unsafe medicines administration. Staff received regular medication training. However, staff members did not undergo competency checks to evidence they were safe to administer medicines. Other training of staff, for example fire safety training, was not always up-to-date. As a result, it could not be ensured whether staff had the relevant skills and knowledge to meet people's needs. Staff had not been receiving regular supervision to support their practice and development. The manager had identified this already and had a plan in place to ensure staff would receive supervision going forwards

People were not always protected from the risk of fire as the testing of fire equipment had not always been carried out in accordance with the provider's policy.
A quality assurance system was in place but it was not always effective as it had failed to highlight and address the issues identified at our inspection.
We found recruitment procedures were safe with appropriate checks undertaken before new staff members commenced their employment. Staff told us their recruitment had been thorough and professional.

The principles of the Mental Capacity Act 2005 (MCA) were understood and were being followed. Mental capacity assessments and best interest decisions were recorded in relation to applications for Deprivation of Liberty Safeguards (DoLS), and the use of bed rails and wheelchair lap belts for people who lacked capacity.

People were supported to maintain a healthy diet and referrals had been made to relevant healthcare professionals. Records confirmed people were seen by doctors, dieticians and care home support service.

There was a calm, warm and friendly atmosphere at the service. People told us staff were kind and caring, which we also observed on the day of inspection.

Staff ensured people were treated respectfully and with dignity at all times. People felt involved and able to make decisions regarding their care.

Staff used the care plans to guide them when providing person-centred care. Most of the care plans contained information about people's past history, the places where they had lived and what interested them.

The service had a complaints procedure which was made available to people they supported. People told us they knew how to make a complaint if they had any concerns.

The manager was approachable and ensured they listened and consulted people, relatives, and staff on how the service was run. Staff understood their responsibilities and took accountability for the role.
We found a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have advised the provider to take at the end of this report.

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 always safe.

Testing of fire equipment had not always been carried out in accordance with the provider's policy.

Systems to alert and guide staff were not always used effectively. This means that some crucial information might not be not readily available in case of an emergency.

Staff knew how to protect people from abuse or poor practice.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff's training was not always up-to-date to ensure they had the skills and knowledge to meet people's needs.

Staff understood the requirements of the Mental Capacity Act 2005 (MCA) and how this applied to their daily work.

People had access to healthcare professionals to make sure they received appropriate care and treatment.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and who delivered care in a compassionate way.

Staff knew the people they were supporting. People and their relatives felt that they received a caring service from the registered provider.

People who use the service and their relatives said the staff were caring and treated them with dignity and respect.

Is the service responsive?

Good

The service was responsive.

Pre admission assessments were carried out to ensure the service was able to meet people's needs.

People were supported to take part in a vast range of activities.

The provider had an effective complaints policy and procedure in place. People and their relatives knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

A quality assurance system was in place but it was not always effective as it had failed to highlight and address the issues identified at our inspection.

Staff and people spoke highly of the manager and the way she ran the home.

Regular meetings kept staff up-to-date and reinforced the values of the organisation and their application in practice.

Mill 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 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.

This inspection took place on 27 July2017 and was unannounced.

The inspection was carried out by three inspectors and an expert-by-experience. 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 also reviewed the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We contacted the local authority commissioning team, the safeguarding adults team and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During our inspection we spoke with ten people using the service and four visiting relatives. We obtained feedback form the manager, the deputy manager, a registered nurse, two care assistants, two agency staff, the activities coordinator and the cook.

Not everyone living in Mill House was able to speak with us and tell us about their experiences of living in the home. We therefore observed how people were supported and how staff interacted with people. 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 to us.

We reviewed care plans for six people, four staff files, training records and records relating to the management of the service such as audits, policies and procedures.

Requires Improvement

Is the service safe?

Our findings

The provider had systems in place to alert and guide staff around risks relating to people's health. However, these systems were not always used effectively. For example, there was a 'traffic light system' used to highlight people's medical conditions and alert staff of such conditions. The forms used were not always complete. One person had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order document in place. The traffic light system had a DNAR box which had not been completed for that person. Another person was diabetic and used insulin injections. The box for medical conditions in the alert form for the person in question had not been filled with relevant information, either. Another person had a waterlow score form completed to assess risks of pressure area damage. The risk score on the form was not totalled thereby rendering it useless. This meant the risk to this person had not been adequately assessed.

