Making Space

Palmyra

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection took place on 17 August 2016 and was unannounced.

Palmyra is a Making Space residential care home which provides accommodation and personal care for 14 people with mental health needs. The home is situated in a residential area of Waterloo, Merseyside which has easy access to local amenities and transport links. The service is provided over four floors with lift access available.

During the inspection, there were 14 people living in the home, including one person who had been admitted to hospital.

A registered manager was 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.

People we spoke with told us they felt safe living in Palmyra and we observed people to be relaxed and comfortable within the home. Staff we spoke with demonstrated a good understanding of safeguarding procedures and were able to tell us how they would report any concerns. Safe recruitment practices were also followed to ensure staff were suitable to work with vulnerable people.

We looked at how medicines were managed within the home and found there were processes in place to ensure safe storage and checking the stock balance of medicines. Not all handwritten directions on the MAR charts were checked by two people and photographs were not always available to ensure all staff could identify people and we made a recommendation regarding this.

We looked at how the home was staffed and found that there were sufficient numbers of staff on duty to meet people's individual needs.

Incidents were reported appropriately using the provider's electronic system. There were systems in place to assess risks to people and the environment to ensure measures could be put in place to minimise risks and help ensure people's safety. Regular fire drills were completed and recorded. The last drill reflected that response was poor and the registered manager took steps to help improve this.

The registered manager told us that no people living in Palmyra required a DoLS to be in place and was aware of when a person may require an application to be made and how to undertake this.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit and within care files. When there were concerns that people may be unable to provide consent, the Mental Capacity Act was followed.

New staff completed an induction in line with the requirements of the care certificate and staff were supported through regular supervisions, an annual appraisal and on-going training.

Feedback regarding meals available was positive. The menu offered choices and advised that alternatives were always available. Staff we spoke with were aware of people's dietary needs and preferences.

People told us staff were kind and caring. We observed people sitting with staff in the dining room throughout the day, listening to music, drawing and chatting and people were relaxed and comfortable. We observed people's dignity and privacy being respected by staff.

All care plans we viewed showed that people had been involved in the completion of relevant risk assessments and the creation of their care plans and had agreed to the care in place.

Care files included information on people's preferences, what was important to people, what people admired about the person and how best to support them to ensure their needs were met. They had been reviewed regularly and it was evident that people were involved in these reviews.

The registered manager told us they had an open door policy and that there were no restrictions in visiting, encouraging relationships to be maintained.

We found that staff knew people well and we observed staff responding to people's needs in a timely way throughout the day.

There were relevant activities available for people to participate in and people were encouraged and supported to maintain leisure interests. Regular day trips were arranged to places people had expressed interest in visiting.

Processes were in place to gather feedback from people, including quality assurance surveys and regular meetings. There was a complaints policy and complaint forms available within the home.

We asked about how the home was managed and feedback from staff was positive.

Staff we spoke with were aware of the home's whistle blowing policy and told us they would always raise any issue they had.

Staff also told us they were encouraged to share their views regarding the service and that their ideas were considered and implemented if possible. Staff told us there was good communication between all staff and that they worked as an effective team.

Records showed that the provider visited to review the service regularly throughout the year. Actions required to further improve the service were identified and those we followed up had been addressed.

We also observed completed audits which covered areas such as medicines management, first aid, staff recruitment and health and safety. This meant that systems were in place to monitor the quality and safety of the service.

CQC had been notified of events and incidents that had previously occurred in the home in accordance with our statutory notifications.

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 always safe.

Not all safer medicine management practices were followed.

People we spoke with told us they felt safe living in Palmyra.

Staff we spoke with demonstrated a good understanding of safeguarding procedures and safe recruitment practices were followed.

There were sufficient numbers of staff on duty to meet people's individual needs.

There were systems in place to assess risks to people and the environment to ensure measures could be put in place to minimise risks and help ensure people's safety.

Is the service effective?

Good

The service was effective.

