Richmond Care Villages Holdings Limited

Richmond Village Letcombe Regis

Inspection report

South Street
Letcombe Regis
Oxfordshire
OX12 9JY

Tel: 01235773970
Website: www.richmond-villages.com

Date of inspection visit:
01 December 2016
05 December 2016

Date of publication:
11 January 2017

Ratings

Overall rating for this service	Good

Is the service safe?	**Requires Improvement**
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

This inspection took place on the 1 and 5 December 2016. It was an unannounced inspection.

Richmond Villages Care Home is a care home with nursing for 53 older people, which includes people living with dementia. On the day of our inspection 51 people were living at the home.

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.

People told us they felt safe. Staff understood their responsibilities in relation to safeguarding. Staff had received regular training to make sure they were able to recognise and report safety concerns. The service had systems in place to notify the appropriate authorities where concerns were identified.

People were supported by staff who were knowledgeable about people's needs and provided support with compassion and kindness. People received quality care that was personalised and met their needs.

Where risks to people had been identified risk assessments were in place and action had been taken to manage the risks. Staff were aware of people's needs and followed guidance to keep them safe. People received their medicines as prescribed. However, accurate records of medicine stock were not always maintained and fluid thickeners were not always used safely. The registered manager also informed us about two recent medicine errors. The registered manager took immediate action to resolve these concerns.

There were not always sufficient staff to meet people's needs. Staffing levels were generally maintained and we saw the use of agency staff had decreased. However, some people and all staff told us there were often staff shortages. The service had robust recruitment procedures and conducted background checks to ensure staff were suitable for their role.

Staff understood the Mental Capacity Act (MCA) and all staff applied its principles in their work. The MCA protects the rights of people who may not be able to make particular decisions themselves. The registered manager was knowledgeable about the MCA and how to ensure the rights of people who lacked capacity were protected, this included Deprivation of Liberty Safeguards (DoLs).

The service had systems to assess the quality of the service provided. Improvements were identified and action taken which promoted people's safety and quality of life. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

People had enough to eat and drink. People told us they enjoyed the food and we saw where people needed support with eating and drinking this was provided appropriately.

Staff spoke positively about the support they received from the registered manager. Staff supervisions and meetings were scheduled as were annual appraisals. Staff told us the registered manager was approachable and there was a good level of communication within the service. However, some staff felt communication with the provider was not effective.

People and their relatives told us the service was friendly, responsive and well managed. People knew the registered manager and staff and spoke positively about them. The service sought people's views and opinions and acted upon them.

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.

People did not always receive their medicines as prescribed. However, the registered manager had taken appropriate action to address our concerns.

People told us they felt safe. Staff knew how to identify and raise concerns.

Risks to people were managed and assessments were in place.

Is the service effective?

Good

The service was effective

People were supported by staff who had the training and knowledge to support them effectively.

People had enough to eat and drink and told us they enjoyed the food.

Staff had been trained in the Mental Capacity Act (MCA) and understood and applied its principles.

Is the service caring?

Good

The service was caring.

Staff were kind, compassionate and respectful and treated people and their relatives with dignity and respect.

Staff gave people the time to express their wishes and respected the decisions they made. People were involved in their care.

The service promoted people's independence.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised and gave clear guidance for staff

on how to support people.

People knew how to raise concerns and were confident action would be taken.

People's needs were assessed prior to receiving any care to make sure their needs could be met.

Is the service well-led?

Good

The service was well led.

The service had systems in place to monitor the quality of service and look for continuous improvement.

People knew the registered manager and spoke to them with confidence.

There was a whistle blowing policy in place that was available to staff around the service. Staff knew how to raise concerns.

Richmond Village Letcombe Regis

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 the 1 and 5 December 2016. It was an unannounced inspection. This inspection was carried out by two 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.

We spoke with six people, two relatives, four care staff, a hostess and the registered manager. We looked at six people's care records and medicine and administration records (MAR). We also looked at a range of records relating to the management of the service. This included five staff files. The methods we used to gather information included pathway tracking, which captures the experiences of a sample of people by following a person's route through the service and getting their views on it. 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.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and notifications we had received. A notification is information about important events which the provider is required to tell us about in law.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. Comments included; "I feel very safe. I've never experienced any harassment", "Yes I feel quite safe" and "I'm very happy with the care I get, I do feel safe". One relative said, "I'm very happy with this place and the care she (person) receives".