Another person was diabetic and had a nutrition care plan in place. The nutrition care plan stated they were on a normal diet and drank standard liquids. The same person had a long term urinary catheter in place which needed changing every 12 weeks. Staff told us the urinary catheter was regularly changed, however, there was no record of when it had last been changed or when it would be next due to be changed. This means that agency staff could not be informed and be unaware of the next catheter change date.

Staff who administered medicines were trained and their competencies checked at the induction. However, thereafter the provider's new policy indicated staff competencies in medicine administration would not be checked but staff would sign a competency disclaimer. Some staff told us they did not feel confident without having their competencies checked on a regular basis. We spoke to the manager who agreed to raise this issue with the provider.

We found that health and safety checks were not carried out in line the provider's policies to ensure people were safe. For example, the last fire system check took place in May 2017 while according to the provider's policy this should be checked on a weekly basis. Also, we found gaps in fire door weekly checks, emergency lightning checks, fire escape routes inspections and carbon monoxide detectors checks. There were only two trained fire wardens in the service. At the time of the inspection both of them were on annual leave. No night staff were trained as fire wardens. The emergency grab bag folder contained an out-of-date list of the residents with information about their mobility and rooms. The emergency grab bag holds things which are essential if people had to leave the home in a hurry. Records showed relevant safety checks were carried out daily in the kitchen, for example temperatures of the fridges, food labelling and expiry date checks. Following the inspection we made a referral to the fire service highlighting our concerns.

The service did not always take appropriate action to reduce potential risks relating to Legionella disease. Legionella disease is a severe form of pneumonia caused by legionella bacteria. The legionella bacteria is found naturally in fresh water. It can contaminate hot water tanks, hot tubs, and cooling towers of large air conditioners. During our inspection we found that weekly flushing records had not been completed twice since 14 June 2017 and monthly hot and cold water temp tests were last recorded on 31 May 2017.

These issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives felt the service was safe. One person told us, "Staff are very good to me, this makes me feel safe". Another person said, "I feel absolutely safe. Staff are nice and kind and I feel I can talk to anybody if I have a problem". One of the relatives told us, "I feel he will be very safe and well looked after here".

We spoke with staff about what actions may need to be taken to ensure people were protected from abuse. Staff were aware that incidents of potential abuse or neglect should be reported to the local authority. A member of staff told us, "Types of abuse include physical, emotional and financial abuse". Staff told us they would report any concerns to the manager and take further action if needed. One member of staff said, "I would speak to the management or the clinical lead. If they didn't act, I would report to the CQC"". The manager knew their responsibilities to report concerns to the relevant authority in a timely way. Staff explained how they knew people well and would be aware if a person was distressed or worried about something.

Prior to people receiving support, risk assessments were undertaken at the initial assessment stage. The assessments related to, for example, eating, drinking or mobility risks. Then a full risk assessment was drawn up when the person started using the service, which was subject to regular reviews. For example, when one person's health had deteriorated, a range of risk assessments had been produced. These risk assessments covered the areas of mobility, choking, manual handling and skin integrity. Where people had been identified as being at risk of developing pressure sores, pressure relieving equipment was in place and this was regularly monitored. With the exception of the one file where the Waterlow was not completed we found that risk assessments were undertaken and fully completed. All the risk assessments were reviewed monthly or, if circumstances changed, even more often.

A thorough recruitment policy and procedure was in place. We looked at the recruitment records for staff and saw that they had been recruited safely. Records included application forms (including employment histories, with any gaps explained), interview records, references, proof of identity and evidence of a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals. This helps employers make safer recruiting decisions and employ only suitable people who can work with children and vulnerable adults.

Most of people and their relatives told us there was a sufficient number of staff on shift. One person told us, "I only used the call bell once, they were very good and came straight away". Another person said, "'There are enough staff about but I care for myself". One of the relatives said, "Definitely, there seems to be enough staff around. It does not take long to get somebody". However, one person remarked, "I'm not sure there are enough staff. Staff are very good but all so busy. I feel sorry for them. They are on their knees by the end of the shift". Another person's relative told us, "There are not enough nurses [staff]. They are all rushed and I think a few more would help". We looked at the staffing rota for the last eight weeks to determine if the staffing levels were sufficient. We saw that the staffing levels were appropriate and in case of a shortage of staff the service used agency staff. The provider used the same agency staff regularly to maintain consistency of care. The service had recently recruited an administrator and a receptionist to relieve staff from not care related tasks and give them more time to interact with people.

