The Orders Of St. John Care Trust

# OSJCT Henry Cornish Care Centre

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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

This inspection took place on 4 January 2017 and was unannounced.

Henry Cornish Care Centre is a residential home that provides accommodation for 36 older adults. In addition to the 36 residential beds there are 14 Intermediate Care beds (ICU). The intermediate care services are provided to people to help them in rehabilitation and to be as independent as possible following discharge from hospitals. At the time of the inspection, there were 47 people living at the service and 14 of these were on the ICU.

There was a new manager in post who had been in post for one day and told us they would be applying to become the registered manager for the service with the Care Quality Commission. 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 manager worked closely with the deputy manager and area operations manager.

Leadership within the service was well structured, open and transparent at all levels and promoted strong organisational values. This resulted in a caring culture that put people using the service at the centre. People, staff and healthcare professionals were complimentary about the management team and how the service was run.
The provider did not always maintain confidentiality. People's care records were left in their rooms accessible to anyone. This was general practice in the home without consulting people on their preferences. However, the provider took immediate actions to address these concerns when they were raised.

People who were living at the service told us they felt safe. The staff had a clear understanding of how to safeguard people and protect their health and well-being. People received their medicines as prescribed. There were systems in place to manage safe administration and storage of medicines.

People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where risks to people had been identified, risk assessments were in place and action had been taken to manage the risks. The service promoted positive risk taking. Staff were aware of people's needs and followed the guidance in care plans to keep them safe.

There were enough suitably qualified and experienced staff to meet people needs. The provider had robust recruitment procedures and conducted background checks to ensure staff were suitable for their roles.

Staff received adequate training and support to carry out their roles effectively. People felt supported by competent staff. Staff benefitted from regular supervision (one to one meetings with their line manager) and yearly professional development reviews (PDR) to help them meet the needs of the people they cared for.

The management team and staff had a good understanding of the Mental Capacity Act (MCA) 2005 and applied its principles in their work. Where people were thought to lack capacity to make certain decisions, assessments had been completed in line with the principles of MCA. The management team and staff understood their responsibilities under the Deprivation of Liberty Safeguards (DoLS); these provide legal safeguards for people who may be deprived of their liberty for their own safety.

People benefited from a pleasant dining experience and their nutritional needs were met. A variety of meal choices was available and people received their meals in a timely manner. Staff treated people with kindness, compassion and respect and promoted people's independence and right to privacy. People received good care that was personalised to meet their individual needs.

People were supported to maintain their health and were referred for specialist advice as required. Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. The service facilitated reflective sessions with people and staff following deaths to celebrate and remember that particular person.

Staff supported and encouraged people to engage with a variety of activities and entertainments available within the service. Activities were structured to people's interests and people chose what activities they wanted to do. Activities were also discussed during residents and relatives meeting to allow a wider variety. The environment was designed to enable people to move freely around the service.

The provider looked for ways to continually improve the quality of the care provided. Feedback on the quality of care was sought from people and their relatives and used to make changes and improve the quality of care. People knew how to make a complaint and complaints were managed in accordance with the provider's complaints policy. The service received many compliments. The provider had effective quality assurance systems in place.

The management team informed us of all notifiable incidents. They had a clear plan to develop and further improve the service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

Risks to people were managed and assessments were in place to manage identified risks and keep people safe. The service promoted positive risk taking.

There were sufficient numbers of suitably qualified staff to meet people's needs.

People were protected from the risk of abuse as staff had a good understanding of safeguarding procedures.

Medicines were stored and administered safely.

### Is the service effective?

Good

The service was effective.

Staff had the knowledge and skills to meet people's needs. Staff received training and support to carry out their roles effectively.

People were supported to have their nutritional needs met.

Staff had good knowledge of the Mental Capacity Act and Deprivation of Liberty Safeguards. People who were being deprived of their liberty were cared for in the least restrictive way.

People were supported to access healthcare support when needed.

### Is the service caring?

Good

The service was caring.

People's care records were left in their rooms accessible to anyone. However, the management team took immediate action.

People were treated as individuals and were involved in their care.

People were supported by caring staff that treated them with dignity and respect.

## Is the service responsive?

Good

The service was responsive.

People received activities and stimulation which met their needs.

People's needs were assessed and personalised care plans were written to identify how people's needs would be met.

People's views were sought and acted upon.

People knew how to make a complaint and were confident complaints would be dealt with effectively.

## Is the service well-led?

Good

The service was well led.

People and staff told us the management team was open and approachable.

The leadership created a culture of openness that made people and staff feel included and well supported.

