My Peace Mills Limited

Peacemills Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 24 March 2016.

Peacemills Care Home provides nursing and accommodation to older people. It is registered for a maximum of 40 people. There were 33 people receiving care and support at the home at the time of our visit.

On the day of our inspection there was a registered manager in place. 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 at the home. They were supported by staff who understood how to identify and report allegations of abuse. Risk assessments were in place, but did not always identify or reduce the risk to people's safety. Some documents were not kept secure and confidential. Sufficient staff were in place to keep people safe and medicines were stored and handled safely.

People were supported by staff who were trained and knowledgeable about people they cared for. People received effective suitable care that met their individual needs, preferences and choices.

People's rights were protected under the Mental Capacity Act 2005. Most people received sufficient to eat and drink, but had not always had a good experience at meal times and some people were not fully supported. People had access to other healthcare professionals and received effective care that was relevant to their needs.

People were encouraged and supported to keep positive caring relationships with others. People were treated with kindness and compassion. Staff interacted with people in a friendly and caring way. People's privacy and dignity was protected and they felt able to contribute to decisions made about their care. Arrangements were in place for people to receive support from an independent advocate if they needed one.

People's care records focused on people's wishes and respected their views. Staff responded to people's needs promptly. They encouraged people to participate in activities that were available in the home which reflected their needs. A complaints process was in place and staff knew how to respond to complaints.

People, relatives, staff, and healthcare professionals all complimented the registered manager. The registered manager actively sought people's views and acted on them. There were systems in place to monitor and improve the quality of the service provided. Some documents were not kept secure or completed correctly. There were auditing processes in place that helped to identified risks to people and the service as a whole, but they were not always completed accurately or any issues were not dealt with quickly and effectively.

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 felt safe in the home and staff knew how to identify potential signs of abuse.

Systems were in place for staff to identify risks, but risks to people were not always managed safely.

Sufficient numbers of staff were on duty to meet people's needs and they were recruited through safe recruitment practices. Medicines were safely managed.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by staff who were knowledgeable and skilled to carry out their roles and responsibilities.

The principles of the MCA and DoLS were used to determine people's ability to make their own decisions. Staff followed guidance to ensure people who lacked capacity made decisions in their best interest, but did not always fully understand these principles.

People were encouraged to be independent and to make their own choices.

People were supported to have sufficient to eat and drink, but for some people the meal time experience was not always good.

People were supported to maintain good health and had access to healthcare services when they needed them.

Is the service caring?

Good

The service was caring.

People were supported to express their views and be actively involved with decisions about their care and support.

People were treated with respect, compassion and in a dignified way by the staff who cared for them. People's privacy was respected.

People has access to an advocacy service if and when required.

Is the service responsive?

Good

The service was responsive.

People participated in activities that was stimulating and of interest to them.

Care plans were reviewed and people were involved with the planning of their care to ensure they received personal care relevant to their needs.

People knew how to make a complaint if they needed to. The complaints procedure was available and the provider responded to concerns when necessary.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a visible management presence and people spoke highly of the registered manager.

Systems and procedures to monitor the service did not always identify issues and concerns.

People, their relatives and staff were encouraged to be involved in the development of the service.

The service worked well with other health care professionals and outside organisations.

Accidents and incidents were managed and responded to.

Peacemills Care Home

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 24 March 2016 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we reviewed the PIR and other information we held about the home, which included notifications they had sent us. A notification is information about important events which the provider is required to send us by law.

We also contacted visiting health and social care professionals and the commissioners of the service to obtain their views about the care provided in the home.

During our visit we spoke with eight people who used the service, six visitors, and five care workers, the head of care, the deputy manager, the registered manager and the provider's representative.

We looked at the care plans for six people, the staff training and induction records for four staff, two people's medicine records and the quality assurance audits that the registered manager completed.

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.

Requires Improvement

Is the service safe?

