The Orders Of St. John Care Trust

OSJCT The Meadows

Inspection report

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Date of inspection visit:
31 May 2016

Date of publication:
28 June 2016

Ratings

Overall rating for this service	Good

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

We inspected this service on 30 May 2016. This was an unannounced inspection. The Meadows nursing home is registered to provide accommodation for up to 68 older people of whom some were living with dementia and required personal or nursing care. At the time of the inspection there were 63 people living at the service. The home is arranged into three units; Bluebell, Poppy and Primrose.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager worked closely with the deputy manager and the area operations manager.

People who were supported by the service felt safe. Staff had a clear understanding of how to safeguard people and protect their health and well-being. People's medicines were stored and administered safely.

The service had enough suitably qualified and experienced staff to meet people's needs. People had a range of individualised risk assessments in place to keep them safe and to help them maintain their independence. Where required, staff involved a range of other professionals in people's care.

The registered manager and staff had a good understanding of the Mental Capacity Act 2005. 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. Where people were thought to lack capacity to make certain decisions, assessments had been completed in line with the principles of MCA. The registered manager 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 received care from staff who understood their needs. Staff received adequate training and support to carry out their roles effectively. People felt supported by competent staff that benefitted from regular supervision (one to one meetings with their line manager) and team meetings to help them meet the needs of the people they cared for.

People's nutritional needs were met and people benefited from a good dining experience. People were given choices and received their meals in a timely manner. People were supported with meals in line with their care plans.

The atmosphere at the service was calm and friendly. Staff we spoke with were motivated and inspired to give kind and compassionate care. Staff knew the people they cared for and what was important to them. Staff appreciated people's unique life histories and understood how these could influence the way people wanted to be cared for. People's choices and wishes were respected and recorded in their care records.

People had access to activities and stimulation opportunities. Activities were structured to people's interests. Staff knew how to best support people and what activities and changes to the support would suit the needs of people.

Where people had received end of life care, staff had taken actions to ensure people would have as dignified and comfortable death as possible. End of life care was provided in a compassionate way.

Leadership within the service was open and transparent at all levels. The provider had quality assurance systems in place. The provider had systems to enable people to provide feedback on the care they received.

The registered manager informed us of all notifiable incidents. The registered manager had a clear plan to develop and further improve the home. Staff spoke positively about the management support and leadership they received from the registered manager.

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 the risk and keep people safe.

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 enable them to meet people's needs.

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 were treated as individuals and were involved in their care.

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

Visitors to the service and visiting professionals spoke highly of

the staff and the care delivered.

Is the service responsive?

Good

The service was responsive.

People received activities and stimulation which met their needs or preferences.

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

People's care plans were current and reflected their needs.

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 feel included and well supported.

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

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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 30 May 2016 and was unannounced. The inspection team consisted of two inspectors, a dementia Specialist Advisor 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 received feedback from two 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 also contacted commissioners of the service to seek their views.

We spoke with 22 people and two relatives. We looked at ten 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 used the Short Observational Framework for Inspection (SOFI). SOFI is a means of understanding the experiences of people who could not speak with us verbally. We spoke with the registered manager, the deputy manager, the area operations manager and ten members of staff which included nurses, care staff, housekeeping, maintenance and catering staff. We reviewed a range of records relating to the management of the home. These included seven staff files, quality assurance audits, minutes of meetings with people and staff, incident reports, complaints and compliments. We reviewed feedback from people who used the service and their relatives.

Good

Is the service safe?

Our findings

People told us they felt safe when supported by staff. Comments included; "I feel safe. The staff are really good", "Oh yes, I feel very safe here" and "Yes I always feel safe in here". People's relatives were also complimentary of the home and felt their family members were safe at the service.

Risks to people's safety had been assessed and people had plans in place to minimise the risks. Risk assessments were reviewed and updated promptly when people's needs changed. Staff were aware of the risks to people and used the risk assessments to inform care delivery and to support people to be independent. Some people had restricted mobility and information was provided to staff about how to support them when moving them around the home. Risk assessments included areas such as falls, using bed rails and moving and handling. Ways of reducing the risks to people had been documented and staff knew the action they would take to keep people safe. The service supported risk taking. For example, one person wanted to self-medicate. A risk assessment had been carried out to support the person in maintaining that part of their independence.

