Keeping People Safe

June 2026

Hello...

Safety is not just compliance—it's culture, values, and everyday decisions

Safety doesn’t happen by policy alone—it’s driven by people, culture, and leadership

Creating a safeguarding culture

- Empowered staff
- “See something, say something” “No blame” culture
- Recognise early and act confidently ‘If it feels wrong it probably is’
- Clear reporting pathways
- Strong leadership visibility
- Managers accessible and responsive
- Open-door culture
- Learning from incidents
- Doing the right thing when no one is watching.

What CQC expects linked to the fundamental standards of

- Safeguarding
- Safe care & treatment
- Staffing
- Duty of candour

And how we aim to meet them

Safeguarding (Regulation 13: Safeguarding service users from abuse and improper treatment)

- Clear, up-to-date **safeguarding policies** aligned to local authority procedures
- Staff demonstrate **deep understanding of all abuse types**, including less obvious ones (self-neglect, modern slavery)
- **Regular safeguarding training** with high completion rates and competency checks
- Evidence staff can **confidently escalate concerns immediately**
- Strong **partnership working** with safeguarding teams (timely referrals, feedback loops)
- **Proactive safeguarding culture** (not just reactive) – e.g. identifying patterns or early warning signs
- Detailed **safeguarding logs and audits**, showing learning and themes tracked
- Outcomes-focused approach: evidence of **how people were protected and risks reduced**
- People using the service report they **feel safe and listened to**
- **Whistleblowing culture** – staff feel supported to raise concerns without fear

Safe Care and Treatment (Regulation 12)

Comprehensive, **person-centred risk assessments** covering:

- Moving & handling,
- Medication,
- Falls,
- Nutrition & hydration,
- Skin integrity,
- Environmental risks in home.

Evidence risk assessments are: **Regularly reviewed** and updated after incidents or changes in condition

- Clear, individualised care plans that **actively mitigate risks**

Robust **medication management systems,** including:

- MAR charts completed accurately
- Regular medication audits
- Protocols for PRN (as-needed) meds

Safe Care and Treatment (Regulation 12)

- Evidence of **learning from incidents and near misses**
- Effective **infection prevention and control (IPC)** practices (especially in home settings)
- **Contingency planning** for emergencies (missed calls, staff absence, adverse weather)
- Use of **technology (if applicable)** to improve safety (e.g. call monitoring, digital care records)
- Consistently **low or well-managed incident rates**
- Strong evidence that **people are supported to take positive risks safely**

To help with this we use..

- Birdie 
- Monday.com 

- Microsoft co-pilot 
- Lumis 

Staffing (Regulation 18)

- **Safe and effective staffing levels**
  - matched to people's needs
- **Reliable systems minimising:**
  - Missed visits
  - Shortened calls
  - Late arrivals
- **Evidence of continuity of care**
  - Same carers where possible
- **Safe recruitment practices:**
  - DBS checks
  - Full employment history
  - References verified
- **Strong induction programme e.g.**
  - Care Certificate
- **Ongoing training and competency assessments, including**
  - Practical observations
  - Regular, meaningful supervision and appraisal
- **Staff demonstrate:**
  - Confidence
  - Competence
  - Knowledge of the people they support
- Evidence of **low staff turnover and good retention**
- Staff report they are **well-supported and not rushed**
- Effective **on-call systems** for support outside office hours

Duty of Candour (Regulation 20)

- Clear **duty of candour policy** understood by staff
- Evidence of **open and honest communication** with people and families when things go wrong
- Documented examples of:
  - **Apologies given appropriately**
  - People being informed promptly of incidents affecting them
- Transparent **incident reporting systems**
- Evidence of **root cause analysis** and learning from mistakes
- Feedback loops demonstrating “You said, we did” actions
- Culture of **openness, learning, and accountability**
- People and relatives confirm they are **kept informed and treated honestly**
- Leadership promotes **psychological safety for staff to admit errors**

What inspectors look for:

- Not just policies—evidence in practice
- Staff knowledge (they will ask carers questions)
- Real examples of safeguarding raised
- Proactive, not reactive safety management
- Embedded safety culture at all levels
- Consistent excellence, not pockets of good practice
- Strong evidence of learning, improvement, and innovation
- People’s experiences confirming safety, not just paperwork

How we prove our service is ‘Safe’

- Documenting
- Auditing
- Auditing
- Closing the loop

We Audit for every client.. Daily observations

Daily: (from Care Professional visit log on birdie)

- Whether or not the client has been to the toilet,
- their general mood,
- food and drink they have been served and how much they ate,
- their confusion and memory levels,
- mobility level,
- physical health,
- and any other general observations.