Nobody living in Palmyra required a DoLS to be in place but the registered manager was aware of when a person may require an application to be made and how to undertake this.

Consent was gained in line with the principles of the MCA.

Staff were supported through induction, regular supervisions, an annual appraisal and on-going training.

People were supported by the staff and external health care professionals to maintain their health and wellbeing.

Feedback regarding meals available was positive and staff were aware of people's dietary needs.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and we observed warm

interactions throughout the day. We observed people's dignity and privacy being respected by staff.

Care plans showed that people had been involved in the completion of relevant risk assessments and the creation of their care plans.

Care files included information on people's preferences and we found that staff knew people well.

There was an open door policy and there were no restrictions in visiting.

Is the service responsive?

Good

The service was responsive.

Care plans were specific to individuals and had been reviewed regularly.

Staff told us they were informed of any changes within the home, including changes in people's needs.

We observed staff responding to people's needs in a timely way throughout the day.

There were relevant activities available for people to participate in.

Process were in place to gather feedback from people.

Is the service well-led?

Good

The service was well-led.

Feedback regarding the management of the home was positive.

Staff were aware of the home's whistle blowing policy and told us they were encouraged to share their views regarding the service.

Staff told us there was good communication within the home and that they worked as an effective team.

Systems were in place to monitor the quality and safety of the service.

CQC had been notified of events and incidents that had previously occurred in the home in accordance with statutory

regulations.

Palmyra

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 17 August 2016 and was unannounced. The inspection team included an adult social care inspector 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 our inspection we reviewed the information we held about the home. We looked at the notifications the Care Quality Commission (CQC) had received from the service and we contacted the commissioners of the service.

During the inspection we spoke with the registered manager, seven people living in the home and four members of staff. Not all people we spoke with wanted to answer our questions, so we spent time socialising with people and staff and observed interactions people had with staff throughout the day.

We looked at the care files of three people living in the home, four staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living in Palmyra and we observed people to be relaxed and comfortable within the home. Quality assurance questionnaires completed in the home asked people whether they felt safe in the home and the responses were positive. One person had stated, "I like living in Palmyra" and a staff member told us, "As long as the residents are safe that's all that matters."

We spoke with staff about adult safeguarding procedures. Staff we spoke with demonstrated a good understanding of safeguarding procedures and were able to tell us how they would report any concerns. A policy was in place to guide staff on actions to take in the event of any safeguarding concerns and staff told us they had access to details of the local safeguarding team. This enabled referrals to be made to the relevant organisations. We found that appropriate safeguarding referrals had been made when required, though there had been no referrals for some time. The registered manager kept a log of any concerns raised and the outcome of these.

We looked at the systems in place for managing medicines in the home. This included the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), for people living in the home. A medicine policy was available for staff and included guidance on areas such as self-administration, controlled drugs (medicine which requires special storage and record keeping arrangements because of its potential for misuse), safe administration and covert administration of medicines (medicines hidden in food or drink), though this form of administration was not in use at the time of the inspection. One person was self-administering their medicines and we found that relevant risk assessments had been completed to ensure this was undertaken safely. Staff told us they had completed training in relation to safe medicine administration and their personnel files reflected this training.

We looked at how medicines were managed within the home. There were processes in place for checking the stock balance of boxed medicines and controlled medicines and we found that all medicines were stored securely. Medicines that required refrigeration were stored in a separate fridge and the temperature of this was monitored daily in line with good practice. Eye drops, bottled medicines and creams were dated when opened in line with best practice guidance.

We looked at people's MAR charts and found that medicines that were handwritten onto the MAR chart were not always signed by two people and one entry had been written incorrectly, though no errors in the administration of the medicines had occurred. MAR charts did not have a photograph of the person to help ensure correct identity when administering medicines, especially if staff administering medicines are not familiar with people living in the home, such as agency staff. We discussed this with the registered manager who told us they would include people's photographs with their MAR charts.

We recommend that the provider considers current legislation and best practice guidance to ensure medicines are managed safely at all times.

