Chataway Residential Home Limited

Chataway Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Requires Improvement
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 6 December 2016 and it was unannounced, we returned announced on 7 December 2016.

At the last inspection 25 August 2015 we told the provider that improvements were needed in the management of medicines, risk assessments, recruitment procedures, providing people with a balanced diet, ensuring referrals for health care services were followed up, ensuring that MCA and DoLS legislation was adhered to, that audits were carried out and that a registered manager was in post. This inspection looked at whether the provider had made improvements.

Chataway Care Home provides residential care for up to 14 people. There were 14 people living at the service at the time of the inspection. The accommodation was provided over two floors and there was access to the upper floor via a stair lift. There was a small accessible garden that people could use.

It is a requirement that the home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. At the time of our inspection the manager had submitted their application to become the registered manager.

People told us that they felt safe. Staff were aware of how to keep people safe knew how to report actual or suspicions of abuse. However they had not received regular training to support their understanding.

The registered manager had investigated accidents and incidents to look at ways to prevent them from reoccurring. Improvements to risk assessments identified what risks people were vulnerable. There were plans in place that were available to staff to support people to keep safe during emergencies.

People received their medicines as prescribed by their doctor, though the reasons people refused medicines were not always consistently recorded. Protocols for medicines prescribed to be taken as and when required where not in place.

People's needs had been assessed prior to them moving into the service and plans of care had been developed from these. Staff were deployed appropriately to keep people safe. Recruitment of new staff was robust and the manager had carried out checks on prospective staff before they started work.

People were being supported by staff that knew about their roles and responsibilities. Staff training was limited but they received on-going support from the manager.

The manager was aware of their responsibility to notify us of any successful DoLS application. Staff had an understanding of the Mental Capacity Act (2005) and understood how to obtain people's consent before

they offered care and support. Staff knew how to support people to make decisions for themselves. Where people may have lacked the capacity to make their own decisions, the provider had followed the requirements of the Act.

Improvements had been made in ensuring referrals to healthcare services were followed. People using the service had access to the required healthcare services, were supported to maintain good health and received ongoing healthcare support.

Improvements had been made in providing people with nutritionally balanced diet People were provided with a choice of meal at each mealtime. Staff understood the need monitor people's food and fluid intake where a risk was identified.

We observed people using the service being treated in a caring and considerate manner. They were involved in making choices about their care and support and when they made their choices, these were respected by the staff team.

People said that they were sometimes bored and would like the opportunity for more activities, particularly in the evenings.

People's preferences were detailed in their care plans and we found things that were important for people to be in place. For example, what time a person preferred to go to bed.

People's care plans were being reviewed regularly which meant staff had up to date information about people. However it was not always clear that people and their relatives were involved in these reviews.

Staff meetings and surveys had been completed. This provided people with the opportunity to be involved in how the service was run.

Staff knew the aims and objectives of the service and worked towards them to deliver a quality service. The manager was described as approachable and supportive.

People felt listened to and knew how to make a complaint if they needed to. The manager understood the requirements of their role. They had carried out quality checks to monitor and improve what the service was offering people.

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.

People felt safe and staff knew how to protect people from abuse and avoidable harm.

There were sufficient staff to keep people safe who had been checked prior to working for the provider.

People received the medicines that they required in a safe way.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Not all staff were provided with training courses to increase their skills and knowledge.

People's consent to care had been obtained where possible and the requirements under the MCA were being followed. Care plans did not always provide a detailed assessment of a person's ability to consent to care.

People were satisfied with the food available and had access to healthcare services to support them to maintain their health.

Is the service caring?

Good

The service was caring.

People told us the staff team were kind and caring and we observed staff members treating people in a caring and considerate manner.

People's privacy and dignity were respected.

People were supported and encouraged to make choices about their care.

Is the service responsive?

Good

The service was responsive.

People received care and support that was based on their individual needs. However people did not always think there were enough activities.

People's care plans were reviewed but their involvement was not recorded.

People had access to a complaints procedure and felt listened to.

Is the service well-led?

Good

The service was well led.

Staff understood their roles and responsibilities and were supported by the manager. They knew how to whistle blow on their colleagues if they needed to and could give suggestions for improvements to the service.