People received their medicine as prescribed and the home had safe medicine administration systems in place. The provider had a medicine policy in place which guided staff on how to give medicines to people safely. We observed staff administered medicines to people in line with their prescription. There was

accurate recording of the administration of medicines. Medicine administration records (MAR) were completed to show when medication had been given or, if not taken, describe the reason for not administering it.

There were protocols in place for medicines as required (PRN). The medicine stocks we checked were kept appropriately. Topical MAR charts were complete with no gaps. Medicine fridge temperatures were checked daily and any temperature excursions reported and actioned.

Medicines in monitored dosage systems were stored securely in locked cabinets in medicine store rooms which were kept locked at all times when not in use. Controlled drugs (medicines which are controlled under the Misuse of Drugs legislation) stocks were checked by two staff members to ensure the medicines had been administered as prescribed. There was also a medicine fridge which was kept at an appropriate temperature.

People were protected from the spread of an infection. The kitchen staff ensured the kitchen remained clean and free from potential cross infection. They adhered to food safety standards and ensured the food was prepared safely. They wore appropriate protective clothing, food was kept at appropriate temperatures and other staff had limited access to the kitchen.

Housekeeping staff followed the colour coding system for their cleaning equipment. As a result, the spread of a potential infection was reduced because, for example, toilet cleaning equipment was not used for cleaning bedrooms and communal areas. Care staff and nurses wore protective plastic gloves and aprons when delivering personal care so as to reduce the risks of cross contamination. We observed that staff washed their hands and used hand cleansing products before performing various tasks.

Requires Improvement

Is the service effective?

Our findings

People told us they received care from staff that were well-trained. One person said "Staff look after me very well. They are very well trained". Another person pointed out, "They done more for me here than anyone did when I was at home". One person's relative told us, "I can't fault them. Staff know [person] well and she gets the right care".

All new staff had undertaken induction training which had included the completion of mandatory training in relevant areas, and completed a probationary period. Newly employed staff members shadowed more experienced staff for two weeks and had their competencies assessed. For example, in how to safely move people with hoists. We were told the period of shadowing could be extended if necessary. The induction programme was linked to the nationally recognised Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. A member of staff told us, "The induction training was great. I had no caring background and it prepared me for the role". However, another staff member told us their induction was shortened due to low staffing levels. The member of staff told us, "I didn't shadow long enough due to staff shortages and didn't feel ready. I could have done with more shadowing shifts than just three days. It worked out fine, though".

We looked at the training records which showed staff had completed a range of training courses which included: moving and handling, first aid, safeguarding adults, the Mental Capacity Act, and infection control. However, some staff lacked training in fire safety, fire drills, and nutrition and hygiene.

We found that not all staff members were supported with regular supervision due to the changes in the management and a high turnover of staff. A member of staff told us, "I have not had any supervision". We did not see recent appraisals in people's files or clear development plans to support staff members to obtain further qualifications and promote their professional development. The manager had identified that this was an area that required improvement and we saw evidence of supervision dates booked for the next months.

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.

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 noted that the care plans contained information about people's mental state and cognition. Some people were unable to give their verbal consent regarding some areas of their care. Records showed that in such cases the person's next of kin and health professionals were involved to ensure decisions were made in the person's 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).

The manager had made applications to the local authority when people were needed to be deprived of their liberty for their own safety. We saw that any conditions were being met and staff were providing care in the least restrictive way. Staff had received training regarding the MCA and DoLS and demonstrated a good understanding of the principles of the MCA and how it applied to their work. A member of staff told us, "The MCA is about having the capacity to make decisions for yourself. Always assume capacity unless proven otherwise". Another member of staff said, "We do best interest decisions for people who lack capacity".

We found Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms were in place to show if people did not wish to be resuscitated in the event of a health care emergency, or if it was in their best interests not to be. Each of the DNACPR forms seen had been completed appropriately, however the existence of a DNACPR was not always highlighted in the 'traffic light system', which was a quick reference document at the front of the care file.

People's nutritional requirements had been assessed and documented. People received the support they needed to ensure their diet was nutritious and well-balanced. People's weight was routinely recorded and monitored to promote their health and well-being.

Staff had a good understanding of each person's nutritional needs and how these were supposed to be met. People who needed support with their meals were assisted patiently and with respect and dignity. The service had gone above and beyond their duty to support a resident and a relative who were predominantly vegetarian but who had a love of fish and chips. At the person's request the chef provided variations on fish and chips every day for lunch for the person and for their relative who came in to support them with eating.