We looked at how the home was staffed. The registered manager told us that there would usually be a

senior, one support worker, an activities co-ordinator, chef, general assistant and the registered manager to support up to 14 people living in Palmyra. Staff rota's we viewed showed these staffing levels were consistently maintained and agency staff were utilised when necessary, though the registered manager tried to limit this to help with consistency of care. There was no staffing analysis tool used to help establish how many staff were required to meet the needs of people living in Palmyra; however staff we spoke with told us there were always enough staff on duty to ensure people received the care they needed, when they needed it. During the inspection we observed staff supporting people in a timely way and we found there were sufficient numbers of staff on duty to meet people's individual needs. For instance, one person wanted to go out to the shops and required staff support to do this safely. Staff were able to meet this request without notice.

We looked at how staff were recruited within the home. The registered manager had recently created individual staff personnel folders within the home as head office had previously retained all recruitment information. We looked at four files and evidence of Disclosure and Barring Service (DBS) checks were in place. DBS checks consist of a check on people's criminal record and a check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff.
Not all of the files contained application forms, photographic identification or references, however the registered manager was able to retrieve most of these from head office during the inspection and include them in the staff member's files. Since the inspection the registered manager has told us the application and references that were not in the file for one person, have now been supplied by head office. The registered manager had recently developed an audit tool which was being completed to ensure all staff files contained the required information.

We looked at accident and incident reporting within the home and found that incidents were reported appropriately using the provider's electronic system. This enabled all incident reports to be shared with the registered manager and the company's health and safety team. Copies of completed incident forms were observed in people's care files and the registered manager told us that there had only been three incidents within the last six months. There were no audits of incidents but the registered manager told us if there was any increase in the number of incidents, they would complete an audit to look for potential themes or trends to enable any risk reduction measures to be implemented.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, choking, self-medicating, managing money, physical health and using the kitchen. These assessments were reviewed regularly to ensure any change in people's needs was assessed to allow appropriate measures to be put in place, such as referrals to other health professionals and provision of assistive technology.

Arrangements were in place for checking the environment to ensure it was safe. A fire risk assessment of the building had been completed and people who lived at the home had a personal emergency evacuation plan (PEEP) to ensure they could be safely evacuated in the event of a fire. Due to hearing difficulties, one person had a device that vibrated under their pillow should the fire alarm be activated, to help ensure they were aware of the alarm and could respond appropriately. We also found that risks had been assessed in relation to a number of tasks within the home, such as use of the dishwasher and a contingency plan was in place to help ensure the service could continue in the event of emergencies.

Internal checks were completed regularly to help ensure the environment and equipment remained safe. These checks included weekly testing of the fire alarm, checks on portable electrical equipment, mattresses, fire doors, water temperatures and fire safety equipment. There was a system in place for people to report

any maintenance issues and records showed what action was taken and when it had been completed. On the day of the inspection there was a fault with the hot water. This had been reported and was repaired within the same day.

Regular fire drills were completed and recorded. The last drill reflected that response was poor and the registered manager told us that a number of people living in the home had not responded to the alarm. In response to this, the registered manager had discussed the concerns with staff and made arrangements for the fire service to visit the home and speak to people about fire safety and show a video and this was noted in the minutes of the last staff meeting. These concerns were also discussed with people living in the home at their last meeting.

External safety checks had also been completed to help ensure the safety of the building and equipment. We saw certificates for areas such as gas, electrics, water boiler and lifts and these were in date.

We looked at the environment and found that the home was clean, though some areas of the home would benefit from some refurbishment. Cleaning schedules were in place and completed daily and communal bathrooms contained liquid soap and paper hand towels in line with best practice guidance. Staff were also observed to wear personal protective equipment such as gloves and aprons when handling food or supporting people to meet their personal care needs. The registered manager told us they had recently made improvements to the environment, such as replacing flooring and redecorating the lounge and entrance hall. There were plans to further improve the environment, such as refurbishing bathrooms and the kitchen.