There were systems in place to monitor the quality and safety of the service and drive improvement.

# OSJCT Henry Cornish Care Centre

**Detailed findings**

## Background to this inspection

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

This inspection took place on 4 January 2017 and was unannounced. The inspection team consisted of 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.

Before the inspection we reviewed the information we held about the service and the service provider. The registered provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We contacted commissioners and social and health care professionals who regularly visited people living in the home. This was to obtain their views on the quality of the service provided to people and how the home was being managed.

We spoke with 19 people and one relative. The methods we used to gather information included pathway tracking, which is capturing the experiences of a sample of people by following a person's route through the service and getting their views on their care. We pathway tracked seven people's care records including medicine administration records (MAR). During the inspection we spent time with people. We looked around the home and observed the way staff interacted with people. We spoke with the area operations manager, the new manager, the deputy manager and 11 staff which included nurses, care staff, housekeeping, activities coordinator and catering staff. We reviewed a range of records relating to the management of the home. These included six staff files, quality assurance audits, minutes of meetings with people and staff, incident reports as well as complaints and compliments.

Good

# Is the service safe?

## Our findings

People told us they felt safe receiving care at Henry Cornish Care Centre. Comments included; "I feel safe here as the staff are helping me to get better to go home" and "I feel very safe here. When we want to go out into the garden, the care leader unlocks the door for us". One person's relative told us, "I am very happy for my mum to live here. I feel she is safe, they [staff] are very pleasant".

Staff knew how to identify safeguarding concerns and they acted on these to keep people safe. Staff had attended training in safeguarding vulnerable people and had good knowledge of the provider's safeguarding procedures. Staff were aware of types and signs of possible abuse and their responsibility to report and record any concerns promptly. One member of staff told us, "We know the residents very well and can easily tell if something is wrong". Staff knew where to report to outside agencies and named the Care Quality Commission (CQC) and the local authority safeguarding team. One member of staff said, "I can report safeguarding issues like abuse to the safeguarding team".

People's care plans included risk assessments and where risks had been identified there were management plans in place to manage the risks. Risk assessments included fire, falls, mobility and skin care. For example, one person was at risk of developing pressure ulcers. We saw the person had appropriate equipment in place, such as a special mattress to help relieve the pressure on their skin. All risk assessments were reviewed monthly and more often when circumstances changed. Another person used oxygen. This was clearly highlighted in the person's fire risk assessment and their breathing care plan. The person's care plan included leaflets with guidance on what to do in case of the oxygen concentrator malfunction or power cuts. The plan also contained information on usage and maintenance of the oxygen concentrator.

The service promoted positive risk taking. Positive risk taking is weighing up the potential benefits and harms of exercising one's choice of action over another. For example, one of the residents self-administered their medicines. This supported the person to remain as independent as possible. Staff ordered, stored and maintained the medicine stock levels for this person. There was an appropriate risk assessment with a disclaimer in place signed by the person.

People received their medicine as prescribed. There were systems in place to manage medicines safely. The provider had a medicines policy and procedures in place which guided staff on how to give medicines safely. We observed staff administered medicines to people in line with their prescriptions. 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 the reason why. Staff ensured people understood the reason and purpose of the medicines they were given.

People were supported by sufficient numbers of staff. Records showed the number of staff required for supporting people was adjusted depending on people's needs. Staff told us, "Staffing levels are appropriate", "The staffing levels are good. We have agency staff on shift if we need them" and "In general, we are doing great. We have a good staff-residents ratio. Staff are fast to answer the bells and we have time for the residents without being rushed". The service used a dependency assessment tool at the beginning of

care provision to assess the staffing ratio required. The dependency assessment was also completed whenever people's needs changed.

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

People were protected from the risk of infection. The premises and the equipment were clean, and staff followed the provider's infection control policy to prevent and manage potential risks of infection. Equipment used to support people's care, for example, weight scales, wheelchairs, hoists and standing aids had been serviced in line with national recommendations. Protective equipment such as aprons and gloves were readily available and utilised by staff.

Good

# Is the service effective?

## Our findings

People told us they received care from staff who had the skills and knowledge needed to carry out their roles. People's comments included; "They [staff] seem to know what they are doing" and "Staff are nice and they seem to be really knowledgeable".

New staff were supported to complete an induction programme before working independently. This included training for their role and shadowing an experienced member of staff. Staff said, "I had induction for a full month and it was the best induction ever", "I had about two-week shadowing when I started. When I was promoted to the care leader, I was also shadowing for quite a few shifts" and "I had induction until I felt confident to work alone".