People we spoke with us told us they felt the service was well managed and the manager was friendly and approachable

The manager was aware of their responsibilities and had carried out regular quality checks of the service.

Chataway Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 December 2016 and was unannounced. We returned on announced on 8 December 2016.

The inspection team consisted of an 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 the inspection, we asked the provider to complete 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 what improvements they plan to make. However due to administrative issues the we did not receive the PIR. The provider made alternative arrangements to provide us with the information we needed.

We reviewed the information we held about the service. This included notifications. Notifications tell us about important events which the service is required to tell us by law. We also contacted the commissioners of the service to obtain their views about the care provided. The commissioners had funding responsibility for some of the people using the service. We also contacted Healthwatch for their views of the service. We received no concerns from these organisations.

On the day of the inspection we spoke with eight people who used the service, a relative of another person who used the service and a visiting professional. We looked at three people's care plans and associated records. We looked at information about support staff received through training and appraisal. We looked at three staff recruitment files to see how the provider operated their recruitment procedures to ensure they only recruited staff who were suited to work for the service. We looked at records associated with the provider's monitoring of the quality of the service.

We spoke with the provider, the manager and three care staff.

Good

Is the service safe?

Our findings

At the last inspection November 2015 we found that improvements were needed in risk assessments, staffing levels, recruitment and the management of medicines. During this inspection we saw that the provider had employed a new manager who had made progress in improving these areas.

People told us they felt safe living at Chataway Residential Home. One person told us, "Oh this is a wonderful place the girls are all very good and kind, they are all the same. Crikey I'll say I feel safe with them, they are very kind and patient with us all and some need a lot of care." Another person said, "I feel safe here, they are always around and very good when you have help from them. I didn't like it here in the beginning but now I am getting used to the routine and the girls are helping me with their kindness." Another comment received was, "I do feel safe, not sure why, I don't have a bad word to say about the place. They are good and kind to me."

Staff we spoke with had an understanding of how to identify, respond to and report signs of abuse. One staff member told us, "If I had any concerns I would tell the manager, if that they didn't do anything I would take it to [the provider] or social services." Another staff member said, "I would tell [the manager] and I know we report to CQC if we are not happy if nothing is done."

Risks associated with people's care were assessed and reviewed monthly. We saw that the provider had carried out risk assessments for a range of areas. For example, where people were at risk of falling we saw assessments that identified what staff should do to reduce the risk. Care plans provided staff with guidance to follow to reduce such risks. This included making sure people had the equipment and supervision they required. During our visit we saw staff following these risk assessments. We saw staff supporting people to use equipment safely to help them move about the lounge. This meant that risks associated with people's support were managed to help them to remain safe. This meant staff had the information they needed to provide people with their medicines in a consistent manner.

Although the provider had systems in place to check the environment was safe these were not always effective. We noticed a radiator cover was loose and when we moved it, the cover fell off the wall. The provider made arrangements for it to be secured before we left the service. We discussed the safety of the environment with the provider who told us that they would arrange for the maintenance person to come to the service and check all areas were safe. The manager confirmed following the inspection that the maintenance person had visited and had competed all safety checks in the environment. Where work was identified this had now started.

We saw that equipment used to support people to move from one place to another was serviced and fire safety systems had been recently tested. The provider had emergency plans in place for staff to follow should there have been a disruption to the service, such as a fire. These plans detailed the support each person would require to vacate the building if necessary. This meant that the provider had considered people's safety should a significant incident occur.

The provider had a recruitment process in place for prospective staff members. This included the provider obtaining two references for each prospective employee and a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions and aims to stop those not suitable from working with people who receive care and support. Staff told us that these checks had taken place and records within their files confirmed this. This meant that people were supported by staff whose suitably to work at the service had been assessed.

The provider took appropriate action when an incident or accident occurred. This included taking action to prevent the likelihood of future occurrences. We saw that all incidents and accidents were recorded and the manager reviewed these incidents to see what action could be taken to minimise future occurrences. Records showed that there had been almost no falls since the manager had ensured there was always a member of staff present in the lounge area to assist people when they wanted to get up. We saw that there were only very short periods of time when there was no staff present in the lounge. People told us that staff came very quickly if they needed them. One person said, "Oh they are there within minutes, straight away I would say."

