Heathcotes Care Limited

Heathcotes (Green Acres)

Inspection report

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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

The inspection took place on 12 January 2018 and was unannounced. This was the first inspection since the provider registered the service in October 2016.

Heathcotes (Green Acres) is a residential care home providing support to up to six people. At the time of our inspection there were six people living at the service. People living at the service had learning disabilities, autism, physical disabilities and mental health conditions.

Heathcotes (Green Acres) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Heathcotes (Green Acres) accommodates six people in one adapted building.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion.

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.

Staff worked with people to identify goals and manage risks in a way that enabled people to develop confidence and skills whilst ensuring that they were safe. The provider took a proactive approach to incidents and which meant that they were deescalated quickly and systems were in place to respond to concerns. Staff understood their roles in safeguarding people from abuse. There were sufficient numbers of staff to meet people's needs and the provider had carried out checks to ensure that staff were suitable for their roles.

Care was planned in a person-centred way. People had their own records to document their care and activities using pictures and photographs. Care planning had achieved positive goals for people and helped them to develop skills and try new things. Care plans were regularly reviewed and any changes to people's needs were actioned by staff. People were supported by allocated staff that oversaw their care and helped to identify choices and preferences. People and relatives were routinely involved in care planning. People had access to a range of activities that suited their needs and interests.

Staff had received appropriate training for their roles. Staff had attended training courses in learning disabilities and autism best practice, as well as mandatory modules. Staff received regular one to one supervisions and there was an appraisal process in place. Staff felt supported by the registered manager and

the provider had systems in place to enable effective communication between staff. Regular meetings took place that involved staff, people and relatives in decisions about the service. The provider had a clear complaints policy in place and had a proactive approach to feedback to identify improvements.

People received their medicines safely. Trained staff administered medicines and the provider managed medicines in line with best practice and regularly audited them. People were supported to access healthcare professionals when required with support from staff. The provider had systems in place to ensure the risk of the spread of infection was reduced and people lived in a clean home environment. Staff knew people well and interacted with them with kindness and compassion. Staff were respectful of people's privacy and dignity when providing care to them. People were supported to maintain relationships that were important to them.

The provider carried out regular checks on the quality of the care that people received. There was a variety of audits in place to monitor quality and the provider had sent surveys to relatives to gather feedback from them. The provider maintained accurate an up to date records and had notified CQC of important incidents and events. People were asked for consent and care was provided in line with the Mental Capacity Act (2005).

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 routinely assessed and appropriate plans were implemented to keep people safe.

Staff took action following incidents to prevent them reoccurring.

There were sufficient numbers of staff to keep people safe. The provider had carried out checks to ensure that staff were suitable for their roles.

People received their medicines safely. Systems were in place to ensure medicines were stored and managed in line with best practice.

Staff followed procedures to protect people from the risk of the spread of infection.

Is the service effective?

Good

The service was effective.

People were supported by staff that were trained to carry out their roles.

Staff prepared food with people that matched their preferences as well as their dietary needs.

People's legal rights were protected because staff followed the Mental Capacity Act 2005.

The provider assessed people's needs holistically and in line with best practice.

People were supported to access healthcare professionals.

Is the service caring?

Good

The service was caring.

People were supported by staff that were observed to be caring,

kind and compassionate.

Staff got to know the people that they were supporting and the provider's systems encouraged this.

People were supported to maintain important relationships.

Staff routinely involved people in their care and promoted people's independence.

People's privacy and dignity was maintained when staff provided care to them.

Is the service responsive?

Good

The service was responsive.

People's care was planned in a person centred way and care plans were accessible to people.

The provider reviewed people's needs regularly and where changes were identified they actioned them.

People had access to a range of activities that reflected people's needs and interests.

People and relatives were informed of how to complain and the provider took a proactive approach to feedback.

Is the service well-led?

Good

The service was well-led.

Staff felt supported by management.

Regular meetings took place that involved people, relatives and staff in the running of the service.