Good

Is the service effective?

Our findings

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us that no people living in Palmyra required a DoLS to be in place and was aware of when a person may require an application to be made and how to undertake this. Staff told us they had attended training in relation to DoLS had an awareness of the process.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit. For instance, we observed staff knocking on people's door and waiting for consent to enter as well as seeking consent before administering medicines. Care files recorded people's consent in areas such as care planning, photography, sharing personal information and staff holding a key to people's rooms, undertaking night safety checks and accessing people's rooms in the event repairs were required.

When there were concerns that people may be unable to provide consent, mental capacity assessments were completed. For instance, one care file contained a completed capacity assessment with regards to managing finances. The assessment followed the principles of the MCA 2005 and showed the person had the capacity to manage their finances. The registered manager was clear on processes to follow should people lack capacity to make decisions and told us decisions would be made in people's best interest after consultation with relevant people.

We looked at staff personnel files to establish how staff were inducted into their job role. New staff completed an induction in line with the requirements of the care certificate. The care certificate is an identified set of standards that health and social care workers should adhere to in their daily working life. Staff we spoke with told us their induction was sufficient.

We looked at on-going staff training and support and found that staff were supported in their role through regular supervisions and an annual appraisal. Staff we spoke with told us they were provided with training relevant to their role and that they completed refresher courses each year. Staff told us training was provided both face to face by trainers as well as through completion of e-learning modules. One staff member told us the company was, "Good with training, there is lots available."

Staff personnel records we viewed showed that training had been completed in areas such as medicine management, food safety, safeguarding, mental health workshop, mental capacity act, infection control, moving and health and safety and fire safety. The registered manager told us head office oversee staff

training and when staff are due to complete refresher courses, they arrange for the training to be provided.

Staff we spoke with told us they felt well supported and were able to raise any issues with the registered manager when required. Staff told us the registered manager was approachable and encouraged staff to raise any concerns or suggestions with her.

Care files showed that people living in the home were supported by the staff and external health care professionals to maintain their health and wellbeing. The care files we looked at showed people received advice, care and treatment from relevant health and social care professionals, such as the mental health team, GP, chiropodist, social worker and optician. During the inspection we observed staff supporting a person who was unwell. They contacted the person's GP and provided appropriate support to meet the person's needs whilst awaiting advice from the GP.

When asked about the food people's feedback was positive and comments included, "It's good" and "I like it." We observed the lunch time meal in the dining room and found that people were served hot meals of their choice. The chef told us that they discussed meals with people living in the home before creating a weekly menu and records showed that meals were also discussed during residents meetings. The menu we observed offered choices and advised that alternatives were always available. One comment recorded on the most recent quality assurance survey stated that the home provided, "Very very good food." Staff agreed that meals were of good quality, that people had a choice and alternatives were available.

Staff we spoke with were aware of people's dietary needs and preferences and these were recorded within people's care files. One person's dietary needs had changed recently and all staff we spoke with were aware of the risk reduction measures in place.

We observed jugs of juice to be available in the dining room during the day for people to access, as well as a water machine. Hot drinks were provided to people regularly and some people had their own kettles in their rooms to enable them to make drinks independently whenever they wanted one.

Good

Is the service caring?

Our findings

People living at the home told us staff were kind and caring. One person told us the staff were all easy to talk to and they were like an extended family. During the inspection we observed interactions between staff and people living in the home to be supportive, warm and genuine. We observed people sitting with staff in the dining room throughout the day, listening to music, drawing and chatting with people; everybody was relaxed and comfortable.

We observed people's dignity and privacy being respected by staff in a number of ways during the inspection. For instance, staff referred to people by their preferred name, personal care was carried out in private and people did not have to wait long if they needed support. We heard staff have conversations with people, discuss organised plans for the day, and offer prompts, explanations and reminders when necessary. This was all undertaken in a supportive, dignified manner.