People and their relatives were satisfied with the number of staff available to safely meet their needs. One person told us, "You understand if they are busy with others in the morning but they still seem to come straight away." Staff members told us they felt staffing numbers were suitable and that they covered for each other when required. We found that staff had the time they needed to provide safe care to people and that staffing numbers were appropriate to meet people's needs safely.

People received their medicines as prescribed. People and the relative spoken with said that they got the medicines that were prescribed for them when they needed them. On person told us, "Oh yes we get our tablets when we need them, I have paracetamol three times a day. I just ask them when I need one for the pain and they tell me if it is too soon or not." Staff had information available to them and could tell us about how each person preferred to take their medicines. We observed staff support people to take their medicines in their preferred manner. We asked people if staff ever just left the tablets on the side table. One person said, "Oh no they always stand and watch me take my tablets. They are very good here with that."

The provider's medicines policy and procedure was available to staff to follow. This covered the safe handling of medicines as well as guidance on what to do should staff have made an error. Staff could describe how to deal with medicine errors. Medicines were being stored safely and were only administered by trained staff. The manager checked them regularly to make sure that they had remained competent.

We noted that protocols were not in place for medicines prescribed as PRN (as and when required) or variable dose. This meant that staff were not directed as to how much, or how often, each medicine should be offered. We also saw that where staff recorded that a medicine had not been given, for example, the person had not needed pain relief, they were not always consistent with the way they recorded this. People we spoke with confirmed they received their pain relief when they needed it. We brought this to the manager's attention who told they would ensure these were completed. We spoke with the manager following the inspection who confirmed all protocols were now in place.

Requires Improvement

Is the service effective?

Our findings

At the last inspection 25 August 2015 we told the provider that improvement was needed in following up referrals to healthcare professionals, ensuring they notified us when a Deprivation of Liberty Safeguard had been agreed with social services and providing a more nutritionally balanced diet.

We found that improvements had been made to how people were supported to access health services when they needed them. People told us that they were able to see a doctor when they needed to they felt their health was well looked after. A relative confirmed they had seen the doctor with their mother two weeks ago and had written a care plan with the G.P. They were very pleased with the health care at the service. "They are very attentive and concerned about her health; I have nothing but praise for them."

Records showed that people were referred to the GP and staff followed these up to ensure referrals were progressed. We found that where people were referred to health professionals these were done in a timely manner ensuring people's health needs were supported. Staff were able to describe what action they would take if they observed changes in people. One staff member told us, "I would report my concerns to the manager and the doctor will be called."

People told us that an optician came to the service during the summer but people were unable to recall seeing a dentist. People reported that they needed to see a chiropodist and that they no longer have one calling at the service. A staff member confirmed that this was the case, they said, "Our last one retired and we have not been able to find a replacement yet." We discussed this with the manager who told us they had been trying to find both a dentist and a chiropodist to visit the service since June 2016 and had been struggling to find anyone but they were continuing the search.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA DoLS require providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty. At the time of our visit the manager was awaiting a response from the local authority regarding applications made. The manager was aware of their responsibility to inform CQC of the outcome where people were placed on a DoLS.

Records showed and staff we spoke with confirmed that most staff had not received training on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However staff we spoke with during our visit had an understanding of the principles of the MCA and DoLS. One staff member told us, "It's about whether people are able to make choices for themselves. Another staff member said, "Someone might need a pressure mat so we know they have got up, that's a restriction so a DoLS might be needed."

The 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Care plans had very basic assessments regarding people's ability to make decisions. Some assessments were not always clear where a person had capacity or not. We brought this to the manager's attention and they said they would rewrite the plan to make it clearer.