People were supported by staff who could explain how they would recognise and report abuse. Staff told us they would report concerns immediately to the registered manager. Staff were also aware they could report externally if needed. Staff comments included; "I would go to the duty nurse and see my manager. I can also call safeguarding or the police" and "I can report any safeguarding concerns to the manager, my colleagues and safeguarding team". One nurse said "I know my staff know how to recognise and report abuse. I'm confident staff would report to me". The service had systems in place to investigate concerns and report them to the appropriate authorities.

Risks to people were managed and reviewed. Where people were identified as being at risk, assessments were in place and action had been taken to manage the risks. For example, one person was at risk of falls. The person used a walking frame to mobilise independently for short distances and a wheelchair for longer distances. The person's care plan provided staff with guidance on how to support this person. This included ensuring the person was wearing suitable footwear and that their wheelchair was safe for use. We observed staff following this guidance and saw the person wearing suitable footwear. A falls diary was maintained to enable staff to look for patterns and trends relating to falls. For example, one person had slipped off their chair several times and following a referral to healthcare professionals, staff were guided to ensure a non-slip mat was used on the person's chair. We saw this mat was in place and being used.

Other risks managed included, pressure care, swallowing and choking and risks associated with any evacuation of the building.

We asked people and relative's if there was sufficient staff to support them and meet their needs. We received conflicting views. One person said "There are definitely enough staff. They are very quick to answer the call bell and respond to my needs. They often come in for a chat". However another person said "No there is not enough staff. I do use the call bell, sometimes they don't come at all. You just have to wait. It can vary depending on time of day". One relative said "Some mornings she (person) has not been got up but generally there are plenty of staff around".

Staff told us there not always enough staff to support people. This was because staff were often off at short notice. Staff comments included; "We seem short staffed all the time. We struggle to manage. We use a lot of agency staff and a lot of new staff have left", "Staffing levels are poor. We never have time to spend with residents. We are constantly on the go. We work like a conveyor belt", "Not always enough (staff) no. We are running around quite a lot and this can impact on people's care if we are short", "I would like to have more time to spend with residents. We put residents who need double up early to bed to ease the pressure on night staff. It's not right" and "No, there is not enough staff. At times when we are short things become a little task oriented, we get little time to interact (with people). They get the care they need but not the

stimulation".

On the first day of our inspection the 'elderly and frail' unit was short of two staff from approximately 08.00 until agency staff arrived at approximately 10.30. Staff on this unit appeared busy and rushed in their duties. We pressed a call bell after lunch and waited for 20 minutes before a member of staff responded to the call. Staff rotas showed staffing levels were generally maintained. However, short falls were seen regularly on the rota and some records contained corrections and crossings out evidencing rotas had been revised on the day due to shortages of staff. On the second day of our inspection staffing levels were maintained and a calmer, more relaxed atmosphere could be felt in the home. We spoke with the registered manager about these concerns. They said, "We do sometimes have shortages, particularly if staff go sick or don't turn up as has happened today (first day of our inspection). We cover with agency but our ongoing recruitment rates have improved and agency use is on the decline. I can now deploy an extra nurse who deals with admissions and assessments where needed and this has helped". A dependency tool was used to assess people's needs and deploy staff appropriately. We also noted the vacant deputy manager's post had not been filled. The registered manager told us the provider was still recruiting. Staff absence and sickness was managed in line with the provider's staff attendance policy. We found that where staff shortages occurred this had a minor impact on people relating to staff interaction and stimulation but could find no evidence this consistently impacted on people's care.

Records relating to the recruitment of new staff showed relevant checks had been completed before staff worked unsupervised at the home. These included employment references and Disclosure and Barring Service checks. These checks identify if prospective staff were of good character and were suitable for their role. This allowed the registered manager to make safer recruitment decisions.

People did not always receive their medicine as prescribed. On the first day of our inspection the registered manager alerted us to two medicine errors that had been discovered the day before. We saw the errors did not harm the two people concerned and the registered manager was taking action to resolve these concerns. This included removing the agency nurse responsible from working at the service.

We found one person being given fluid thickener prescribed for another person. Both people were given the correct consistency and were not at risk. We informed the registered manager who immediately took appropriate action and resolved this concern. This included ensuring this person was prescribed their own thickener. On the second day of our visit we saw this concern had been resolved.

On the 'elderly and frail' unit, we could not find accurate records that the home maintained stocks of people's boxed medicines. Carry forward balances were not recorded therefore accurate stock levels could not be audited. The registered manager said they had a member of staff booked to update them on the night following the inspection. On the second day of our inspection we saw the record inaccuracies had been resolved.

Records confirmed staff who assisted people with their medicine had been appropriately trained and their competency had been regularly checked. We spoke with staff about medicines. Staff comments included; "I receive refresher medicines training every six months" and "I've no problem with medicines, my competency gets regularly checked".