People were encouraged to drink liquids to avoid dehydration and were offered hot drinks, water and fruit squash throughout the day. People's food and fluid intake was monitored. We looked at records which were completed daily and showed that people received the recommended amount of fluid daily.

When there were concerns about a person's health or well-being, immediate action was taken, such as contacting the person's GP or seeking guidance from professionals such as the care home support services or a dietician. People were supported to maintain good health by accessing health care services and obtaining advice from their GP, a chiropodist and an optician. One person told us, "What I like is if you have an appointment at the doctor's or the hospital, telephone a member of staff and there is always a carer to go with you".

Good

Is the service caring?

Our findings

People using the service and their relatives spoke very positively about staff and the care they received. One person complimented staff saying, "They are nice kind people, know me well. Very lucky to be in such a nice place". Another person told us, "Staff are fantastic, staff are remarkable in the way they care for people". One person's relative said, "Staff take very good care of him. They are all very good carers. They care for [person] very well".

People told us that they had developed good relationships with staff who understood their needs, preferences and goals. People felt they received regular and consistent care, no matter how complex their needs were. One person told us, "They are compassionate and caring towards everybody".

We observed that staff respected people's dignity and privacy. Staff knocked on people's doors before entering their rooms. They also ensured the curtains were pulled and the doors were closed while they provided people with personal care. One person told us, "They always knock on my door. Bath or showers, I feel well-supported. Yes, I feel treated with dignity and respect". Another person said, "They treat me with dignity and respect. They talk and listen to me, I have no complaints".

We used the Short Observational Framework for Inspection (SOFI) and observed staff assisting people with their meals. People were offered food options by staff who talked to them or used gestures and other prompts to ensure people understood them and could make their choices. We observed staff assisting people with eating and drinking in a calm and caring manner. Staff worked well as a team; there was frequent communication among staff members who shared all information needed to ensure people's needs were met.

People were able to have visitors at any time and they could talk to their guests in the privacy of their own rooms. One person told us, "Visitors come in when they want to-any time". Another person's relative said, "I come in every day to support my husband. I can come in any time I want to".

People were given a choice of where and how they preferred to spend their time. We saw staff helping people to be as independent as possible, providing support and assistance where required. Staff gave examples of people's choices in their day-to-day routine, for example the time they went to bed and got up and the activities they joined in. People were supported by staff to maintain their independence and this was reflected in their care plans. When we asked a staff member how they promoted people's independence, they replied, "We give people choices and continuously encourage them to do what they still can".

Staff were discreet and respected people's confidentiality. A member of staff told us, "We do not discuss the residents with other residents or visitors". Another member of staff said, "We keep care files locked in the office ". We saw that records containing people's personal information were kept in the main office which was locked so that only authorised persons could enter the room. People knew where their information was and they were able to access it with the assistance of staff. Some personal information was stored on a

password protected computer.

Good

Is the service responsive?

Our findings

People' needs were assessed before they came to live at Mill House. The aim was to make sure the home was able to fully meet the person's needs and expectations. Following the initial assessments, care plans were prepared to ensure staff had sufficient information about how people wanted their care needs to be met. Care plans were reviewed to reflect people's changing needs. When a person's needs changed, the care plan was updated to reflect these changes. For example, one person's skin condition had deteriorated. The person had been referred to their GP and the tissue viability team who had given staff guidance and new treatment plans. The care plan had been updated in line with the guidance given and records showed staff followed the guidance.

Staff used the care plans to guide them when providing person-centred care. Most of the care plans contained information about people's past history, the places where they had lived and what interested them. The manager was in process of updating care plans and obtaining people's life history from people and their relatives.

A variety of social activities were available at the service. Each resident had a weekly activity sheet in their room and the activity coordinators visited each person to let them know what was happening and encourage them to join in. A 'six days a week' activity programme was organised and run by two activity coordinators. Day-to-day activities ranged from exercises, art and craft, gardening, cookery, reminiscence to cinema showings, bingo, quizzes, and word games. The service was visited by entertainers, musicians and singers, and a group bringing in zoo animals to enrich the activity programme. One person told us, "Every day there is something going on". Another person said, "We have lots of chatting sessions. Enjoy what is going on. I like quizzes and word games".

The activity programme at Mill House provided an important community link, offering young people the chance to come in and work with and entertain older people. Pupils from a local primary school, together with some of the residents had created a mosaic in the garden. The pupils had chatted with the residents and had gained an insight into history which had helped them to prepare projects concerning the Second World War.