Staff were knowledgeable about the procedures to keep people safe from abuse. For example, staff had attended training in safeguarding vulnerable people and had good knowledge of the service'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 would report cases of abuse to our care leaders".

People were supported by sufficient staff with the skills to meet their individual needs. The home used agency staff, however, they used the same staff and maintained continuity of care. One of the agency staff told us, "I am treated like permanent staff. I have worked here for a year". One health care professional said, "The home has had a large staff turnover of nurses which has resulted in the home using a number of bank nurses, who are very capable". Staffing levels were determined by the people's needs as well as the number of people using the service. Records showed the number of staff required for supporting people was increased or decreased depending on people's needs. The service used a dependency assessment tool at the beginning of care provision to assess the staffing ratio required. The registered manager considered sickness and staff vacancies when calculating the number of staff needed to be employed to ensure safe staffing levels.

Safe recruitment procedures were followed before staff were appointed to work at The Meadows nursing home. Appropriate checks were undertaken to ensure that staff were of good character and were suitable for their role. 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.

Medicines were stored and administered safely. We saw people received their medicines when they needed them. We observed staff administered medicines to people in line with their prescription. Where people had

limited capacity to make decisions about their own treatment, the provider had a detailed covert medicines policy which they followed. The policy stated how the covert medicines were to be given and that this was the least restrictive way. 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.

The home was clean. Equipment used to support people's care, for example, wheelchairs, hoists and standing aids were clean and had been serviced in line with national recommendations. Where people had bedrails to reduce the risk of falling out of bed, checks were conducted by maintenance staff. We observed staff using equipment correctly to keep people safe. Staff were aware of the providers infection control polices and adhered to them.

Good

Is the service effective?

Our findings

Staff were knowledgeable and skilled to effectively carry out their roles and responsibilities. People commented, "The staff are knowledgeable and have the right skills for me. I'm content here" and "They have the right knowledge".

Newly appointed care staff went through an induction period which gave them the skills and confidence to carry out their roles and responsibilities. This included training for their role and shadowing an experienced member of staff. This induction plan was designed to ensure staff were sufficiently skilled to carry out their roles before working independently. One member of staff commented, "The induction was very good. It ended when I said I was ready". There was a clear guidance and induction process in place for agency staff.

Staff had completed the provider's initial and refresher mandatory training in areas such as, manual handling, safeguarding and infection control. Staff were supported to attend other training courses to ensure they were skilled in caring for people. Staff told us they had the training to meet people's needs. We observed staff were aware of people's needs and could identify any need for extra training. One member of staff said, "You can voice 'I'm interested in courses' and they can easily sort it out for you".

Staff were supported to improve the quality of care they delivered to people through supervision and annual appraisal. One member of staff told us, "I think it (supervision) highlights your strengths and weaknesses. Something you may not see yourself". Regular supervisions gave staff the opportunity to discuss areas of practice and improvement. Any issues were discussed and actions were set and followed up at subsequent supervision meetings. Staff were also given the opportunity to discuss areas of development and identify training needs. Development and training plans also formed part of the annual appraisal process.

People were supported to stay healthy and their care records described the support they needed. People had access to healthcare services and on-going healthcare support. One person told us, "They would notify my GP if I need to see them".

Health and social care professionals were complimentary about the service and told us, "Staff refer residents to me regularly and appropriately. My recommendations are implemented in a timely manner". People's care records showed details of professional visits with information on changes to treatment if required.

People told us they enjoyed their food. Comments included; "There are always food options" and "The food is great. I can choose anything even if it's not on the menu". People were supported to have a meal of their choice by organised and attentive staff.

People's specific dietary needs were met. Kitchen and care staff had the information they needed to support people. People's dietary needs and preferences were documented and known by the chef and staff. The home's chef kept a record of people's needs, likes and dislikes. The kitchen staff knew all the residents and had flexible menus. Some people had special dietary needs, and preferences. For example, people having diabetic diet, no salt diet, pureed food or thickened fluids where choking was a risk. The home contacted

GP's, dieticians, speech and language therapists as well as care home support if they had concerns over people's nutritional needs. Records showed people's weight was maintained. Snacks were available for people throughout the day, such as fruit, cakes and biscuits. Staff were aware of how much fluid or food people needed on a daily basis and this amount was clearly recorded on each chart.