Our findings

Individual risks were identified, but not always managed safely. We saw where some people were at risk of falls the risks were assessed, but not always managed and reviewed. For example, one person who had a fall we saw the accident form had been completed. A risk assessment had been updated and a plan for staff of how to manage any risk for the person had been put in place. There was a trigger identified and action taken to minimise the risk. Another person who was identified as partially sighted was moved from an upstairs room to a downstairs room, so they could move around the home with ease and not be at risk of falling down the stairs. However, when looking at the person's care file we found there was no risk assessment in place for the stairs or any reference to the bedroom move or reason for the move. Staff had worked with the family of this person and implemented equipment to make it easier for the person to identify objects and hazards that may impact on their movement in their room and around the home. One person who lived with diabetes were looked after by the district nurse, however there was no information or advice for what staff should do if the person had symptoms of high or low blood sugars. Neither was there information on what action should be taken or what the risks for the person were.

People were protected from abuse and harm, because the provider had systems in place to identify the possibility of abuse and to reduce the risk of people experiencing abuse. People told us they felt safe living in the home and their relatives confirmed this. One person told us that sometimes things could get a bit heated between people living in the home. They said, "The staff stay calm and soon nip things in the bud." Another person described how they thought someone (another person living in the home) had been into their room and moved some of their personal items. They said, "I told a member of staff. They could see that it worried me, so they [staff] organised for me to have a key for my room." We asked the person if this had changed how they felt about their safety after they had got their own key. They replied, "Crikey yes. It's like my own front door now. Perfectly safe." One relative said, "When I leave here, I know that my relation is in safe hands than if they were living at home."

Discussions with staff confirmed that they had knowledge of how to protect people from abuse. They had attended or were booked on to safeguarding training. They could describe different types of abuse and knew who they should report concerns to, both internally and externally. One staff member told us they were confident to report any concerns as the people they cared for were their top priority.

We found Information on safeguarding was displayed in the home to give guidance to people and their relatives about what they could do if they had concerns about their safety. Appropriate safeguarding records were kept. The registered manager discussed the process for reporting concerns of a safeguarding nature. This included how to contact the local authority and the Care Quality Commission. The registered manager told us they included agenda items in team meetings for safeguarding related issues. This showed us the provider took action to help to protect people's safety.

We discussed a number of safeguarding issues that had been raised in the last 12 months. We were satisfied from records we saw and information received from other professionals and the provider that these had been dealt with. Any action or recommendations required had been followed.

People had their own personal evacuation plans in place (PEEP) to ensure they were supported in an emergency. We found the premises were well maintained and the member of staff responsible for the maintenance of the home undertook and recorded weekly and monthly checks. These included checks such as, water temperatures, call bell systems and fire tests to make sure people were safe.

People told us there were sufficient numbers of staff on duty. One person commented that there were plenty of staff on during the week, but they went on to say there seemed to be a lot less at the weekends. We asked what the person meant by "a lot less" and they said, "Well I think it's a team leader and three care workers."

Staff told us they felt there were enough staff to cover any shortfalls. They said they had use of bank staff to cover annual leave and absence. One staff member said, "Yes there is enough staff." They also went on to say how many staff were allocated on all shifts including the night shift and at weekends. Other staff said they had a handover each shift and this included useful information about people's needs and how to keep them safe.

The registered manager told us they used a dependency tool to identify how many staff they required on a daily basis to meet people's needs. We checked staff rota's and noted the numbers of staff were consistent with the rota on the day of our visit.

Staff confirmed they had been through a robust recruitment process. We looked at recruitment files for staff employed by the service. The files showed appropriate checks had been carried out for staff before they started work. However, we found one member of staff had been employed since 2011 and their Disclosure and Barring Service (DBS) (formally a criminal records bureau CRB) had not been refreshed since that date. The registered manager told us this should be done every three years. For another member of staff we saw their start date was October 2015, but their DBS check was dated nine days after they started working at the home. The registered manager told us the staff member would have only completed their induction during this period, but we could see no evidence that this was the case.

