Mach Care Solutions Limited

Mach Care Solutions (Birmingham)

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

Summary of findings

Overall summary

This inspection took place on 17 and 18 February 2016 and was an announced inspection. At the last inspection on 22 and 23 April 2015 the provider was found to be requiring improvement in four out of the five areas we looked at, safe, effective, responsive and well-led. Therefore we re-inspected within 12 months as standard set by CQC.

Mach Care Solutions (Birmingham) is a Domiciliary Care Service which is registered to provide personal care services to people in their homes. We were told that since our last inspection improvements had been made and they were now providing personal care services to more people. At the time of our inspection Mach Care Solutions (Birmingham) were providing care and support to 157 people including three children. The provider also offers other services to people such as support with shopping or household tasks that we do not regulate.

Mach Care Solutions (Birmingham) is required to have a register 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A registered manager was in post at the time of our inspection.

People we spoke with told us they felt they received a safe service. However, we found that the systems and processes in place to monitor people's safety were not always effective in detecting late or missed calls; leaving people at risk.

People's safety was not always protected because the provider did not have robust recruitment processes.

People were supported by sufficient numbers of staff who understood their responsibilities to keep people safe from abuse and avoidable harm; they knew how to raise concerns if needed.

People were supported to have their prescribed medication safely.

People were supported by staff that understood their responsibilities to protect people's rights. However, the provider had not always fulfilled their responsibilities to ensure care was provided with lawful consent.

People were supported by staff who had received the training they needed to do their job effectively.

Staff felt supported in their role and knew who to contact for advice or information should they require it.

People received enough food and drink and were supported to have food that they enjoyed.

People were supported to maintain good health and to have access to other health and social care agencies when required.

People were treated with kindness, dignity and respect by staff that knew them well and knew what was important to them.

People were involved in planning and reviewing their own care.

People were encouraged to maintain their independence.

Care was delivered in a way that met people's individual needs and preferences.

People knew how to make a complaint if they were unhappy and were confident that their concerns would be acted upon responsively.
We saw improvements had been made to monitor the quality and safety of the service since our last inspection. However some of these were not always effective.

We found a clear leadership structure within the service which was supportive and transparent to staff and to most of the people who used the service.

However, sometimes people found the management team to be inaccessible and other professionals reported them to be un-cooperative and defensive when trying to address service deficiencies.

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 consistently safe.

People we spoke with told us they felt they received a safe service. However, we found that the systems and processes in place to monitor people's safety were not always effective in detecting late or missed calls; leaving people at risk.

People's safety was not always protected because the provider did not have robust recruitment processes.

People were supported by sufficient numbers of staff.

People were protected from the risk of abuse because staff understood their responsibilities and knew how to raise concerns if needed.

People were supported to have their prescribed medication safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported by staff that understood their responsibilities to protect people's rights. However, the provider had failed to fulfil their responsibilities to ensure care was provided with lawful consent.

People were supported by staff who had received the training they needed to do their job effectively.

Staff felt supported in their role and knew who to contact for advice or information should they require it.

People received enough food and drink and were supported to have food that they enjoyed.

People were supported to maintain good health and to have access to other health and social care agencies when required.

Is the service caring?

Requires Improvement

The service was not always caring

Systems and processes were not always used effectively to ensure people were kept safe and their rights protected.

People were treated with kindness, dignity and respect by staff that knew them well and knew what was important to them.

People were involved in planning and reviewing their own care.

People were encouraged to maintain their independence.

Is the service responsive?

Good

The service was responsive.

Care was delivered in a way that met people's individual needs and preferences.

People knew how to make a complaint if they were unhappy and were confident that their concerns would be acted upon responsively.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We saw improvements had been made to monitor the quality and safety of the service since our last inspection. However some of these were not always effective.

We found a clear leadership structure within the service which was supportive and transparent to staff and to most of the people who used the service.

However, sometimes people found the management team to be inaccessible and other professionals reported them to be un-cooperative and defensive when trying to address service deficiencies.

Mach Care Solutions (Birmingham)

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 17 and 18 February 2016 and was an announced inspection. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in. The inspection team comprised of two inspectors and an Expert by Experience. An Expert by Experience is a person who has experience of using or caring for someone who uses this type of service.