People enjoyed the lunch time meal experience. The atmosphere was pleasant. There was chattering throughout the dining room. People chose where they wanted to sit and did not wait long for food to be served. People were given choices and staff presented them two plates for each course of meal. Staff sat with people and engaged with them whilst supporting them to have their meals at a relaxed pace. People supported with meals in their rooms had the same pleasant dining experience as those in dining rooms. Staff asked people if they wanted more and this was provided as needed.

People's consent was sought before any care or support was given. 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, when people were assisted with drinks or food. Records showed people, or family members on their behalf, gave consent for care they received and in line with best interest decision making guidance. For example, all files reviewed showed consent for taking and using photographs.

The provider followed the Mental Capacity Act 2005(MCA) code of practice and made sure that the rights of people who may lack mental capacity to take particular decisions were protected. The MCA provides a legal framework to assess people's capacity to make certain decisions at a certain time. People were always asked to give their consent to their care, treatment and support. Where people were thought to lack the capacity to consent or make some decisions, staff had followed good practice guidance by carrying out capacity assessments. Where people did not have capacity, there was evidence of decisions being made on their behalf by those that were legally authorised to do so and were in a person's best interests.

The provider followed the requirements in the Deprivation of Liberty Safeguards (DoLS). These provide legal safeguards for people who may be restricted of their liberty for their safety. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to do so. Applications under the DoLS had been authorised and the provider complied with the conditions applied to the authorisation. People who had DoLS in place were 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 were positive about the care they received. Comments included, "The girls are good. The older ones are excellent", "They are very kind. They listen to me even if I bother them", "I quite like it. It's okay. They do look after us wonderfully well – certainly no problems on that score" and "The nurses see to it that I've got plenty of drink when they come. I get up when nurses can help me".

We observed many caring interactions between staff and the people they were supporting during our inspection. For example, we saw staff encouraging people to have drinks and food. People's preferred names were used on all occasions and we saw warmth and affection being shown to people. The atmosphere in the home was calm and pleasant. There was chatting and laughter throughout the day. One health care professional told us, "The staff display a warm and respectful attitude to residents and have demonstrated abilities to respond to those with a range of quite demanding behaviours with understanding and patience".

Staff told us they enjoyed working at the service. Some of the staff members had been with the provider for a number of years. Comments included; "It's a good place to work. It's clean and people are well looked after- they don't just stay in bed" and "I know the residents very well. I have worked in many places as an agency worker but here the place has got really warm atmosphere".

Staff showed they cared for people by attending to them in a caring manner. We observed people being assisted in a patient way offering choices and involving people in the decisions about their care. One member of staff said, "Residents are given the choices. For example, they have a choice of participating in activities". People were given options and the time to consider and choose. When people were unable to verbalise their choices easily, staff gave them time to express their preferences through non-verbal cues, such as nodding and smiling.

Staff were aware of people's unique ways of communicating. Care plans contained information about how best to communicate with people who had sensory impairments or other limitations to their communication. Staff knew how to comfort people who were in distress and unable to communicate their needs verbally. People's care plans specified the facial expressions and body language of people and the sounds they would make to express their discomfort if they were unable to explain it verbally. Additionally, the actions required to comfort people were described clearly. Records guided staff to respond appropriately, for example by speaking calmly, offering reassurance and identifying the source of a person's distress. We observed staff followed the guidance. For example, during our visit one of the residents got confused and distressed. They put their raincoat on and wanted to leave saying, 'I want to go home, I need to get to the bus station or the train station. My mum is not well and I need to see her'. Staff managed to calm the person down and persuaded them to stay at the home by talking to them in a gentle and respectful way and offered them a cup of tea.

People were treated with dignity and respect by staff and they were supported in a caring way. We saw staff ensured people received their care in private and staff respected their dignity. For example, staff told us how

they treated people with dignity and respect. One member of staff told us, "I do close the curtains, the door and the outside door if they request it. I put the towel on them so they are not totally exposed". One person also commented, "They treat me with so much dignity. They are wonderful, really". Another person said, "The staff always respect my dignity when they take me to the bathroom and also when they wash me". The home had dignity champions. A Dignity Champion is someone who believes passionately that being treated with dignity is a basic human right, who acts as good role model and educates all those working around them.
Staff understood and respected confidentiality. One member of staff said, "We only discuss personal information on a need to know basis". Records were kept in cabinets in nurses' stations. However, these were not locked. We discussed this with the registered manager and area operations manager who immediately locked the offices.