The provider undertook a range of audits to check the quality of the care that people received.

Staff maintained up to date records and the provider notified CQC of important events, in line with the responsibilities of their registration.

Heathcotes (Green Acres)

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 12 January 2018 and was unannounced.

The inspection was carried out by one inspector due to the small size of the service.

Before the inspection we gathered information about the service by contacting the local and placing authorities. In addition, we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with the registered manager, the regional manager, the quality assurance lead, the administrative assistant and four care staff. We also observed the care that people received and how staff interacted with people. After the inspection, we spoke with two relatives. We read care plans for two people, medicines records and the records of accidents and incidents. We looked at mental capacity assessments and applications made to deprive people of their liberty.

We looked at three staff recruitment files and records of staff training and supervision. We saw records of quality assurance audits. We also looked at records about food, activities and minutes of meetings of staff and residents.

Good

Is the service safe?

Our findings

Relatives told us that people were safe living at the home. One relative told us, "Oh yes it's definitely safe, it's brilliant there." Another relative said, "It is safe, they are not too risk averse."

Staff managed risks that people faced and this enabled them to develop skills and independence, whilst ensuring that they were safe. People's care records contained detailed risk assessment tools. These assessed risks to people in a number of areas such as nutrition, epilepsy and behaviour. For example, one person was assessed as being at high risk of choking. This was because they often ate quickly which increased the risk. The plan to reduce this risk was for the person to have their food cut up so that they could eat independently. Staff supervised the person whilst eating and encouraged them to slow down where necessary. A plan was outlined for staff to follow if the person showed signs of choking. Staff were knowledgeable about what the signs were and we observed the person being supported to eat in line with this guidance. Where people developed new interests and took part in new activities, clear plans were drawn up to manage the risks associated with these activities.

The provider kept a record of all accidents and incidents. There had been no incidents that resulted in any type of harm to people for over twelve months. This demonstrated that the provider's risk management plans were effective, along with staffing levels to ensure people benefitted from the supervision required to keep them safe. The provider kept a record of any minor behavioural incidents. These included incidents in which people had become agitated or displayed aggressive behaviour towards staff. For example, staff were supporting one person whilst out in the community and they displayed a new behaviour that could be perceived as anti social in a public place. Staff reported this back and the incident was discussed at a team meeting. Staff discussed the best plan to support the person in a dignified way if a similar incident occurred again. The person's risk assessment was updated following this and a new plan was drawn up for staff to follow. This demonstrated that systems were in place to learn from incidents and take actions to ensure people's safety.

People were supported by staff that understood their roles in safeguarding them from abuse. Staff had received safeguarding training and this had been regularly updated. Safeguarding was discussed at every meeting and at one to one supervisions. Staff were knowledgeable about the correct process for raising any potential safeguarding concerns that they may have. One staff member told us, "We'd check records to see if there is any recent changes but would report it straight away to a team leader or manager. If still concerned we can ring CQC or the safeguarding team." There had not been any safeguarding incidents for the last twelve months. Where there had been a safeguarding concern in 2016, staff and the provider had acted appropriately to ensure a person's safety.

There were sufficient staff present to meet people's needs. The provider calculated staffing based on assessed needs and local authority funding. The calculated levels matched the numbers observed on the day and recorded on rotas. People were interacting with staff throughout the day. Where people needed to go out on planned activities, staff were able to take them. People benefitted from staff being present to engage with them in activities and games throughout the day. Where people were assessed as needing one

to one care, this was fulfilled by the provider.