As part of the inspection we looked at previous inspection reports and checked the information that we hold about the service. This included notifications from the provider that they are required to send us by law, safeguarding alerts and information from local authorities. We also received feedback from external agencies and other health and social care professionals who are familiar with the service, including service commissioners from the local authority.

During our inspection we spoke to 11 people who used the service, six relatives of people who used the service, seven care staff, an administrator, the Registered Manager and the Operational Manager.

We looked at the care records of 13 people, reviewed the records of six members of staff and at records maintained by the provider about the quality of the service including training records, feedback surveys and telephone reviews, staff meetings and spot checks.

Requires Improvement

Is the service safe?

Our findings

At the time of our last inspection, the service was found to be requiring improvement in this area. Whilst no breaches of the regulations were found, the service was required to make improvements to their risk assessment and management plans, quality and safety monitoring processes as well as their recruitment records and processes. People we spoke with and records we looked at, confirmed that some of these improvements had been made including improvementsto policies and procedures around safeguarding adults for example. However, other areas continued to require improvement.

However, some of the people we spoke to told us they had experienced late and missed calls which meant they did not always feel safe. One person told us, "I never know what time they [staff] are coming; sometimes they turn up sometimes they don't". Another person said, "It's not been very good; sometimes the carers are late or they don't come at all". The registered manager and operations manager told us that they do not have an electronic call monitoring system and that in order to detect late or missed calls; they rely on people notifying the office. They informed us that if they are notified, they send out alternative care staff to cover the call, or the management team will visit people themselves. We asked the registered manager, how they monitor this for people who lack the mental capacity to inform the office themselves. They told us, "We have a good system whereby staff visit regular people, so they always know where they are going and who they need to see; this reduces missed calls". They also told us that staff work in their own geographical area making it easier for them to travel to their visits to reduce the risk of late calls. Furthermore, they informed us that they do regular spot checks on staff and audit the daily record logs to monitor any late or missed calls.

However, we found that these systems were not always effective in keeping people safe. One person told us they had experienced symptoms of physical ill health because they were unable to take their insulin injection on time as a result of the care staff being late; the person had not received the support they required to prepare a meal in time to self-administer their insulin. We looked at this persons care records and found that the times of their care calls were sporadic and their care calls were rarely at the time stipulated in their care plan. Furthermore, their risk assessment did not detail the importance of regular meal times in relation to their medication routine nor did it include the potential risks to their physical health including the symptoms of diabetes (hypoglycaemia or hyperglycaemia) or what action staff should take in the event of the person experiencing such symptoms. Some of the staff we spoke with told us they knew what to do in this situation; however others told us they would rely on the care plan for this information. We fed these concerns back to the operational manager who informed us that they would review this person's care package as a matter of urgency and update their care plans and risk assessments promptly.

People we spoke to told us they were involved in an initial assessment which included assessing the risk to people to agree how these would be managed and to ensure people received the care they required in the way that they wanted it. One person told us, "They [operations manager] came out to see me before the carers started coming in to do an assessment". A relative told us, "Risk assessments were done before the care package started". During the inspection we found that some risks to individuals had been identified

and management plans were in place. These included standard, generic risk assessments as well as more individualised risk management plans, specific to the care needs of people. However, some of these lacked personalisation and detail which meant that staff did not always have the information they needed to inform safe practice. For example, we saw that some people's risk management plans were exactly the same and did not make reference to people by name. We also saw, where the risk management plans made reference to a clinical condition; the information provided was presented generically with a list of potential symptoms and which were not always specific to the symptoms experienced by that individual specifically. Nevertheless, staff we spoke with told us they found these risk assessments and care plans useful. They also told us that because they see the same people regularly they get to know what people need and know how to support them. One member of staff told us, "Information we need is usually in the risk assessments and care plans, but I always speak to people to make sure I am doing what they need me to". Another member of staff said, "There is information in the risk assessments and care plans, but I always ask [people] because things can change".