People told us they received their medicine as prescribed. People's comments included; "Medication is administered on time. They bring it to me and wait whilst I take it", "They give me my medication every day at 7.30" and "I only have medication when I need it". One relative said, "What I have seen they (medicines) are managed well".

Good

Is the service effective?

Our findings

People told us staff had the skills to support them effectively. People's comments included; "I was briefly in the care sector so would say they (staff) are well trained in what they do", "Oh yes, they seem well trained" and "Staff are fairly consistent and they are still training when they are here". One relative said, "Yes, the staff are well trained".

People were supported by staff who had the skills and knowledge to carry out their roles and responsibilities. Staff told us they received an induction programme linked to the Care Certificate and completed training when they started working at the service. The Care Certificate is a set of standards that social care workers adhere to in their daily working life. It is the new nationally recognised set of minimum standards that should be covered as part of induction training of new care workers. Induction training included fire, moving and handling, safeguarding and infection control. Staff then spent two days observing experienced staff practice followed by a period of shadowing an experienced staff member before being signed as competent to work on their own.

Some staff told us they did not receive effective support in the form of supervisions. Supervision is a one to one meeting with their line manager. One staff member said, "I have not had any supervision in a year". Another staff member said, "It's impossible to have supervisions. My last supervision was more than a year ago". We raised this concern with the registered manager who said, "I have now recommenced supervision meetings and they are scheduled to take place throughout the year. We saw that supervisions were now scheduled and some had recently taken place.

We discussed the Mental Capacity Act (MCA) 2005 with the registered manager. 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. The registered manager was knowledgeable about how to ensure the rights of people who were assessed as lacking capacity were protected. Where people were thought to lack capacity mental capacity assessments were completed. Assessments related to specific decisions and the person's best interests were considered.

People were supported by staff who had been trained in the MCA and applied it's principles in their work. Staff offered people choices and gave them time to decide before respecting their decisions. Staff demonstrated an understanding of the MCA. Staff comments included; "We assume everyone has capacity unless proven otherwise. We give people choices of activities, clothing and food" and "This is about how I communicate with people with dementia and whether they have capacity to make certain decisions. You have to give them choices. Both tell them and show them".

Staff demonstrated a good understanding about how to ensure people were able to consent to care tasks and make choices and decisions about their care. Throughout our visit we saw staff offered people choices, giving them time to make a preference and respecting their choice. For example, during the lunchtime meal

we saw people's preferences regarding food and drink were respected. We spoke with staff about consent. One member of staff said, "I always ask first. They do let me know, especially when the answer is no. I ask again but always respect their decisions".

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). These safeguards protect the rights of people by ensuring that if there are any restrictions to their freedom and liberty these have been authorised by the supervisory body. On the day of our inspection four people were subject to a DoLS authorisation. The registered manager told us they continually assess people in relation to people's rights and DoLS.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GP, care home support service (CHSS) and speech and language therapist (SALT). Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans. One person said, "If I need a doctor it is arranged quickly and they will arrange for me to see a dentist".

People told us they enjoyed the food. Comments included; "Food is excellent, very fresh. There are choices, plenty of food. I like to have a sandwich for lunch and I did have a cooked breakfast which was cooked perfectly", "I like to go downstairs and eat with my friends or visitors. The restaurant is very good and it is a good place to eat and meet" and "Cannot complain about food and drink. You have choices, It's very nutritious and well cooked. Yes mealtimes are good". One person told us how staff supported other people. They said, "The staff are very kind to the residents, they come and feed some in the dining room. They never make a fuss".

We observed the midday meal experience. This was an enjoyable event where the majority of people attended. Food was served hot from the kitchen and looked 'home cooked', wholesome and appetising. People were offered a choice of drinks throughout their meal. People were encouraged to eat and extra portions were available. Where people required special diets, for example, pureed or fortified meals, these were provided.

Good

Is the service caring?

Our findings

People told us they enjoyed living at the home and benefitted from caring relationships with the staff. People's comments included; "Staff are very caring, oh yes", "I am very happy with the service and the very good staff", "They are quite caring" and "Staff are very friendly with all us residents. They do know my likes". One relative said," Staff are very caring and very good, never patronising. They are good with dementia".

Staff told us they enjoyed working at the service. Comments included; "I love it here, the whole atmosphere. Our residents are lovely" and "I really enjoy it, I love working with people and other staff".