Staff confirmed they were aware of the provider's whistle blowing policy and felt comfortable to use it if the need arose. One staff member said, "I would have no choice, but to report any concerns if I was witness to them. Staff said they felt supported, listened to and valued at all times.

People's medicines were stored and handled safely and people received them in a safe way. One person told us they knew what the tablets they were taking were for, but could not always remember the names. We asked people if staff watched over them while they took their medicines and they replied yes. One person said, "They [staff] stand over me and hand me the water to take my tablet with.

Staff who administered medicines described the process they followed and how they had access to the NHS website to check and monitor side effects. Staff were very specific about the timings of medicines, for example if the medicine needed to be given an hour after food, or if the previous medicine round had run late. Staff made appropriate adjustments for this. Staff and records we saw confirmed training for medicines had been completed. The registered manager told us that competency assessments for staff were not yet in place, but this was work in progress. We saw a template to support this process was in place.

We looked at a sample of medication administration records (MAR) and found procedures had been followed. For example, photographs of people were in place to identify who the medicine was for and any known allergies were recorded. Variable doses of medicines were prescribed and staff recorded the amount administered on the MAR. Food supplements were available and signed as administered. Where medicines were stopped this was clearly marked on the MAR.

We found body charts were in place to advise staff when and where to apply creams or other topical applications and these were generally signed for as administered. However, we found creams were administered from people's bedrooms. These creams did not always have a prescribed label and were not always dated on opening. We also found several had expired. For example a cavillion spray for one person was not dated on opening and was prescribed on 21 December 2015. We also found a tube of zinc and castor oil with no lid. This cream had not been dated on opening and was prescribed on 29 January 2016. This meant the cream could become contaminated. We saw a pharmacy audit had been carried out in June 2015. The issue that creams were not kept in a locked cupboard was identified, which also remained the same at the time of our visit. The audit also stated that not all topical (creams, eye drops and ointments) applications were dated on opening and that PRN (as required) (PRN medications are not intended to be given as a regular dose or at specific times) protocols need to be updated. We discussed this with the registered manager and they told us they would take action to address these issues.

Requires Improvement

Is the service effective?

Our findings

People received effective care, which reflected their needs, from staff who were knowledgeable and skilled to carry out their roles and responsibilities. One person said, "I think the staff knows more about me than my own family. They sometimes get me talking about my childhood, which I love." People and relatives we spoke with gave positive feedback about the staff and the care and support they provided.

People were supported by staff who had the necessary skills and knowledge to provide effective care. Staff felt supported and confirmed they had opportunities to undertake specialist training or complete the care certificate. The care certificate was developed by 'The Skills for Care', which is a nationally recognised qualification. One staff member said, "I have had good training." They told us how they had a different working background to caring, but were confident they had been fully supported in their new role.

Staff told us they received supervision, appraisals of their performance and an induction when they first started with the service. One staff member told us they had been shadowing another member of staff for two weeks and were in the process of completing relevant training. The registered manager told us and records we saw confirmed staff training was up to date. There were systems in place to ensure staff were supported and able to share working practices that provided effective care. The registered manager told us that staff attended a handover before each shift. They said, "This was to make sure staff were up to speed with what was happening with people and the home." Staff confirmed there were daily meetings where discussions took place and where information was shared.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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 DoLS applications were made where appropriate.

The requirements of the MCA were adhered to. We found a number of DoLS had been applied for, but none had been authorised at the time of our visit. When a person lacked the capacity to make some decisions for themselves, a mental capacity assessment and best interests documentation had been completed.

People told us and records we saw confirmed they had consented to care and support. We observed staff ask people what they wanted to do, where they wanted to sit and if they could support them in any way. Staff told us they had received training in the MCA and DoLS. Staff we spoke with had limited understanding of how the MCA reflected on people's right to make decisions and choices for themselves. We spoke with the registered manager and they told us through discussions with staff during their supervision they had identified this. They told us they felt staff lacked understanding and they were in the process of increasing training and awareness and this would be discussed in supervision and monitored regularly.