Staff members we spoke with were able to explain to us their understanding of abuse and were aware of their roles and responsibilities, including what the reporting procedures were. One member of staff told us, "I know the different types of abuse like physical, verbal, emotional abuse like bulling and if I suspected anything I would report it to the office or the local authority or the Police, if I didn't think anything was getting done about it". Another member of staff said, "If I was concerned I'd contact the office and would be guided by them, but I know I could call social services, the police or CQC myself if I needed to". Another member of staff told us, "We have training on protecting older people and what signs to look for like bruises; we have refreshers in our team meetings as well" they said, "I'd definitely report it to the office and record it; I know they would deal with it properly".

Records showed that staff had recently received training on how to keep people safe from avoidable harm and abuse. We saw that one of the latest team meetings had included a training session on safeguarding adults. The operational manager told us that they had recently introduced these '"training briefings"' at the end of the staff meetings to ensure staff felt confident to deal with any risk issues such as safeguarding if they were to arise.

Safeguarding concerns had been raised with us either by people who used the service, the local authority or the provider themselves since their last inspection. We found that on most occasions the provider had taken appropriate action and had liaised with the appropriate investigating bodies in order to assess and address the issues being raised, including notifying CQC as required by law.

Staff recruitment files we looked at and all of the staff we spoke with confirmed that the provider's recruitment processes included a formal interview, references and a Disclosure and Barring check (DBS). However, we found that these recruitment checks continued to require improvement since the last inspection because they were not always robust.We found unexplained gaps in employment histories, inconsistencies within the information provided and some of the references did not satisfy the required standard to ensure the safety of people. We fed this back to the registered manager and operations manager at the time of our inspection. They both acknowledged our concerns and agreed that they would address these issues with the individual staff members directly and ensured us that they would improve their recruitment processes accordingly. On the second day of our inspection, we saw that the operations manager had requested a meeting with two members of staff individually and had requested further employment details and references to satisfy the standards for safe recruitment.

Some of the people we spoke to told us they needed support with their medication. One person told us, "Yes, they [staff] help me with my medication". A relative told us, "They make sure he [person] has everything

he needs, food, medication and so on". Care plans and risk assessments we looked at confirmed that staff were required to support some people with their medication either by prompting or administering their medication. We found that both the care plans and risk assessments provided step by step instructions to staff to promote safe medication management. Staff we spoke to and training records we looked at showed us that staff had received training in medication management and that medication management was one of the topics included in the team briefings as a refresher session. One member of staff said, "We have training [in medication management] and this is also sometimes covered at team meetings so we get regular refershers; its good". This showed us that arrangements were in place to support people with their medication if identified as a support need.

Requires Improvement

Is the service effective?

Our findings

People we spoke to told us that care was provided to them with their consent. 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. However, we found that some people were known to the provider to lack the mental capacity to consent to the care they received but we did not find any evidence of a mental capacity assessment, a best interests meeting having been held or an application to the court of protection to authorise another person to make a welfare decision on their behalf. We fed this back to the operations manager at the time of our inspection and they acknowledged the concerns we had raised. They were able to articulate their knowledge and understanding of the Mental Capacity Act 2005 and recognised that they had failed to fulfil their roles and responsibilities in complying with this legislation. However, we saw that they took immediate action in addressing this issue for the people we identified during our inspection and assured us that they would act accordingly for all of the other people they supported who may lack the mental capacity to consent to their care.

People we spoke with told us that they felt their rights were protected and staff offered them choice. One person told us, "They always ask me what I want doing and what I need". Another person said, "It's always my choice; they know what I need by now anyway, but they still always ask if it's ok first". Staff we spoke with understood the need for consent and were able to give examples of how they offered choice and protected people's rights. One member of staff said, "We do have training; I always ask people before I do anything, but if they can't consent, we are guided by their care plan which the social worker and family have usually put together and we work in their best interests'". Another member of staff said, "I always ask people if it's ok for me to do things and give them choice".

We found that most people were supported to have sufficient to eat and drink and were given choice. One person told us, "[Staff member] comes in the morning and helps me with my breakfast; she always asks me what I like and she does what I ask her". Another person said, "[Staff member] always makes sure I have enough to eat and drink; they leave me with three drinks and a sandwich to make sure I have enough; they even feed my cat for me!".