We checked the training records and these showed that staff received limited training opportunities in the last 12 months. With some staff not having any update in their moving and handling, safeguarding or infection control training. Only two staff had received MCA and DoLS training. Staff comments included, "training is not brilliant." And "we do Red Crier training (this is a company that provides training to people in the health and social care sector)." Staff also told us they did not think the training they had received was very good. One staff member told us, "It's in a booklet and it isn't very good." Training records indicated most staff had not received safeguarding training since they started working at the service, staff we spoke with confirmed this. We discussed this with the manager who told us they were aware of the lack of refresher training and face to face training amongst the staff and they were investigating other training avenues. Following the inspection the manager contacted us to confirm they had arranged training for all staff on the MCA and DoLS for 16 December 2016.

People were satisfied with the quality and amount of food they had been offered. People particularly enjoyed the fact there was a choice of two main meals in the lunch time and they could have soup or sandwiches in the evening. One person told us, "Oh its lovely we have a proper lunch cooked for us at lunchtime. There is always a choice of two cooked meals and they will get us something else if we don't like the menu, we tell them the day before when they ask us." Another person said, "I enjoy the food. Choice, if don't like it I can ask for something else. I can't always remember the menu so it's a surprise when it comes."

We found that improvements had been made in providing people with a well balanced diet. We saw that food was appetising and the menus were balanced, we also saw that people had been involved in deciding on menus. Where people had specific dietary needs such as diabetes or softened food these were met. We saw that the lunchtime meal was unhurried and people were supported to eat their meals where necessary. However staff did not always remind them what the meal was or what they had chosen. Meals were brought ready plated so people did not have opportunity to add vegetables or gravy if they so wished. Also people were not asked if they wanted more although we were told later people could ask for more if they wanted anything. People did comment that it was a long time from when their received their tea at 4.30 pm to when they had their breakfast the following morning. A person told us, "Sandwiches at 4.30pm are a bit early, seems a long evening, long time before breakfast the next day but we are just sitting." Another person added, "We have a couple of biscuits and a drink around 8.20pm, then we wait for breakfast the next morning around 8.30am."

We saw people were offered hot and cold drinks throughout the day and staff encouraged people to drink. Staff were aware of who was on a food and fluid monitoring chart and why this was important to record.

We did notice that the menu was written on a notice board in the dining room and not everyone used this area so did not see the menu. We spoke with the manager and they showed us they were in the process of creating a photographic version of the menu to support people when making their choice.

The staff members we spoke with told us that the registered manager was supportive and very much available if they needed help or advice. A staff member told us, "I have regular supervision and [the manager] observes my practice, which I find useful. We talk about the care I give and where I can improve."

Good

Is the service caring?

Our findings

People we spoke with were very positive about the care they received. Everyone we spoke with reported that the care they received was kind, respectful and not rushed. One person told us, "They are kind and patient; they don't rush me when they get me washed and dressed. I think they are good carers." Another person said, "It's a wonderful place here. The girls (staff) are all the same, kind, patient. They are very, very good."

Everyone we spoke with reported that they were treated with dignity and respect when they were being cared for especially during baths and showers. People all said that curtains were closed, doors shut and towels were used as well as dressing gowns to respect privacy. Staff we spoke with were able to describe how they supported people with their dignity when providing personal care. This included knocking on people's doors, closing curtains and supporting people to do as much for themselves as possible.

We observed the staff team interacting with the people using the service. Staff were kind and respectful. They spoke with everyone in a cheerful manner and we heard pleasant conversations during our visit. People were treated kindly and support was provided in a caring and considerate manner. We saw members of staff getting down to people's eye level, calling people by their preferred name and engaging in conversation which people clearly appreciated.

People using the service had been involved in making day to day decisions about their care and support whenever possible. For example, people told us they were asked if they preferred a bath or a shower.

We observed people asking for assistance and it being given straight away. People told us that their call bells were answered promptly when they asked for help. We also observed staff asking people if they could put their clothes protectors on during meal times, "[Person] can I please put this apron on you to keep your clothes nice and clean?"

Staff told us how they supported people to make choices in their daily lives. One staff member told us, "When someone is new we ask them what their likes and dislikes are." Another staff member said, "If we help them get up in the morning we offer them a choice of clothes to where, we ask if they want help when getting washed and always encourage them to do as much for themselves as possible." We were also told by staff that the manager had updated all the care plans and they now better reflected what care people were actually receiving.