We saw care records for people who had a decision not to attempt resuscitation order (DNACPR) in place. These had been completed appropriately.

People were supported to eat and drink sufficient amounts and to maintain a balanced diet. One person said, "The chef knows exactly how I like my eggs." One relative said, "My relation lost a bit of weight since being at the home, but not too much. I know staff are aware, because they have mentioned it to me. They keep an eye on my relation at mealtimes and encourage them to eat." Another relative said, "The food always looks nice. I am allowed to come at mealtimes and sit quietly with my relation and help assist them to eat." They also told us the person was on a soft diet and thickeners as they had trouble swallowing their food. A third relative said, "Sometimes I think the food is too good here. Some of my relative's clothes have got a bit tight recently, but they are happy. That's what counts."

Staff were knowledgeable about peoples dietary requirements. They knew who were living with diabetes and who required special diets or pureed food. Staff talked about people having sufficient to eat and drink. One staff member said, "I always ask if people would like some more." This showed us people's needs were supported and staff were aware of these needs.

People's individual dietary needs were recorded. The cook told us they worked on a five weekly rota for the menu and people were offered choices and a balanced varied diet. Food options were included in the menu for people living with diabetes and food supplements for people who had difficulty swallowing or required high calorie diets. The cook told us they attended resident meetings to discuss the menu to make sure they provided what people wanted to eat.

We found the dining experience for most people was positive and there was interaction from staff for some of the people. However, for two people living with dementia they had a slightly different experience. We saw one person had not got a drink. The gravy boat was on the table, so the person poured some gravy straight into their mouth. Staff were not aware and did not intervene. Another person proceeded to put pepper into their drink. Staff were not adequately observing people during the lunch time period. We spoke with the registered manager and they told us they would complete an observation for the dining room experience to make sure people received appropriate support.

We found the fridge and freezer temperatures were recorded and within acceptable limits. An environmental health report had been completed in 2015 and recommendations had been made. However, we found a number of these recommendations were still outstanding at the time of our visit. We spoke with the registered manager and they told us they would address these issues immediately. We checked at the end of our inspection and action had been taken.

People told us they had access to a GP and other services. One person said, "A GP visited the home on a weekly basis." We saw recorded in people's care plans they had access to a GP, dentist and chiropodist. We saw one person had an injury to their leg and there had been regular input from the district nurse. We saw people had been referred to appropriate health care professionals. However, we found people who were at risk of developing pressure sores had not had their information recorded accurately to ensure they received a positive and effective outcome. We also found another person should have had pressure relieving equipment in place. We observed that the person was not sitting on a pressure cushion. Two out of three staff we spoke with about this issue told us this person did not need to use a pressure cushion. This meant the person may not receive effective care and support to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People told us they were encouraged to make friends with each other and have a positive relationship with their family. People and their relatives were consistently positive about the kind and caring staff. One relative said, "From the moment I set foot in this home I knew it was a nice place. I was made to feel welcome. Staff always call people by their preferred name.

People told us they could receive visitors at any time. Relatives told us the home was welcoming and that there were no restrictions when they could visit. One relative said, "I can visit any time I want, which works well around my shifts. I can honestly say that I feel they love [name]." Another relative said, "The staff really do not mind when I visit my aunt. Sometimes I arrive early and they let me eat breakfast with her." The relative went on to say the staff were very nice and they would give the staff ten out of ten for caring.

We observed staff engaging with people for example, staff were encouraging people to take part in the daily activities. Some staff were in conversation with people. They spoke to people at the same level. This meant if a person was sitting down in a chair the staff member also sat down next to them. Staff interactions with people were good. We saw three people jesting with a member of staff. There was good humour and laughter between them all. We observed staff to be kind and considerate to people's needs.