People were cared for by staff who were knowledgeable about the care they required and the things that were important to them in their lives. Staff spoke with people about their careers, families and where they had lived. One staff member said, "One resident was difficult to talk to so I found out what he used to do for a living and researched this and where he worked. We then had a brilliant chat about it and he really opened up to me. It was wonderful". During our visit we saw numerous positive interactions between people and staff. For example, one person, who was living with dementia, was dancing to some music. A staff member approached them and said, "That's lovely, can I join you". The person held out their hands and they both danced together. Both the member of staff and the person were laughing and smiling. There was clearly a genuine warmth and affection between the two.

We observed staff communicating with people in a very patient and caring way, offering choices and involving people in the decisions about their care. People were given options and the time to consider and choose. For example, one person came into the lounge and staff asked them where they would like to sit. The person considered this for a moment before pointing at a particular chair. They were then supported to their choice of chair and made comfortable by staff.

People's independence was promoted. For example, one person needed assistance with washing and dressing. The care plan highlighted the person could 'wash their own face' and 'choose their own clothes'. Staff were guided to 'pass the flannel' to the person and 'guide their hand to their face'. We spoke with staff about promoting people's independence. Staff comments included; "I use the saying 'use it before you lose it' to promote independence", "We encourage residents to do what they can as much as possible" and "I try to get people to walk where they can. I do the same with personal care".

People's dignity and privacy were respected. When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. We observed staff treating people with dignity and respect throughout our visit. One relative said, "Yes her dignity is protected. She is able to give yes or no answers. She is offered choices about who helps her".

We spoke with staff about promoting people's dignity and respecting their privacy. Comments included; "I close doors and draw curtains to keep things private", "We ensure residents are dressed before we let in visitors" and "I always knock on their doors, keep them covered during personal care and I check for their consent".

People were involved in their care. People were involved in care reviews and information about their care was given to them. People had also provided personal information enabling the service to involve them on a personal level. People's birthdays were recorded and celebrated and personal information was used by staff to allow them to engage with people. For example, where people became anxious or upset staff referred to people's histories or interests to reassure them or distract them. We saw this approach calmed people.

People told us they were involved in their care. Comments included; "I can be very vocal and yes, they do listen", "They are very precise with my care plan. They do make notes about my preferences", "We are kept informed of everything" and "I was involved in a review six months ago". One relative said, "Yes her care is reviewed regularly, it is all documented".

People's advanced wishes were respected. One person had an advance care plan, (a plan of their wishes at the end of life) and a do not attempt cardio pulmonary resuscitation (DNACPR) document in place. People, their families and professionals contributed to the plan of care so that staff knew this person's wishes and made sure the person had dignity, respect and comfort at the end of their life. For example, one person had stated they did not wish to become hospitalised if they became very ill. Staff understood the importance of keeping people as comfortable as possible as they approached the end of their life.

The provider ensured people's care plans and other personal information was kept confidential. People's information was stored securely it the Nurses office. Where staff left their desks when in the office, computer screens were turned off securing people's information. Staff understood and respected confidentiality. One staff member said, "We don't talk about residents with other residents". Another said, "We do not automatically give confidential information over the phone".

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission to the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person had stated they liked magazines and 'social company'. Another person's plan stated they enjoyed music and we saw this person being supported to listen to their choice of music. Care plans were detailed and were reviewed regularly.

People's care records contained detailed information about their health and social care needs. They reflected how each person wished to receive their care and gave guidance to staff on how best to support people. For example, one person sometime experienced difficulty speaking and 'often used non-verbal communication'. Staff were guided to 'give [person] time to think and respond'. Staff were aware of this person's needs. One staff member said, "I don't rush them or make decisions for them".

Care plans and risk assessments were reviewed to reflect people's changing needs. Staff completed other records that supported the delivery of care. For example, where people needed creams applied, a body map was in use to inform staff where the cream should be applied. Staff signed to show when they had applied the cream. Where people's needs changed the service sought appropriate specialist advice. For example, staff responded to a person whose condition changed. The person experienced difficulty in swallowing and was referred to their GP who prescribed fluid thickener. We saw the new thickener was being used.

People were offered a range of activities including games, sing a longs, arts and crafts, keep fit and visiting musicians. A programme of activities was published and circulated around the home. On the second day of our inspection a local school was visiting the home to perform a carol service.

People told us they enjoyed activities in the home. Comments included; "It is excellent. Everyone is very friendly. There is plenty going on if you want to get involved", "It is lovely. I don't go out but can go down to the restaurant with my friends. I'm not into activities I just like meeting my friends" and "We have lots of exercise sessions, tai chi, singing and they arrange outings. We are occasionally asked about what we would like to do".

During our inspection we saw one person enjoying a manicure in their room. We saw the staff member was patient, caring and kind and the person was fully involved making comments and suggestions. This was clearly an enjoyable experience for the person. We also saw staff engaging with people on the dementia unit. Staff chatted with people and read and discussed newspapers with them.