Other links with the local community had been established with the local community, such as a link with a local beauty salon. People regularly visited the salon and were offered manicures, head massage and hand massage done by supervised students. Peoples' spiritual needs were met through regular church services.

The managers sought people's feedback and took action to address issues raised. People and their relatives participated in an annual satisfaction survey. The results of the survey were analysed and improvements were made in areas highlighted by people. For example, the service had enhanced the activity programme.

The service had a complaints policy and procedure. The manager and staff were able to explain how they would deal with a complaint. Since our last inspection, the service had received one complaint which had been dealt with to the complainants' satisfaction. Staff were aware of the complaints policy and told us they

would immediately help people to raise an official complaint if needed.

People had been provided with all the information they required to be able to make a complaint. The information was also available in an accessible format to make sure people with a disability, impairment or sensory loss were provided with a clear explanation of how to raise a complaint. None of the people and relatives we spoke to had made any complaints but they said they would feel comfortable to talk with any of the managers if they were unhappy about any aspect of their care. One person told us, "No complaints at all. If I had one I would tell them straight". Another person said, "I don't have anything to complain about".

The equal opportunities policy was available at the service. This stated the provider's commitment to equal opportunities and diversity. People's cultural and religious backgrounds as well as people's gender and sexual orientation were recognized and respected within the service.

Requires Improvement

Is the service well-led?

Our findings

There was a registered manager in post, who was a regional support manager with the provider. The service was being managed on a day to day basis by a new manager who had been in post since February 2017 and was supported by the registered manager. The new manager was planning to apply to become the registered manager. 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 provider had a number of systems in place to monitor the standard of care delivered to people. The quality assurance and monitoring system was in place to assess the quality and safety of the service and to ensure continuous improvements. Where audits had shown that improvements had been needed, action plans had been produced. These had been reviewed and updated to ensure that the required actions were completed and the improvements achieved. For example, a copy of the MCA was made available for staff and the whole kitchen was in the process of being renewed.

However, the systems for monitoring care quality were not always effective as they had failed to address some issues. For example, the fire logbook had been reviewed and the service identified same issues we found during our inspection, such as the lack of fire emergency checks. However, the service had not ensured action was taken to address the issues.
Although some relatives were concerned about communication with the management and were unsure who the manager was, other relatives and staff told us the leadership had improved.

People and their relatives said that a number of improvements had been made over the last year. People's rooms had been redecorated, floor covering replaced, the quality of meals improved and a wider range of activities was available. One person's relative told us, "I was horrified when I first came in. Cleanliness, more activities and in-house catering is so much better".

People living at the service and their relatives told us they felt the service was well-led. People and their relatives said they found the manager and care staff approachable and helpful. One person said, "The manager is approachable". A relative of a person told us, "The manager has been so reassuring when she came to see [person]".

Staff told us they enjoyed working at the service and found the management team supportive. Staff said they could speak with the manager and provider about any issues. They were listened to and saw actions taken regarding their suggestions or requests. Staff told us there had been changes at the service and were positive about this. One staff member said, "The manager is supportive and approachable". An agency staff member told us, "The manager is very nice and approachable. [Name], the deputy and I have worked shifts on the floor. How they (managers) make me feel is one of the reasons I want to work here".

We saw evidence of regular staff meetings. The meetings kept staff up-to-date and reinforced the values of

the organisation and their application in practice. Staff told us the meetings were useful and enabled staff to contribute to the service development and improvement by sharing their ideas. The recent meetings included topics such as communication, staffing levels and infection prevention. One staff member said, "We have had two staff meetings in the last four months".

There was a procedure for recording incidents and accidents. Any accidents or incidents relating to people who used the service were documented and actions taken were recorded. However, the registered manager had not had access to the system and therefore had not been able to review all accident and incident reports.

There was a range of policies and procedures specifying how the service needed to be run. They were kept up-to-date in line with new developments in social care. The policies protected staff who wanted to raise concerns regarding instances of malpractice within the service. Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported. Staff told us that they would escalate concerns to the CQC as well as to the local authority. Effective procedures were in place to keep people safe from abuse and mistreatment.

The provider and the manager had produced a business continuity plan which covered many contingencies. These included, for example, fire, bad weather conditions or events of a flu epidemic or pandemic. The business continuity plan was very thorough and prepared the service for running smoothly through many possible events that could affect the well-being of people using the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service failed to ensure that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do safely. The service failed to ensure that the premises used by the provider are safe to use for their intended purpose and are used in a safe way. 12 (2) (c) (d)