All care plans we viewed showed that people had been involved in the completion of relevant risk assessments and the creation of their care plans and had agreed to the care in place. This was evident through signed consent, recorded discussions between people living in the home and staff and through the level of information available regarding people's preferences in relation to their care and support.

Plans were written in such a way as to promote people's independence and there were plans specifically to record how staff should support people to rehabilitate if this was appropriate to the individual. One care file reflected that the person's main dislike was if people tried to take away their independence. We observed staff encouraging people to be independent and maintain their skills during the inspection. For instance, people were encouraged and supported to wash their laundry, access the community and attend to their personal care needs.

Care files included information on people's preferences in areas such as meals, daily routines and activities, as well as their social and family history and their health needs. There was detailed information within care files on what was important to people, what people admired about the person and how best to support them to ensure their needs were met in line with their choices and preferences. This helped to ensure that people were supported by staff who knew them well.

We found on discussion, that staff knew the people they were supporting well, including their needs and preferences. On the day of the inspection, we observed staff supporting a person whose behaviours had changed due to their health needs. Staff told us they were able to recognise these signs as they knew the person's history and could therefore support them in a way that was effective for the individual and met their needs.

Care files were stored securely in the registered manager's office in order to maintain people's confidentiality. Records showed that staff had discussed these care files with people and recorded who they had agreed could have access to them.

The registered manager told us that there was nobody living in the home that had any specific religious or cultural needs, however if they did, staff would support people to meet these needs.

We observed relatives visiting at the end of the inspection and the registered manager told us they had an open door policy and that there were no restrictions in visiting, encouraging relationships to be maintained. Many people living in the home were able to access the community and visit friends and relatives independently, though staff support was available for people who required it.

For people who had no family or friends to represent them, contact details for a local advocacy service were available within the home; however the registered manager told us that nobody living in the home required these services at the time of the inspection.

Good

Is the service responsive?

Our findings

We looked at how people were involved in their care planning and care plans showed that people were involved in assessing and deciding upon the support that would best suit them. People we spoke with told us they were happy with the support planned. People had signed all parts of their care plans to show agreement with the content.

Care files included a core assessment profile and a complex assessment profile and the information from these was used to complete a document named "My plan." This provided information regarding the person in areas such as mental health, medicines, physical health, personal care, domestic skills, education, social skills and culture. Care plans also provided information regarding people's rehabilitation and included goals and actions required to meet those goals.

Care plans we viewed were specific to the individual person and were detailed and informative. For instance, one care file we viewed clearly described the person's preferred day and night time routines and explained why adhering to routines was important to the person. This helped to ensure that staff had access to information that would enable then to provide person centred support.

All care plans were reviewed regularly and it was evident that people were involved in these reviews. Staff also recorded when people had chosen not to be involved with the review of their care and whether people agreed for their family members to be involved.

Care files contained life histories for people which enabled staff to get to know people, understand their experiences and backgrounds and provide support based on their preferences.

Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily written and verbal handovers between staff, use of a communication book and through viewing people's care files.

We observed staff responding to people's needs in a timely way throughout the day. For instance, one person was unwell and staff had contacted the GP for advice, another person wanted to go shopping and staff supported them with this and another person was observed to be prompted by staff to remove excess layers of clothing as the day became warmer.

People's preferences and personalities were reflected through the decoration of their personal spaces, such as their bedrooms. Three people invited us to view their rooms during the inspection and we found that décor, furniture and belongings were reflective of their choices. Pictures, photographs, soft toys, music memorabilia and other individual items all helped to ensure that people had a personalised space to spend time in. One person told us they loved their room.

We looked at the social aspects of the home and spoke to people about their preferences with regards to activities. We found that pictures displayed around the home had been drawn by people living within the

home and had an interest in art and we observed that this was encouraged by staff during the inspection. Other people had been encouraged to pursue their interests and one person told us they particularly enjoyed the garden and watching birds. Bird tables had been purchased and the garden was nicely maintained with seating areas available for people to enjoy the garden. The registered manager told us that people were always encouraged to develop or maintain interests and one person had recently completed a cooking qualification at a local college.