The provider carried out appropriate checks to ensure that staff were suitable for their roles. The provider had obtained appropriate records as required to check prospective staff were of good character. These included two written references, proof of the person's identification, employment history and a check with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

People received their medicines safely. The provider stored medicines securely and in an organised manner. The provider carried out daily checks of the temperatures of storage areas to ensure medicines were stored in line with the manufacturer's guidance. Staff carried out a daily count of medicines as well as a weekly audit. A further medicines audit was included in the provider's monthly and quarterly audits at the home. There was also an annual visit from the pharmacy, the most recent visit had identified no concerns with medicines practice. Staff had been trained in how to administer medicines and the provider assessed their competency every six months. Staff were observed administering medicines to people and they did this in line with best practice. Staff checked who they were administering medicines to and followed guidance in care plans. For example, one person liked to take their medicine from a spoon. The staff member administered this person's medicines in line with guidance and explained to the person it was time for their medicine. This was done in a patient manner, allowing the person time. Once administered, two staff signed the medicine administration record (MAR) to record the medicine had been given.

MARs were up to date with no gaps. Where people had not been administered their medicines, for example if they had been on leave and with relatives, this was made clear on MARs. People's records contained protocols for 'as required' (PRN) medicines. PRN protocols provided guidance on how staff should recognise that one person may require pain relief medicine. The person was not able to tell staff verbally so it described signs staff should look for, such as agitation that could indicate that the person was in pain. Another person suffered allergies that could impact on their wellbeing, causing changes to their behaviour. Staff were knowledgeable about both the physical signs that the person was becoming allergic and also changes to the person's behaviour. The information staff gave us matched what was recorded in the person's PRN protocol.

People were protected against the spread of infection. The home environment was clean with no malodours. We observed that people's bedrooms were free from clutter with clean linen and surfaces. Records showed that people were involved in cleaning their rooms as well as communal areas. Daily charts were completed that tracked cleaning tasks and ensured staff were accountable for work that they had completed. The provider frequently audited infection control and cleanliness and staff had received training in this area.

The provider ensured the safety of the premises. Regular checks were carried out on the health and safety of the building and maintenance works were actioned where improvements were identified. The provider had plans in place for in the event of a fire and equipment in place to support staff. Staff were trained in fire safety and regular drills were conducted.

Good

Is the service effective?

Our findings

Relatives told us that they felt staff were competent. One relative said, "They [staff] definitely seem to know what they're doing." Another relative said, "Most of the staff seem well trained, [staff member] is very good with [person]."

People were supported by staff that were trained to carry out their roles. Staff told us that they received an induction before working directly with people. The induction involved completing training courses as well as shadowing an experienced member of staff to learn about their role and meet the people that they supported. Training courses were completed in areas such as health and safety, safeguarding and infection control. The provider kept a record of all training completed and records showed staff were up to date in all mandatory areas. Training covered all modules of the care certificate. The care certificate is an agreed set of standards in adult social care that staff are trained to. All staff had also been trained in further qualifications, such as Qualifications Credit Framework (QCF). QCF is a further qualification in adult social care.

Staff received training and support specific to the needs of the people that they supported. Staff supported people with autism and all staff had received training in this. Staff were knowledgeable about autism and the people that they supported. For example, one person had a specific routine each day and staff understood the importance of this. All staff were able to tell us how they supported this person in line with what was important to them. Where staff supported a person with epilepsy, staff had been trained in this and demonstrated a good understanding of how to respond in the event of the person having a seizure. Staff had regular one to one supervision meetings where they discussed people's needs and any areas for training and development.

People were supported to eat food in line with their preferences. People's records detailed their favourite foods and any foods that they did not like. Meals were prepared for everyone in line with their preferences. For example, one person really liked crunchy textures and particularly crusty bread. This was listed in their records and staff were able to tell us this about the person. Records showed the person regularly had crunchy foods and bread in line with their preferences. People were involved in menu planning and staff used pictures of foods to involve people in this. People also went shopping with staff to involve them further in this process.