Staff told us they received mandatory training when they started working at the service and were supported to refresh this training regularly. Mandatory training included safeguarding, medicines management, infection control, fire safety and manual handling. Staff were supported to attend specific training courses to ensure they had the skills to meet people's needs. These covered areas such as dementia, positive behaviour support, palliative care and malnutrition care. Staff told us, "We are required to complete mandatory training but we can always ask for additional training" and "Our medical competencies are reviewed every two years", "We had a resident who was quite challenging and we became stressed out in our job. Then we were provided with stress reaction training to enable us to do our job".

Staff told us they felt supported. Staff had regular supervisions (one to one meeting with their line manager) and annual professional development reviews (PDR). Staff told us they found one to one time with their manager useful. Staff comments included; "I have my supervision every six months. I find it really useful", "Supervisions gives you an insight on how you do in jour job, in your environment. This may give you also new ideas that you can take and put into practice" and "I have my supervision every three months. I receive feedback on what I have done well and what I need to improve on".

People were supported to stay healthy and their care records described the support they needed. People's care records showed relevant health and social care professionals were involved with people's care. On the intermediate care unit, people's progress was monitored and reviewed through weekly multidisciplinary team meetings.

People told us they liked the food and were able to make choices about what they had to eat. Comments included; "The food is good here. I love spaghetti bolognaise and curry. We have a hot drinks trolley with choices at 11, 3 and 8pm", "There is a good choice of food here" and "I like the food. Most of the times I eat as much as I can".

People's dietary needs and preferences were recorded and known by the kitchen staff. Records showed each person completed a 'dietary advice for chef' form to show people's needs, likes and dislikes. Some people had special dietary needs and preferences. For example, people having diabetic food or soft food where choking was a risk. The service contacted GPs and dieticians if they had concerns over people's

nutritional needs. Records showed people's weight was maintained. Drinks and snacks were available to people throughout the day.

We observed people having lunch in dining rooms. The atmosphere was pleasant. There was chattering throughout the dining room. People chose where they wanted to sit and did not need to wait long for food to be served. People were supported to have meals in a dignified way by attentive staff. We observed staff sat with people and talked to them whilst supporting them to have their meals at a relaxed pace. We saw staff asked people if they wanted more and this was provided as needed. Some people chose to have meals in their rooms and staff respected that. One person told us, "I choose to eat on my own in my room as I am happier doing this". Another person said, "I prefer to eat with my lap tray in my room and the staff come and check that I am ok". People supported with meals in their rooms had the same pleasant dining experience as those in dining rooms.

People or their legal representatives were involved in care planning and their consent was sought to confirm they agreed with the care and support provided. On the day of our inspection, we saw staff knocked on people's doors and sought verbal consent whenever they offered care interventions. Staff told us they sought permission and explained care to be given. For example, where people were supported with personal care. One member of staff said, "We always tell residents what we are doing and ask for their permission. They have the right to say yes or no".

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The management team was knowledgeable about how to ensure the rights of people who were assessed as lacking capacity were protected.

Staff understood their responsibilities in relation to MCA. One member of staff said, "Everybody has got capacity to make a decision unless assessed otherwise. People have a choice to make unwise decisions". Another member of staff told us, "We presume all people have capacity to make their choice".

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. The provider followed the requirements of the DoLS. People's records included information relating to a best interest process being followed where the person had been assessed as lacking capacity to make a specific decision. For example, one person lacked capacity to consent and was prevented from leaving the service. This was a deprivation of their liberty. A best interest process had been followed and this person was being supported in the least restrictive way. Staff had been trained and understood the requirements of the MCA and the specific requirements of the DoLS.

Good

# Is the service caring?

## Our findings

People told us they enjoyed living at Henry Cornish Care Centre and that staff were caring. Comments included; "The staff are very happy and have the time to chat to us", "They [staff] are nice. Sometimes they spend time chatting with me" and "Everyone is nice. I like living here". One person's relative told us, "I am very happy for my mum to live here. I feel that the staff know her well and they are all friendly towards her".

Staff spoke with kindness when speaking about people. Staff told us they were caring and treated people with kindness and compassion. One member of staff told us, "We know our residents well. When they are happy, staff are happy. We take our time during tasks". We observed many caring interactions between staff and the people they were supporting during our inspection. For example, we saw a member of staff offering people drinks. They knelt to that person's height and spoke to them softly and patiently waited for a response. The person smiled and nodded their head. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. There was chatting and appropriate use of humour throughout the day.