One staff member said, "I chat with people when I can." Staff was respectful and ensured people maintained their dignity. The home had a dignity champion and we saw dignity training had been booked for staff to attend. Staff demonstrated care and kindness towards people. They showed dignity and respect at all times. Staff described how they involved people in decisions about their care and support. One staff member said, "I ask people if they want to receive personal care. They went on to described how they would preserve the person's dignity during this procedure.

People described what choices they had, such as, a bath or shower. One person said, "I prefer a bath to a shower every time." We asked how many baths they get a week. The person told us they only got one, but would like more. We asked if they had told the care staff they would like more baths and they replied no. They said, "That would be nice. I will speak to them about that."

Care plans contained people's preferences and some had good detailed life histories, but this was not consistent. Some people had a life map, which identified who and what was important in the person's life. People were supported to express their views and be actively involved with decisions about their care and support. Care records demonstrated that the person or their relatives had been involved in the development of their care plans.

Staff told us they were encouraged to learn about the people they cared for and what was important to them. One member of staff described the documents in a person's care file that included notes about the person's past and how staff discovered information about the person by speaking to friends and relatives. There was information running throughout the care plans about people's preferences, likes and dislikes. For example what time they would like to get up or go to bed. What their food choices were and their

preferences for a female or male care worker.

We asked the registered manager if they had any information about how people could access an advocacy service. Advocacy services use trained professionals to support, enable and empower people to express their views. The registered manager told us one person had a friend who supported them to make important decisions. They also told us they would contact other homes and colleagues to acquire further information to share with people, but felt there was no one in need at the moment.

Staff were aware how to communicate with people effectively. One member of staff told us how a person struggled to be vocal. The staff member said, "I make eye contact with them, concentrate on what the person is saying and try not to make them repeat themselves." Another member of staff told us they gave people time to find the right words or use visual techniques like picture cards or point to things. This meant the person was supported to express their views and communicate at their own pace.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. We observed staff responding promptly to most people when they required assistance or support. Relatives told us staff responded well to people. One relative said, "My relation lost their glasses when they first came to the home. The home sorted it and he got a replacement pair. Another relative told us that staff reassured their relative, as they had a tendency to fret when they were unavailable and cannot visit.

We observed one person get upset as someone had sat in their seat. The staff responded to the situation calmly and explained to the person that people could sit where they wanted. The staff continued to chat to the person until they were happy and moved away. The staff member noted the person was still not settled and asked them if there was somewhere else they would like to go.

We noted that although staff were attending to tasks they took time to chat to people and make sure they were all right. They helped people who were struggling. Asking if there was anything else they would like them to do before they returned to the task in hand.

Care plans identified aspects of care that people could do independently, while also identifying areas of support. For example, staff talked about people who were living with dementia and how they communicated with them effectively. A visiting healthcare professional gave positive feedback on how responsive the service was. They told us about one person who was receiving one to one care. They described how the person was now responding to care and that the service had done really well to get the person to eat better and come out of their room.

People were supported to take part in activities. One person told us they spent time in the garden, as that is what they liked doing. They said, "I love gardening. Sometimes I just go out for the fresh air." We observed one person being assisted to the lift, so they could go and have their hair done in the salon. Staff spoke to the person encouragingly and told them when they might feel a bump or step as the person was visually impaired.

Staff told us regular activities took place three to four times a week, which included exercises, singing and bingo. One staff member told us people liked the singing and exercises. They said it helped people get motivated. We saw some people participating in exercises during our visit. People were alert and were enjoying the activity. Other staff told us people go on outings, such as, goose fair and shopping in the local community.