People's care was recorded in daily notes maintained by staff. Daily notes recorded what support was provided and events noted during the day. These provided a descriptive picture of their day. For example, one member of staff had written 'ate well at breakfast and was very chatty'. Another had noted 'enjoyed the music this morning with our entertainer'.

People knew how to complain. Details of how to complain were provided to people and their relatives when they moved into the home. This included contact details for the Local Government Ombudsman (LGO). All concerns and complaints were recorded and investigated. Minor concerns were dealt with by staff immediately whilst the registered manager dealt with formal complaints. The complaints we saw had been dealt with in a timely and compassionate manner in line with the provider's policy. We spoke with people about complaints. Their comments included; "I haven't had any cause to complain. This place is very exclusive", "I haven't had any concerns or complaints" and "I haven't had any experience about complaints so can't comment". One relative said, "Not had any cause to complain. There is always someone with their eye on the ball".

Good

Is the service well-led?

Our findings

People knew the registered manager who was visible around the home throughout our visit. We saw the registered manager engaging with people who greeted her warmly and with genuine affection. The registered manager knew people and called them by their preferred name. We asked people their opinion of the service. People's comments included; "[Registered manager] is very accessible and staff are very good", "If there is anything of concern I would ask to see the manager, yes I do know her" and "I think it is very well managed. The staff work very well together".

Some staff told us the registered manager was supportive and approachable. Comments included; "I get on really well with [registered manager]. She is approachable and she listens to suggestions. We work together really well" and "She is absolutely lovely and I feel well supported. She is approachable".

However, some staff gave a conflicting view when speaking about the provider. One staff member said, "I don't feel supported. Management does not listen to us". Another staff member said, "The provider does not listen to staff. They think as carers we are easily dispensable. The provider's core values are not realistic and only achievable with more staff".

The registered manager led by example. The registered manager supported people individually throughout the day and greeted relatives and visitors in a warm and welcoming fashion. Their example gave staff clear leadership and we saw this enthusiastic, person centred approach repeated by staff throughout our visit.

The service had a positive culture that was relaxed, homely, open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the registered manager and staff spoke openly and honestly about the service and the challenges they faced.

Accidents and incidents were recorded and investigated. The registered manager analysed information from the investigations to improve the service. For example, following a medicine error the registered manager provided staff with further training, advice and guidance to reduce the risk of reoccurrence. We also saw that where people suffered from falls healthcare professionals had been consulted and were fully involved in actions to improve people's care. A 'senior carer's folder' was used to pass on information to staff relating to accidents and incidents. The registered manager also monitored accidents and incidents to look for patterns and trends.

The registered manager monitored the quality of service provided. Regular audits were conducted to monitor and improve procedures and systems. Audits covered all aspects of care and results were analysed resulting in identified actions to improve the service. For example, one audit identified an issue relating to new admissions to the home and the assessment process. An extra nurse had now been deployed to deal with new admissions and assessments to resolve the identified issue. The registered manager had also identified the stock errors relating to medicine and had taken action to resolve this concern.

The registered manager shared learning with staff through briefings, handovers and staff meetings. Staff were able to raise and discuss issues at staff meetings. Weekly 'registered nurse' meeting were conducted to discuss clinical risks. Clinical governance meetings were held every six months with GPs where hospital admissions, medicines and general practice were discussed. This allowed the registered manager to look for patterns and trends relating these discussed issues. Staff told us learning was shared through briefings and meetings. Staff comments included; "We get briefings, meetings and we talk to each other. Information is also put on the notice boards" and "I think we share learning much better now, there was an issue with communication but things have improved. Personally, I would involve all the staff at handovers, just the one meeting instead of two".

People and relatives opinions were sought through regular surveys. The surveys asked people questions about all aspects of the service, care and staff. We saw the results of the last survey which were positive. Where people and their relatives raised issues the service responded to address them. For example, at the last survey relatives had asked for menus to be displayed in a picture format. We saw this request had been implemented. People had also asked for the name of the nurse in charge to be displayed on a notice board on each unit. This had also been implemented. The results of surveys were fedback to people and relatives via meetings and newsletters.

'Residents and relatives' meetings were held enabling them to raise and discuss issues at the home. These meetings were planned to be held every three months. Where people made suggestions or raised an issue the registered manager took action. For example, at the last meeting one person requested an email 'mailbox' be created to improve communication via emails. The registered manager told us two mailboxes were being installed for people and relatives emails.

There was a whistle blowing policy in place that was available to staff around the home. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.