Records we looked at, identified people's likes and dislikes and staff we spoke with told us how important it is to offer choice around meal times. One member of staff said, "Sometimes if they [people] are confused, I will show them what they have, so they can see and choose what they want to eat". Another member of staff told us, "If a person can't choose because they have dementia or something, we see what they have in and we will rotate it so they have a variety". A different member of staff said, "I think it's important to know about different cultures and respect how they like things cooked for example".

However, some people we spoke with told us that they don't always receive their care calls on time which affects their dietary routine. Other people told us that they have had difficulty communicating their

preferences to staff because of cultural differences and potential language barriers. For example, One relative told us, "I don't think they [staff] always understand when you speak to them; mom asked for some toast and she got bread and butter, it's not good when she is already confused". Records we hold also show that a safeguarding was raised because a gentleman had been served food that was cold. The operations manager informed us that this was investigated and that this concern was not upheld but the person chose to change care agencies as a result.

People we spoke with told us that the staff who visited them seemed to have the knowledge and skills they needed to meet their needs. One person told us, "The carers I have at the moment cannot be faulted in anyway; they are excellent". Another person said, "They [staff] are very good, they seem to know what they are doing". A relative we spoke with told us, "It's exceptional; it's a very good service where the care is of a very good standard; the staff are very well trained". Another relative said, "They [staff] are really good and seem to know what they are doing". Staff we spoke with told us they felt confident in doing their job and confirmed that they received adequate training. One member of staff told us, "The training is very good; I have been a carer for a long time but the training I have had since joining Mach Care has made me feel born again in my job!" Another member of staff said, "We do a lot of training and we have refreshers [refresher training] during team meetings; we cover a different topic each month". Another member of staff told us, "The induction was good when I first started; I did training and got to shadow another carer until I felt confident".

The provider had a record of the training that staff had completed and this showed that all staff had received the training they needed to meet people's needs. Staff we spoke with told us that the registered manager and operations manager had encouraged them to attend training and team meetings where learning and development were on the agenda. One member of staff told us, "They [management] send us an SMS' [text message] to remind us to attend". Another member of staff said, "They [management] remind us when training is due". We saw that team meetings were held on the first working day of each month, at three different times throughout the day to optimise attendance and team discussions were recorded and made available to staff for future reference. The operations manager told us, "Team meetings are compulsory; all staff are expected to attend which is why we make them available at different times of the day".

Staff we spoke with told us that they felt supported in their roles. We found that help and advice was readily available to support staff in their daily duties either by contacting the office or by using the on call system. One member of staff told us, "There is an open door policy; we can always go in [to the office] for support and even out of hours, they will come to support you if you need it". Another member of staff said, "They [management] are very supportive; we get on well as a unit".

Staff told us and records showed that they had regular supervision. One member of staff said, "We [staff] have supervision every three months". Another staff member told us, "I have supervision; they will call us and send us text messages to remind us". This shows that staff communicated effectively in order to get the help and support they required to do their jobs effectively.

People we spoke to told us that staff support them if they are feeling physically unwell. One person said, "I haven't been feeling very well recently, I am waiting to see my GP; I don't want to worry my family so I get support from the girls [staff]". They also said, "[operations manager] has been very supportive too, he calls me to see how I am". A relative we spoke with told us, "I was concerned about [person] and [operational manager] suggested I contact the GP; they are very helpful". Staff we spoke with were clear about the signs and symptoms people may present with to indicate that they were physically unwell and knew what action to take. One member of staff said, "I would report it and call a Doctor". Another member of said told us,

"Sometimes people tell you they feel unwell and other times you notice they don't look or seem quite right, so we might suggest they call their GP or we call an ambulance if we are really concerned". Records we looked at showed that staff are advised to report any physical or mental health changes and seek medical treatment as required. We also saw referrals had been made to social services for re-assessment or care review to ensure that any changes to peoples care needs were met.

Requires Improvement

Is the service caring?

Our findings

We found that the service was not consistently caring. The systems and processes in place were not used effectively to ensure that all people received the care they required with consent and when they needed it; leaving people at risk. However, people we spoke with recognised that this was an organisational weakness rather than a reflection on the individual staff members; they told us that they were happy with the staff that provided their care.