The home environment was dementia friendly. There was directional signage for people living with dementia to assist them to orientate around the home. Toilets and bathrooms were marked in a dementia friendly way. We saw on people's care notes where the Dementia Outreach Team had been involved with a person's care needs. They also helped staff to understand what it was like for people living with dementia and how they should respond to people's needs. (Dementia outreach ensures the quality of care for people with dementia in care homes. They help staff to develop their knowledge, skills and confidence to plan and

deliver appropriate and individualised dementia care.) The registered manager told us they were working with a system to help support people living with dementia to make sure staff understand people and know what's right for them.

People were aware of the complaints process and how to raise any concerns. One relative said, "I am not afraid to complain. I would speak with the manager or one of the senior care staff." Staff we spoke with were aware of how to deal with complaints and who they should report any concern to. There was a complaint process and procedure in place. We saw where issues had been identified, action was taken. All complaints had been dealt with in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives were actively involved with the service. People told us they had attended resident meetings. We saw copies of meetings that had been held. There were discussions around a dignity day, a mad hatter's tea party and a person wanting to help paint some window frames in the home. We also noted one person had raised ideas for the garden. From information given by staff and confirmed by relatives, the service was open to suggestions and ways to improve people's experiences of living in the home. The service acted and introduced activities identified by people to stimulate interest and meet people's needs. We saw some suggestions people had made had taken place. This showed us people were involved with the service.

People's feedback about the service was consistently good. People told us they knew who the registered manager was and could speak with her. One relative said, "I know I can speak with the manager any time I need to." Staff told us the management team were approachable. One staff member said, "They are very good at what they do." Another staff member said, "I have been very well supported in my role." We observed a good team spirit and lots of communication between staff and people throughout the day. We asked staff what they found good about the home. They told us the home was really homely and staff were like a big family. One staff member said, "There are a good mix of people living here and they are not institutionalised." Staff felt the layout of the building could be better, but on a positive note they liked working at the home.

A registered manager was in post. All staff we spoke with felt the registered manager was approachable and listened to their views or concerns. We saw that staff meetings had taken place and the registered manager had clearly set out their expectations of staff. Their roles and responsibilities were discussed, including those of night staff. Staff told us they had handover meetings at the end and start of each shift. This told us staff were supported and the service was well managed.

The provider had systems to assess and monitor the quality of service that people received. We saw that regular audits had been completed by the registered manager and also by representatives of the provider. The registered manager told us they completed a number of audits, which covered safety and cleanliness of the premises. Other audits were carried out in the areas of infection control, care records, medication, health and safety, laundry, kitchen and domestic areas. An environmental health report had been completed in 2015 and recommendations had been made. However, we found a number of these recommendations were still outstanding at the time of our visit. For example, the sealant by the wash hand basin needed replacing. The service had replaced the sink, but there was a gap between the sink and the wall. The fly screens were damaged and needed replacing. We found three fly screens were still damaged. It was recommended by the environmental health that probe wipes should be used, but these were not in place. We found internal monthly audits had been completed for the kitchen area in March 2016. Although this had not been completed accurately. For example, the audit showed that there were no issues with the sink or the fly screens, but there was. The audit also said that there was sufficient supply of probe wipes. The cook told us they did not use probe wipes. We spoke with the registered manager and they told us they would address these issues, which they did before the end of our visit.

We saw turn charts were completed, but not always stored safely. We found on the first floor four people's documents for monitoring food, fluid and repositioning charts for the last two months had been left outside their rooms by staff. One person was no longer living at the home, but their records had not been removed. There was a risk these documents could be misplaced or information was not kept confidentially or stored securely. We spoke with the registered manager. They told us they had implemented a system and staff should be following this system. They told us they would reiterate to staff and take action accordingly.

Incidents, accidents and complaints were responded to in a timely manner. People and their relatives told us they had no concerns or complaints about the care provided, but they would know who to speak to if they did. We saw that incident and accident forms were completed. There were appropriate procedures for incidents and accidents for staff to follow to ensure they reported correctly.

The service worked well with other health care professionals and outside organisations to make sure they followed good practice. We noted the service followed their legal obligation to make relevant notification to CQC and other external organisations.