Staff told us that people were encouraged to be as independent as possible. One member of staff told us, "We do not take over care. We encourage people to do the little things they still can to give them that little bit of independence". One person commented, "Staff encourage us to do everything we can". Records showed people's independence was promoted. Staff involved people in making day-to-day choices and decisions. For example, staff asked people if they would like to sit at the table in their wheelchair or preferred to use a dining chair.

People and relatives were involved in decisions about their end of life care and this was recorded in their care plans. For example, one person had an advance care plan, end of life care plan (a plan of their wishes at the end of life) and a do not attempt cardio pulmonary resuscitation (DNACPR) order document in place. We saw the person and their family were 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. They told us how they would maintain people's dignity and comfort and involve specialist nurses in the persons care.

Good

Is the service responsive?

Our findings

People's needs were assessed before they came to live at the Meadows Nursing home to ensure they could be met. These assessments were used to create a person centred plan of care which included people's preferences, choices and interests.

Care planning was focussed on a person's whole life, including their skills and abilities. The provider used a 'My life story' document which captured people's life histories including past work and social life enabling staff to provide person centred care and respecting people's preferences and interests. People's care records contained detailed information about their health and social care needs. Care plans reflected how each person wished to receive their care and support. For example, people's preferences about what time they preferred to get up. People and relatives confirmed they were involved in planning their care.

Records showed staff considered details of what was important to each person living at The Meadows nursing home as important information. This information was used to engage with people and ensure they received their care in their preferred way. One healthcare professional commented, "Over time, the complexity of medical conditions of the residents has increased very markedly. The home now operates in lieu of a mini hospital for many of the patients, but neither the staff numbers nor their expertise is comparable to those available in a hospital. It's really good".

The provider had a key worker system in place. A keyworker is a staff member responsible for overseeing the care a person receives and liaise with families and professionals involved in a person's life. This also allowed staff to build relationships with people and their relatives 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 was seen to be more withdrawn. The person's medicine was reviewed and the GP increased their antidepressant medicine to uplift their mood. We saw the care plan had been updated to reflect the changes. Another person's condition had deteriorated and they were nursed in bed. The person was referred to Care Home Support Services (CHSS) who gave repositioning advice with pictorial aids. The care plan reflected the changes and the daily records showed staff followed the advice.

The provider employed two activities coordinators. One of the activity co-ordinators told us, "Activities are about empowering residents. We link hobbies to activities and residents have options to change or choose different activities". They told us this helped them plan activities to meet people's needs. Staff told us activities were based on people's preferences. For example, staff told us that they had arranged opportunities for one of the residents who enjoyed dancing, art and bingo. Records showed there were one to one activities such as jigsaws, reminiscence and creative arts and crafts as well as group activities including music therapy, knitting, board games and bingo. There were also two weekly religious services and visiting entertainers. Records also showed people had been involved in several day trips. Other people preferred to remain in their rooms and staff respected that and supported them in their rooms to reduce the risk of social isolation. On the day of our inspection we observed excellent staff engagement as well as 'The Making of Me' (an arts based project) and a 'cognitive stimulation therapy'. The activities coordinator told us

activities were offered not only during the day but in the evenings as well.

The Meadows nursing home was suitable for people who lived with dementia. People could move freely in the communal areas of the building and large gardens with chickens, rabbits and a secured fish pond. There were sitting areas with dolls and soft balls for people to engage with and offered a choice of where they spent their time. People's bedrooms were personalised and contained photographs, pictures and the personal belongings each person wanted in their bedroom.

Feedback was sought from people through regular family meetings, suggestion boxes as well as satisfaction surveys. Records showed that some of the discussions were around what changes people wanted. Minutes of resident and relatives meetings confirmed people's opinions were sought and action was taken to respond to issues raised. For example, people requested a review of the menu and wanted better soup. Follow up meeting minutes showed these changes had been implemented and people were pleased with the changes.

People and their relatives knew how to make a complaint and the provider had a complaints policy in place. This was given to people and clearly displayed on notice boards. People commented; "I know how to complain", "They listen to my voice. We always have a chat with staff and the manager" and "No complaints whatsoever. If I need to complain I say 'do this and do that'. If I need something I get it". People's relatives told us the registered manager was always available to address most issues.