People we spoke with were happy with the care staff who visited them and the consistency of the care staff. One person told us, "I generally see the same ones [care staff]; they are very very kind; they are lovely". Another person told us, "They are kind and friendly". Another person said, They are very kind; I can ask them to do anything". A relative we spoke with told us, "They [staff] are very kind, caring and helpful; they go above and beyond, the extra mile". Another relative said, "They are all caring and compassionate people; very kind to mom". Staff we spoke with told us how they developed positive relationships with the people they cared for. One member of staff told us, "We see the same people regularly so we get to know them and they get to know us". Another staff member said, "One man has dementia, but we are in a routine now, he knows me and I know what I need to do to help and support him".

We found that people were supported to be independent. One person told us, "It's always my choice; I am very independent, so they [staff] only do what I need them to". Another person said, "They [Staff] are very good, but I hopefully won't need them much longer because I want to be independent again; they support me to do as much as I can for myself". We saw care plans reflected people's level of independence and informed staff of ways to promote independence. For example, one care plan we looked at said "Allow me enough time to do as much as I can for myself". Another care plan stated, "I can put my own clothes on but I may need a bit of help with buttons". Staff we spoke with told us how they encouraged people to remain as independent as possible. One member of staff told us, "I support people to do as much as they can for themselves but I support them to make sure they are safe and give them help if they need it". Another staff member said, "I think if people aren't very independent, you can help them feel more independent by giving them choices". A different member of staff said, "We ask people what they would like to wear; I show them so they can pick".

People were communicated with in a way they understood. One relative told us, "It's difficult to understand [person] sometimes, but the carers are great; they go through her wardrobe with her so she can pick what she wants to wear; they are getting used to the gestures she uses now". Another relative said, "Dad don't talk, so there is a set procedure in the care plan that they [staff] follow but we have the same carers so they have got to know dad and the way he likes things now". Staff we spoke with told us how they adapted their communication styles when caring for people. One member of staff said, "Some people don't speak English, so they can't always tell you but we can show people things to give them choice, or it's usually in their care plan or we can speak with family". Another member of staff told us, "One person has dementia, so I have to change how I communicate; I try to speak slower and use shorter sentences; I show him things like food and clothes".

All of the people we spoke with said that the staff treated them with dignity and respect. One person said, "They [staff] help me to wash; yes, they mind my privacy". Another person told us, "They always cover me the best they can [during personal care] and keep me private".

Staff we spoke with were mindful of respecting equality and diversity and the need to protect people's privacy and dignity during care. One member of staff told us, "We always make sure we protect people's privacy by keeping doors and curtains closed". Another staff member told us, "I make sure people are treated equally but also respect their individual needs". A different member of staff said, "It's important to respect peoples culture and be guided by them to give them dignity and respect". We saw care plans acknowledged people's cultural needs and preferences and people were referred to by their preferred name.

Good

Is the service responsive?

Our findings

People told us and records showed us that people were actively involved in and contributed to the planning and review of their care. One person told us, "They asked me about my likes and dislikes during the assessment". Another person said, "I asked for female carers so I only have female carers come to see me". A relative we spoke to told us, "I was involved in the assessment, it was very clear; we knew what to expect from the care staff". Another relative said, "They involved my mom in the assessment and asked her how she wants things done". Staff we spoke with were mindful of respecting people's preferences. One member of staff said, "We ask people what they want us to do and it is all in their care plans". Another member of staff told us, "We get to know what people like but we still always ask". Most of the care plans we looked at were detailed, personalised and included a section about people's life histories and preferences. We also saw that care plans were regularly reviewed.

However, we found that some care plans did not always correspond with the care that was being given. We addressed this with the registered manager and operations manager at the time of our inspection. They told us that the local authority have instructed them to include all of the care needs identified in the social work assessment in peoples care plans, despite whether or not the person has identified these as a need in the initial assessment that the provider had facilitated. The management team recognised that this needs to be made clearer in the care plan to prevent confusion.

People told us that questionnaires are sent out asking for feedback and people felt listened to. One person told us, "I received a questionnaire which I filled in and returned". Another person told us, "I have had a telephone call from the manager just the other day to see how things are going and to make sure I am happy with the carers". A relative we spoke with told us, "The managers call to see if there are any problems now and again". Records we looked at confirmed that people's opinions and feedback were sought through telephone reviews and questionnaires. Most of the feedback we saw was positive about the service and where feedback was either neutral or poor; this was followed up with an action plan.