Staff were respectful of people's privacy and maintained their dignity. Staff gave examples of how they promoted and respected people's dignity. This included making sure people were covered as much as possible when supporting them with personal care and waiting outside the bathroom where people wished to remain independent. Comments included; "I always promote people's dignity. I always ask for permission to do anything and I always knock before I get in" and "When we give them personal care, we always shut the door and cover them with towel". People told us staff respected their dignity. People said, "Oh yes, they do treat me with respect and dignity" and "They always cover me when they are washing me". Care records reflected how staff should support people in a dignified way and respect their privacy. Care plans were written in a respectful manner. The service was in the process of developing the role of a dignity champion. A dignity champion is someone who believes passionately that being treated with dignity is a basic human right and not an optional extra.

The provider did not always maintain confidentiality. On the day of our inspection, we found people's care records left in their rooms and were accessible to anyone. This was general practice in the home without consulting people on their preference. This was a potential breach of confidentiality. We discussed these findings with the area operations manager who immediately took action and locked the records away whilst the service established the best way forward. The area operations manager told us, "All personal information going forward will be kept in the office until we establish residents' preferences and appropriate information that should be stored in a more secure location". Staff had mixed views on how to maintain confidentiality. One member of staff said, "We do not discuss residents with other residents". Another member of staff told us, "Confidentiality is maintained if the information is kept in people's rooms. It has to stay there, you can use that personal information and access this when a health care professional needs this".

People were involved in their care. Care plans had been signed by people to confirm they agreed with the way their care needs would be met. People were involved in reviews of their care.

Staff understood the importance of promoting independence and involving people in daily care. They explained how they allowed enough time for tasks and did not rush people. This enabled people to still do as much as they could for themselves with little support. One member of staff told us, "Our goal is to keep residents as independent as possible. We ask them to do as much for themselves as possible". People told us staff supported them to be independent. Comments included; "The carers let me do as much as I can and then they will wash my back for me", "The carers are helping to keep me independent, as I shall be going home soon" and "I walk with my zimmer frame. It is good exercise for me, but I always have a carer beside me to keep me company and safe".

People's advanced wishes were respected. Where people did not wish to discuss any advanced wishes, staff respected that. For example, one person did not wish to discuss any advanced wishes and had a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person was fully involved in this decision. 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. Staff understood the importance of keeping people as comfortable as possible as they approached the end of their life. Records showed staff had attended training in palliative care and end of life care. The service facilitated reflective sessions with residents and staff following deaths to celebrate and remember that particular person.

Good

# Is the service responsive?

## Our findings

On our last inspection on 6 November 2014 we found the service was not always responsive to people using the intermediate care unit (ICU). Care plans in the ICU centre did not always provide instructions to staff on how to support people. At this inspection in January 2017 we found improvements had been made to address this. We found people's care plans were tailored to meet their needs and ensure achievable and acceptable rehabilitation goals were set. People were pre-assessed prior to being accepted to the service. Staff ensured they received discharge letters and MAR charts from hospitals complete with enough information to make a plan of care for each individual. People's care plans reflected their needs and guided staff about each person's care needs.

On the residential unit people's care needs were also assessed prior to accessing the service to ensure their needs could be met. Staff completed the assessments and these were used to create a person centred plan of care which included people's preferences, choices, needs and interests.

Care plans were in place to give staff guidance on how to support people with their identified needs in such areas as personal care, medicines management, emotional wellbeing, nutrition and mobility. Staff were provided with information which detailed what was important to each person, described their life history, daily routine and the activities they enjoyed. Staff members told us that the care plans were a good source in terms of obtaining sufficient information to provide effective care.

Staff told us and records confirmed the provider had a keyworker system in place. A keyworker is a staff member responsible for overseeing the care a person receives and liaises with families and professionals involved in that person's care. This allowed staff to build relationships with people and their relatives and aimed at providing personalised care through consistency.

Care plans were reviewed monthly to reflect people's changing needs. Where a person's needs had changed, the care plan had been updated to reflect these changes. For example, one person had suffered two consecutive falls. Staff acted promptly to investigate the possible causes. With the person's consent, a sensor mattress was put in place and risk assessments and mobility plans were reviewed. A falls action plan was put in place which included an environmental audit to ensure the equipment was fit for purpose.

There was a wide choice of activities offered to people, ranging from visits of entertainers to daily activities people could attend within the service. These activities included games, quizzes, listening to music and exercises. Activities were reviewed and feedback was sought from people to see what they preferred most. We observed an activities session where people sat in the communal areas chatting and knitting. Some people preferred to stay in their bedrooms, to watch television, read or enjoy visits from their relatives. Staff respected people's choices and ensured they provided one to one sessions especially to those who chose to stay in their bedrooms to prevent social isolation.