People's dietary needs were met. Where people had specific dietary needs, these were listed in their care plans. People's weights were taken each month and recorded and any changes were responded to. One person had recently been noted to have been gaining weight. Staff noted this and the person was referred to the dietician. The dietician recommended a more balanced diet for the person to help them to gain weight. Records showed that staff worked with the person to identify fruits and vegetables that they enjoyed and prepared meals in line with the dietician's guidance. Records showed that the person had started to lose weight following this being put in place.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected because staff followed the correct legal process outlined in the MCA. We noted that staff carried out decision specific mental capacity assessments wherever a new decision was made. Examples seen showed that assessments were made on decisions such as finances, medicines and consenting to having a flu vaccination. Where people were assessed as unable to make a decision, a best interest decision was documented that involved relatives and healthcare professionals. Where restrictions were placed on people in their best interests, an application was made to the local authority DoLS team. For example, one person was assessed as unable to make the decision to manage and take their own medicines. A best interest decision was documented involving staff and relatives and support with medicines was included in the person's DoLS application.

People's needs and choices were identified through a thorough an assessment process. Records contained evidence of an assessment on admission and these captured important information such as people's needs, their backgrounds and their preferences. One person's assessment documented areas that they had lived and they types of activities that they enjoyed. No people had been recently admitted to the home, but we noted that their needs had been regularly reassessed and any changes documented and actioned.

People were supported to access healthcare professionals. Every person had their own 'Health Action Plan' that identified any medical conditions and any medicines that they were prescribed. Staff supported people to arrange and attend appointments and documented these. One person had ongoing support from the community team for people with learning disabilities. Staff handled letters from the team and records showed that notes were taken following visits. People's records also contained evidence of regular visits to the dentist, optician and GP.

Good

Is the service caring?

Our findings

Relatives told us that they found the staff to be caring. One relative told us, "They [staff] are all really nice sweet people." Another relative said, "The staff are very good, always chatty."

We observed pleasant caring interactions between people and staff. Staff were observed sitting with people and engaging in activities throughout the day. People looked comfortable in the presence of staff and responded positively to interactions with them. In the morning, we observed one person spending time in the sensory room with a staff member. The person was smiling as the staff member involved them in playing musical instruments. Later, we observed staff playing the tambourine with another person. The staff member told us that this person enjoyed music and the person was smiling whilst the staff member engaged with them and played music.

People were supported by staff that knew them well. All staff that we spoke with displayed a good knowledge of people's backgrounds and their preferences. Care records contained information about people's backgrounds and choices and staff were knowledgeable about these. For example, one person liked particular musical DVDs and these were listed in their care plan. Staff were able to tell us about these and we observed staff listening to music with this person. Another person's relatives lived in another part of the UK and they liked to speak to them at a certain time each week. Staff knew where the person's relatives lived and told us when they supported them to maintain contact with them. Each person had an allocated keyworker. A keyworker is a member of staff who works closely with a person, getting to know their needs and choices so that they can oversee their care and reviews. The provider also had good staff retention. We noted that staff had worked at the home for a long time and had got to know the people that they supported well.

People were supported to maintain important relationships. People's care plans showed involvement of relatives and plans were in place for them to maintain regular contact. Care plans contained pictures of people's relatives and how they wished to maintain contact. One person had recently been to stay with their relatives. Their care plan had photographs from the visit that the person liked to look at with staff. Relatives told us that they had good communication with staff. Visits from relatives were documented and we saw evidence of written correspondence between relatives and staff. Relatives views were documented at reviews and relatives told us they were encouraged to visit whenever they wished.

People were routinely involved in their care. Where people could not make choices verbally, effective communication methods were used to empower them to make choices. For example, one person's care plan recorded that they used certain hand gestures to express choices. We observed staff responding to this person using hand gestures to confirm they wished to take part in an activity. Pictorial communication cards were used throughout the home. We saw cards used for people to choose foods, drinks and activities. Staff documented people's responses to foods and activities and where people responded positively to things, it was recorded and added to their care plans. A staff member told us, "We don't rush people to make a choice, they need time. People choose different breakfasts every morning." Assessments and reviews took into account any specific religious or cultural needs people may have so that these could be identified and

met.