People we spoke with told us that they knew how to complain. They told us if they were unhappy or had any concerns they would contact the office. One person said, "I have never had to make a complaint but I have the number if I need to". Another person told us, "I have never complained I talk to the girls [staff] directly if I need to; but I do have the number to call the manager if I need to". A relative we spoke to told us, "They [operations manager] went through the complaints procedure during the assessment; when we have had a problem, they [operations manager] have got back to us straight away". Another relative said, "I had to raise a concern at the beginning; they were very helpful who I spoke to and got it sorted for us". We saw that the provider had a complaints procedure in place. The registered manager told us that they had not received any formal complaints recently and any constructive feedback they had received had been acted upon to improve the service. For example, we saw that where a person had raised a concern relating to late or missed calls, the provider had kept an audit log which detailed what action they had taken to address the issues raised and follow up contact was also made to monitor the progress.

Requires Improvement

Is the service well-led?

Our findings

At the time of our last inspection, the service was found to be requiring improvement in this area. Whilst no breaches of the regulations were found, the service was required to make improvements to the quality assurance systems and record keeping. The registered manager and operations manager told us that since the last inspection, they had acquired more office space for the safe storage of records and had started to use electronic records. They also assured us that quality monitoring systems had been improved. People we spoke with, records we looked at and from observations we made during our inspection, confirmed that some of these improvements had been made.

However, the quality assurance processes had not identified all of the shortfalls we found during our inspection. These included poor standards of record keeping in daily logs, for example, some entries were written in pencil, wererepetitive in nature and lacked personalisation. We found inconsistencies between Medication Administration Records and daily report logs, unidentified late/early calls and inadequate recruitment checks. We discussed this with the management team and they acknowledged that further improvements were required. They informed us that they have recently expanded the management team and have now recruited a Care Quality Controller and a Services Manager, both of whom will be responsible for improving and maintaining the quality monitoring systems and processes.

The service was required to have a registered manager in place as part of the conditions of registration. There was a registered manager in post at the time of our inspection. Information we hold about the service showed us that the provider was meeting the registration requirements of CQC. The provider had ensured that information that they were legally obliged to tell us, and other external organisations, such as the local authority, about were sent. However, some of the people we spoke with also told us that the management team are sometimes difficult to get hold of and are unreliable at returning calls. We also received feedback from external agencies who informed us that the management team at Mach Care Solutions were not always co-operative and were found to be defensive when addressing service deficiencies.

We asked the registered manager to tell us about their understanding of the Duty of Candour. Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they receive. The registered manager and operations manager was able to tell us their understanding of this regulation and explained that they also expect this level of openness and honesty from the staff they employ. We saw an example of where a complaint had been raised and investigated by Mach Care Solutions, a report had been produced and sent to the complainant which stated the provider's duty of candour and recognised their accountability of errors and lessons learned.

Most of the staff we spoke with confirmed that they felt supported in their role through open communication links with the management team via supervision, team meetings and on call support systems. They also told us they felt comfortable and confident in raising concerns with the registered manager. One member of staff told us, "I would go straight to [registered manager] if I needed to, she is very approachable". Another staff member said, "I can always ring [operations manager]; he is very good". A

different member of staff told us, "I would not hesitate to tell the manager if I thought something was not right or someone was unsafe; I know I can ring CQC as well if I needed to".

We saw that the provider also had a whistle-blowing policy in place to support staff to raise any concerns. Whistleblowing is the term used when someone who works in or for an organisation raises a concern about malpractice, risk, wrongdoing or illegality. At the last inspection, this policy was found to lack contact details for external agencies such as the CQC; we saw that this had been updated and was now comprehensive in the information it provided. The registered manager told us, "If something is wrong, I want to know about it so we can deal with it". Information we hold about the service told us that there had been two whistle-blower concerns raised since our last inspection. Both of these raised safeguarding concerns which were investigated by the local authority and we also followed these up during our inspection. We did not find any evidence to substantiate the concerns raised.