People's views and feedback was sought through regular family meetings as well as through suggestion boxes and satisfaction surveys. Records of family meetings showed that some of the discussions were

around what changes people wanted. People's opinions were sought and action was taken to respond to issues raised. People and their relatives also received newsletters with updates of changes and planned activities within the service.

People told us they knew how to complain if they were not satisfied with the quality of care. Comments included; "I know how to complain. I just ring the bell and talk to them [staff]", "I have no complaints, but would speak to the care leader if I needed to" and "There is always someone to talk to if you have a problem". Staff told us people knew how to complain. They said, "People complain to us and they take the matters to the care leader" and "They [people] are aware of how to complain". People's concerns and complaints were monitored and appropriately investigated. Furthermore, this information was used as a basis for actions aimed to enhance the service. For example, we saw that some of the complaints had been discussed on staff meetings. There had been nine complaints raised by people and their relatives in the last year. This had resulted in an improvement in the records of people rejecting personal care. We also saw letters of appreciation. Relatives wrote in their comments that they were grateful and thankful as people at the service were well looked after, safe, and could rely on staff's constant support.

Good

# Is the service well-led?

## Our findings

Henry Cornish Care Centre was led by a new manager who had consistent support from a deputy manager, head of care and an area operations manager. There had been a very recent change in managers and the manager had only been in post for one day. There was a clear leadership structure which aided in the smooth transition in management and running of the service.

The service a positive culture that was honest, open and inclusive. On the day of our inspection, we were welcomed by staff who were clearly happy to see us. During our visit, management and staff gave us unlimited access to records and documents. They were keen to demonstrate their caring practices and relationships with people.

Staff were complimentary of the support they received from the management team and the way the service was managed. Staff comments included; "I am well supported", "The management team is very knowledgeable. I can approach them anytime" and "I think this home is run quite well. We know our job roles and this works quite well". The area operations manager held 'care to chat' drop in sessions for staff which allowed continuous contact with staff for support. The manager told us they had an open door policy and was always visible around the home. The provider facilitated an employee support system which included a telephone counselling support service.

The area operations manager had been overseeing the service for the past six months. They told us their biggest challenge was turning around the ICU. They said, "It's been challenging trying to recruit the right staff for the ICU. I have previously managed an ICU so I brought the knowledge and experience to run the process, build relationships with GPs and create team work".

There was a relaxed and friendly atmosphere in the service and staff told us they were happy to work there. Staff said, "I'm happy being here. So far they [management team] are doing a really good job", "I'm very happy working here. The managers are very kind. I may move here when I retire" and "I enjoy and really love working here. We have a really good team".

People told us the service was well managed and they enjoyed living there. People's comments included; "I'm happy being here. So far they are doing a really good job", "I wouldn't change anything here" and "I think this place is run really well".

Staff told us there was good communication between all staff within the home. Staff received handovers at the end of each shift which gave them current information to continue to meet people's needs. Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. During one meeting staff were involved in discussion about how to improve the prevention and management of pressure ulcers.

We received complimentary feedback from health and social care professionals. They spoke highly about their relationship with the management team and staff. They commented on how well staff communicated

with them in a timely manner. One healthcare professional said, "I have been visiting Henry Cornish Care Centre for a number of years now and feel I have a good working relationship with the home".

The provider had quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including infection control, care plan records, dining experience, medicine safety and care quality. Quality assurance systems were operated effectively and used to drive improvement in the service. For example, one medicine safety audit highlighted the need for clearer directions on application of creams. This had been actioned and instructions were now in place and body maps had the areas to be applied highlighted. The provider's senior management undertook routine monthly operational visits to monitor the quality of care.

The provider had a clear procedure for recording accidents and incidents. Accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the risk of further incidents occurring. The manager audited and analysed accidents and incidents to look for patterns and trends to make improvements for people who used the service. Staff knew how to report accidents and incidents. The provider promoted a culture of learning from incidence. For example, staff participated in reflective learning exercises following incidents and this was shared across the team.

The provider had a whistle blowing policy in place that was available to staff across the service. The policy contained the contact details of relevant authorities for staff to call if they had concerns. Staff understood and were confident about using the whistleblowing procedure and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy. Staff comments included; "I have the contacts for whistleblowing. If I have to, I can whistle blow to CQC and safeguarding team" and "I would whistle blow to my line manager. I would then report things further if they didn't act on this".

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