Staff identified ways to encourage people to develop skills and confidence. People's care plans had recorded goals and we saw evidence of people being supported to achieve them. One person was developing skills and confidence in completing household tasks. Their care plan contained plans for staff to help them to clean their room. Staff used pictures to communicate with the person and recorded each time the person supported with this. Another person was developing skills and confidence in going out into the community. Their records contained pictures of trips and staff documented their progress at reviews. People had attended colleges and keyworkers considered people's goals and aspirations at reviews and meetings. People's schedules included support to gain skills and go out into the community; staff told us that this was an important part of people's routines. A staff member said, "People help out with a lot of things here. [Person] really likes putting the cutlery out."

Care was provided in a way that promoted people's privacy and dignity. Staff carried out personal care discreetly in people's rooms. Where we wished to discuss people's needs, we noted that staff were mindful to ensure discussions took place where they could not be heard. This showed a commitment to people's confidentiality. Staff were able to tell us how they provided care to people in a way that respected their privacy. One staff member said, "I always knock on people's doors before going into their room. If people need to use the toilet or get changes, I make sure we close doors and curtains and give them privacy."

Good

Is the service responsive?

Our findings

Relatives told us that people received person-centred care. One relative told us, "We have a copy of [person]'s care plan and they [staff] are going to update it with us."

People received personalised care that reflected their needs and preferences. People's care plans contained detailed information about what they needed support with and what they enjoyed doing. For example, one person enjoyed musicals and music and their care plan had pictures of theatres and musical instruments, as well as other activities that they enjoyed. Care plans gave staff the information that they needed to provide support to people. For example, one person could become anxious or agitated if they did not have time to rest between activities. Through recording any incidents in which the person was agitated, staff identified that they became anxious when taking part in continuous activities. The person's care plan was updated and clearly informed staff this person liked to rest between activities. A staff member was able to tell us why this person liked to rest after activities and daily records showed that this was being done each day.

Care plans were accessible and people were involved in creating them. People's care plans contained pictures of things they liked and were brightly decorated. One person liked action films and their care plan was decorated with pictures of superheroes and characters from their favourite films. Staff told us that the person had been involved in choosing these and liked to look at their care plan at reviews. The provider had set up 'multi development toolkits' for people. These were books that people created with staff. They were photo albums that were used to document activities that people did and things that they enjoyed. Staff also used these to help people develop skills and confidence in attending activities and accessing the community by talking through routines with people, using the photographs as a point of reference. Staff told us about one person who would become very anxious when out on trips. Through working with the person and taking them to a variety of places, they had become able to attend the theatre recently. We saw photographs of this trip and numerous others. The person's relative told us, "[Person] went to see Cinderella and he didn't want to leave."

Regular reviews took place to identify any changes to people's needs or choices. People's care records contained evidence of regular three monthly reviews. Where staff identified changes, people's care plans had been updated. For example, at a recent review, staff noted that one person's mental health was improving and they required less support around their behaviour. This was clearly documented and the person's mental health plan had been updated to reflect this. At reviews, staff used pictures to involve people in making choices and these were added to records. Reviews also contained input from people's relatives and relevant healthcare professionals.

People had access to a range of activities. People's care records contained activity schedules and these were regularly reviewed. Staff used people's interests and preferences to find activities that they would enjoy. For example, one person had an interest in travel and vehicles. Their timetable contained regular trips to airfields and museums and outings that reflected this interest. We saw recent photographs of the person at a transport museum, at 'Digger World' and the Cutty Sark. Activity schedules covered a variety of interests such as shopping, cinema trips, cycling and day trips. The provider arranged regular outings for people and

relatives told us they were consulted when identifying these.

Care plans were developed to document people's wishes at the end of their lives. At the time of inspection, nobody at the home was receiving end of life care. People had care plans in place that documented wishes and preferences. Records of these were in a pictorial format and documented clearly for staff. For example, one person had a list of 'things that make me comfortable', with pictures and these included music and sitting on the sofa with staff.