We looked at the complaints records and saw all complaints had been dealt with in line with the provider's policy. Records showed complaints raised had been responded to appropriately, followed up to ensure actions completed and any lessons learnt recorded. People spoke about an open culture and felt that the home was responsive to any concerns raised. Since our last inspection there had been many compliments and positive feedback received about the staff and the care people had received.

Good

Is the service well-led?

Our findings

The Meadows Nursing home had a registered manager who was supported by a deputy manager and an area operations manager. The registered manager had been in post for nine months. They demonstrated strong leadership skills and had a clear vision to develop and improve the quality of the service.

People and their relatives we spoke with knew the registered manager. They told us, "If I need something she [manager] is very approachable. She says: 'What can I do for you' [person]" and "The manager is very good. I have never had a problem with them".

Staff told us they had confidence in the service and felt it was well managed. Comments included, "If I had a problem she [manager] would listen to me but normally we report it to our care leaders", "I have worked here for a year. The manager is very supportive" and "The support from the manager is top class".

The service had a positive culture that was open and honest. Throughout our visit management and staff were keen to demonstrate their practices and gave unlimited access to documents and records. Both the registered manager and staff spoke openly and honestly about the service and the challenges they faced. Staff told us they felt the service was transparent and honest. One member of staff said, "Here we learn from our mistakes. It is the way forward". Staff had requested monthly reflective meetings and these had resulted in identification of need for extra training in end of life. We saw an end of life workshop had been scheduled. The registered manager told us their biggest challenge had been staff recruitment. Records showed the service was continuously recruiting staff.

Feedback received from health and social care professionals was complimentary. They spoke highly about the service offered to people, their relationship with the manager and how well the management and staff team communicated with them. One healthcare professional told us, "The manager is very approachable and seems to have a good knowledge of staff and residents. They have worked extremely hard to improve things at The Meadows".

The registered manager spoke with us about their achievements and vision for the service. They said, "My biggest achievement has been empowering residents in the running of the home as well as building good rapport with doctors and health centres to allow mutual respect". The registered manager applauded their staff for 'being excellent' in looking after their residents with complex needs. Records showed the registered manager attended Multi-disciplinary Team (MDT) meetings with local GPs, Pharmacists and practice nurses to discuss the best way to support people.

The offices were organised and any documents required in relation to the management or running of the service were easily located and well presented. The provider had good quality assurance systems in place to assess and monitor the quality of service provision. For example, quality audits including medicine safety, environmental safety, care plans and levels of residents need. The registered manager undertook six monthly unannounced night visits as well as monthly quality visits to monitor the quality of care. They also undertook care leader shifts to support staff on the unit and provide in depth understanding of people's

needs.

Staff told us the registered manager and deputy manager had an open door policy and were always visible around the home and regularly worked alongside staff. People, their relatives and other visitors were encouraged to provide feedback about the quality of the service. For example, family meetings were held regularly, relatives could visit anytime to speak with the registered manager and a suggestion box was available to post any feedback or raise concerns.

Staff commented positively on communication within the team. Team meetings were regularly held where staff could raise concerns and discuss issues. The meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. During one meeting staff discussed recent death incidents and how to cope as this had been emotionally challenging. Staff had discussed how to effectively use the 'Employee Assistance Help Line" and the registered manager had provided staff with the contact details.

There was a clear procedure for recording accidents and incidents. Any accidents or incidents relating to people were documented, thoroughly investigated and actions were followed through to reduce the chance of further incidents occurring. The registered manager discussed accidents and incidents with staff and made sure they learnt from them. All accidents and incidents were audited and analysed every month by the registered manager. The registered manager told us this was to look for patterns and trends with accidents to see if lessons could be learnt and changes made where necessary.

Learning from accidents and incidents was shared through reflective staff meetings and handover meetings. For example, one incident involved poor communication regarding medicine handover which resulted in a person receiving a wrong dose of medicine. The incident was discussed and an action plan followed with clear learning outcomes to prevent reoccurrences.

There was 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 were aware of the whistle blowing policy and said that they would have no hesitation in using it if they saw or suspected anything inappropriate was happening. Staff were confident the management team and organisation would support them if they used the whistleblowing policy.

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