We Audit for every client.. Alerts received

Daily: we can receive alerts for any of the following;

- Medication not taken
- Medication partially taken
- Medication error
- Essential task not completed
- Visit plan not completes
- Concern raised
- Action raised
- Visit not started in time
- Forced check in
- Forced check out
- Visit overran
- Fall/near miss

We Audit for every client.. Weekly: ‘not completed summary’

Here is a clear, data-driven summary for **XXXXXX**, and grounded directly in the uploaded task records.

Summary of Trends in Not-Completed Tasks
Across the period reviewed XXXXX non-completed tasks show a **consistent pattern linked to feeling unwell, choosing to remain in bed, or declining personal care**.

The majority of missed tasks fall within **Medical (cream application & medication), Personal Care (washing, dressing, continence), and Cleaning tasks requiring movement**.

Notes repeatedly state: *“XXXXXX declined”, “Didn’t want any on this morning”, “Stopping in bed due to not feeling very well”*, and *“XXXXXX requested not to move.”*

Quantified Refusals / Non-Completions
- **Administer Cream:** 12 refusals out of 40+ entries (≈30%).
- **Administer Medication:** 2 refusals, both due to feeling unwell.
- **Transfers (Assist out of bed):** 2 refusals, both linked to illness and choosing to stay in bed.
- **Dressing:** 2 refusals (“Kept nightie on”, “Didn’t want to be changed”).
- **Washing / Bathing:** 2 refusals (“XXXXX declined”).
- **Hair Care:** 1 refusal (“Didn’t want it brushed”).
- **Continence Care:** 3 refusals (“Didn’t want it on”, “Didn’t want to be changed”).
- **Oral Hygiene:** 1 refusal (“Didn’t want them done”).
- **Cleaning / Bed Making:** 3 non-completions due to XXXXX remaining in bed.
- **Meals:** 1 refusal (“Didn’t want anything this morning”).

We Audit for every client.. Weekly: ‘not completed summary’

Overall Summary of Care Delivered
Despite periods of illness and reduced engagement, **the majority of tasks were completed across all categories**, including medication administration, continence care, washing, dressing, cleaning, laundry, meals, safety checks, and wellbeing monitoring. Carers consistently adapted to XXXXXX preferences, respected refusals, and documented changes in her condition (e.g., breathlessness, headaches, choosing to stay in bed). Care delivery remained **consistent, responsive, safe and caring

Final Summary after being reviewed by Care Co-ordinators: 01st-07th June 2026
Overall Summary & Concerns
XXXXX experienced a noticeable decline in her health midweek, presenting with breathlessness, headaches, fatigue, and reduced appetite. During this time, she chose to remain in bed, declining aspects of personal care and medication, which Care Professionals respected while ensuring she remained comfortable and hydrated. Escalation to professionals occurred appropriately, including GP input and district nurse review. By the end of the week, XXXXX showed significant improvement, becoming more mobile, eating and drinking well, and returning to her usual routine with positive mood.
Key concerns:
- Acute illness during the week (breathlessness, headache)
- Refusal of care and medication at times
- Skin integrity concerns and ongoing continence needs
- Increased dependency during illness period

We Audit for every client.. Weekly MAR audit

MAR Audit May 26

Details / Timeline / Actions

Tags: Well led / Safe

1st - 3rd May 26 Medication administered as planned. Co

4th - 10th May 26 Medication given as required, 3 N/T with sufficient reasoning. RM

11th - 17th May 26 Medication given as required. RM

18th - 24th May 26 All medication given as required. RM

25th - 31st May 26 All medication given as planned - 2 x N/T due to client not wanting cream on. Co

Other Audits & Evidence we use

- Quarterly owner self audits
- Annual Care Professional file audits
- Annual independent PEAQ (Pursuing Excellence Advancing Quality) survey for all Care Professionals, clients and their families
- WhatsApp groups for each client, and whole staff groups if urgent information needs to go to everyone immediately
- Birdie Family circle app
- We introduce ourselves to the client’s GP and other professionals with client permission when we start their service
- Can share client information with GP and other professionals straight from birdie
- Medication is restricted to NHS medicines database – can’t free type
- Feedback: positive, negative or how something was handled.

6 Key Messages

- Safety starts with culture
- Staff confidence is critical
- Safeguarding is everyone's responsibility
- Prevention is better than reaction
- Learning drives improvement
- If it's not recorded it didn't happen
- Recording alone isn't enough, it's what you do with it.

Policies don’t protect people—people protect people. Our job is to give them the confidence, skills, and culture to do that every day.