People were provided with information on how to raise a complaint. The provider had a complaints policy and information on how to raise a concern was displayed within the home. At the time of inspection, there had been no formal complaints. However, we saw evidence of the provider responding to issues raised in a proactive manner. Keyworkers worked closely with people and relatives had regular contact with staff. Where relatives had requested changes, these had been actioned by management. One relative told us "I did raise some issues and I now meet with [registered manager] every week and things have improved."

Good

Is the service well-led?

Our findings

Relatives told us that they felt the service was well-led. One relative told us, "[Registered manager] takes a therapeutic and holistic approach to people's care." Another relative said, "You can always get hold of them [management] when needed."

Staff told us that they felt supported by the registered manager. One staff member told us, "It is a nice place and we have a really good management relationship." Staff told us that they had worked with the registered manager for a long time. We noted that the registered manager had been at the service for five years and some of the staff had been at the home longer. This meant people were supported by a consistent management team that they were familiar with. During the inspection, we observed the registered manager working alongside staff to provide care to people. Staff and people interacted with the registered manager who was accessible throughout the day.

The provider involved people, relatives and staff in the running of the home. Regular meetings took place that gave people a voice in the running of the home. People living at the home were not able to express themselves verbally. Keyworkers worked with people, using pictures and sign language to establish their needs. Minutes showed that staff advocated for people at meetings to ensure that they were represented. For example, at a recent meeting, staff fed back that one person enjoyed a trip to the cinema and another person wanted support with nail care. Following the meeting, both these points had been actioned by staff. Relatives told us that they were regularly consulted on people's care. One relative told us that they visited regularly and met with the registered manager each week. Another relative told us that they visited every month and had good telephone communication with staff and their family member between visits.

Staff benefitted from regular meetings that involved them in decisions about the home. Staff told us they had regular team meetings and records showed that these took place regularly. Minutes of meetings documented that staff frequently made suggestions to identify improvements at the home. For example, staff had identified a new activity centre for people to attend. This was discussed at a recent team meeting and people had attended trial days at the activity centre. There were regular meetings to enable good communication between staff. Staff completed a communication book and had a daily handover meeting. These ensured that important messages about people's care, health or activities were delivered to the staff working with that person. One staff member said, "We have a communication book that is completed daily. We have a handover meeting each day and it is important to check the shift planner."

Checks were in place to identify improvements at the home. The provider carried out a variety of audits to check the quality of the care that people received. Audits covered areas such as infection control, health and safety, medicines and documentation. Any actions required following audits were added to a central plan and signed off by management. For example, a recent audit had identified that there was not an up to date legionella certificate in place for the home. This was identified and actioned by staff. The provider had a vision for the service and an ongoing plan to continually improve. The provider shared improvements that they intended to make with us in their provider information return (PIR) and we found they had been implemented by the time of our inspection. For example, the PIR identified that people living at the home

were getting older and their activities had been reviewed to reflect changes in needs and interests. This work had been carried out by the time of our inspection and people were trialling new activities.

The provider also carried out a monthly visit that covered all aspects of people's care. A further quarterly audit was undertaken and records showed that this was also holistic and identified areas for improvements. For example, at a recent audit staff were observed looking at their phone when sitting with people. This was then addressed with the staff member and staff were reminded at a meeting about mobile phone use. Relatives were sent regular surveys on the quality of the care that their family members received. At the time of inspection, surveys had just been sent out and the provider was awaiting the responses.

The provider maintained accurate and up to date records. People's care plans all showed signs of recent reviews and information was stored in an orderly manner. People had separate files for care plans, photographs and their health records. During the inspection we noted that we were able to find information about people's needs without difficulty. Staff maintained accurate daily notes and important information, such as people's weights, were completed on charts.

The registered manager and the provider understood the responsibilities of their registration. Providers are required to notify CQC of important events such as allegations of abuse, deaths or serious injuries. There had been very few notifiable incidents at the home and CQC had been notified where appropriate. The registered manager demonstrated a good understanding of when to send notifications to CQC when we spoke with them.