An activity co-ordinator was employed by the home and we spoke with them about social activities available to people. They told us that activities were provided based on what people enjoyed and people we spoke with agreed. One person told us they had a passion for cats and had expressed the desire to attend the theatre to watch a performance of the musical Cats. The activity co-ordinator had arranged this recently and they had enjoyed the experience. One person told us they enjoyed the weekly bingo and another person enjoyed using the touch screen computer that was available in the lounge.

People living in the home and staff told us that regular day trips were arranged and records showed that this had been discussed in resident's meetings where it had been agreed that people would prefer to go on regular day trips rather than an annual holiday. There was a mixture of group and one to one activities provided by the activity co-ordinator and this helped to ensure that all people were able to participate in activities that they enjoyed.

We looked at processes in place to gather feedback from people and listen to their views. Quality assurance questionnaires had been completed recently by people living in the home and responses were positive. These surveys asked for people's opinions on areas such as staffing, meals, quality of the service, whether people knew how to make a complaint or report abuse, whether they felt safe and whether they would recommend the service to others.

Views were also gathered from people through regular resident meetings. Records showed that topics such as the homes policies, activities and meals were discussed.

There was a complaints policy available within the home and a log of previous complaints and the outcomes of these were observed. The registered manager told us there had not been any recent complaints and the log for 2016 was blank. Complaint and compliment forms were available for people to complete within the home.

Good

Is the service well-led?

Our findings

The home had a registered manager in post. We asked about how the home was managed and feedback from staff was positive. One staff member told us the manager, "Is the most approachable person I have ever met in management." Other staff described the registered manager as, "An easy listener" and "Approachable." Staff told us of the many improvements that had taken place within the home since the registered manager had been in post, such as new floors, redecoration and general organisation of the service.

Staff we spoke with were aware of the home's whistle blowing policy and told us they would always raise any issue they had. Having a whistle blowing policy helps to promote an open culture within the home. Staff were confident that they could raise issues in confidence and that they would be dealt with.

Staff also told us they were encouraged to share their views regarding the service and that their ideas were considered and implemented if possible. One staff member described a number of their suggestions that had been implemented to help improve the service and quality of care provided. This culture helps staff to feel valued and part of a team. Staff told us there was good communication between all staff and that they worked as an effective team.

We looked at processes in place to gather feedback from people and listen to their views. As well as resident meetings and quality assurance surveys, there were also staff meetings held regularly to ensure views were gathered from staff. Records we viewed showed that staff meetings took place every few months and covered areas such as health and safety issues, training, policy updates and changes within the home.

During the visit we looked at how the manager and provider ensured the quality and safety of the service provided. Records showed that the provider visited to review the service regularly throughout the year. Some visits record detailed information as to whether they found the service to be safe, effective, caring, responsive and well led. During other visits, themes within the home were reviewed, such as staffing or infection control. The reports identified actions required to further improve the service and those we followed up had been addressed.

We viewed completed audits which included areas such as medicines management, first aid boxes, staff recruitment files and health and safety. Medicine checks were completed weekly to ensure there was adequate stock and that records were up to date. The audit did not highlight the issues we identified regarding hand written prescriptions on MAR charts, however the audits had been completed prior to the completion of the MAR chart. A quarterly audit was also completed that reviewed all areas of medicine management within the home. The last full audit had been completed in February 2016 and recorded 100% compliance. There were no audits in place to monitor care plans and the registered manager agreed to include this within the regular audits to ensure care plans continued to provide accurate, person centred information. This meant that systems were in place to monitor the quality and safety of the service.

CQC had been notified of events and incidents that had previously occurred in the home in accordance with

our statutory notifications. The registered manager told us there had been no reportable incidents since she had been in post, but through discussion it was clear that the registered manager was aware of the types of incidents that we should be notified of. This meant that we were able to monitor information and risks regarding Palmyra.