We looked at people's plans of care to see if they included details about their personal preferences or their likes or dislikes within daily living. We saw that whilst some did include people's preferences others could have been more personalised. For example, two different formats were currently being used for care planning. One enabled plans to be personalised and information easily understood by staff whilst the second format was less accessible. We discussed this with the manager who told us they would look at developing the care plan by using the positive features of both formats.

People's personal and sensitive information was being kept secure. There were confidentiality and data

protection procedures in place which were known by staff. We saw that people's support plans and written information relating to them was being kept safe and there were lockable facilities to safeguard this. In these ways the provider had made arrangements to protect peoples' privacy and to only allow access to those entitled to the information.

Good

Is the service responsive?

Our findings

People's needs had been assessed prior to moving into the home. This process included looking at, for example, people's medicines, their safety and communication needs. This helped the manager to understand the needs of people and to make sure that the service could meet these. People we spoke with told us that they had been involved in deciding what care and support they needed. One person told us, "They asked me what I like to eat and I told them what I didn't like." One relative described how they had helped write their loved ones care plan with the manager. They told us, "We have just written [person] first one following their respite care and their decision to stay here."

People had support plans that were focused on them as individuals. They were written in such a way that staff would know how to support people in line with their preferences. For example, there was information on how some people liked their bedtime routine, including what time they preferred to go to bed and whether they wanted staff to check on them during the night. We found that people's care plans included information about their likes and dislikes. Some plans had brief life histories but not all histories had been completed. The manager and staff told us that this information was gained from people where they could contribute or from their relatives and so in some cases they had not been able to complete it. We also saw information available for healthcare professionals if people required a hospital admission. This information included how a person liked to be supported, their medical history and their current medicines. This meant care staff involved in providing support to people had up to date information.

Staff could describe how they had learnt about people's needs. One staff member told us, "We are able to sit and talk with people, we get to know them and they tell us about their lives." Another staff member said, "We read the care plans but we also spend time talking with them and they tell us a lot of things, their likes and dislikes."

The manager told us that at the start of every shift staff had the opportunity to handover key information to the staff coming on duty. This information was recorded and all staff had the opportunity to read it when they had started their shift. It included how the person had been during the shift, if they had seen a GP or needed closer observation. This ensured that staff had information available to them to offer the right support to people based on their current or changing needs.

People we spoke with could not recall if they had been involved in the creation or review of their care plan. However when we asked people if staff were flexible about the support they received they all told us they could do what they wanted, when they wanted. One person said, "If the girls [staff] come and I am not ready to get up, I tell them so and they go away and come back later, no problems at all with this."

The care plans we looked at did not show whether people or their relatives had been involved in the creation or review of the plan. We discussed this with the manager who told us that they did talk to people but did not get people to sign their plan. They told us that they would look at ways of ensuring they recorded this information in the future.

People had mixed views about the activities on offer. People told us they would prefer activities to be more frequent and planned. We saw a notice board that described what activities took place each day. These included films, craft and , keep fit activities. As the service did not employ a dedicated activities organiser they relied on staff having time to lead activities. We saw evidence in records that people were involved in arts and craft activities such as colouring and making Christmas decorations. One person told us, "We really could do with a few more activities, especially in the evening, we all just sit here and it can be a bit boring." People told us they rarely go out unless a relative takes them out and they miss the contact with the local community. We discussed this with the manager who told us that staff do lead activities but they don't always record them.

We asked staff about how they had responded to people's cultural or religious needs. The staff members we spoke with were not aware that people had these. Care plans did identify where people had cultural needs, for example if a person had a faith, however they did not always identify how this was to be supported.

People told us they that felt listened to. If they wanted to raise a concern people told us they would either speak with the manager or their relative. Relatives confirmed that they knew how to make a complaint and that they would speak to the manager in the first instance. We saw that there was a service user guide that was available to people that had the complaints procedure detailed in it. There was also a complaints procedure available for family members and visitors which detailed the procedure that the provider would take in the event of receiving a complaint.

People we spoke with told us they knew the manager and felt able to talk with them about their views of the service. The manager told us that as they worked alongside staff providing support to people, they often asked people their views and ideas about how to improve the service. However the manager did not record these conversations or if any changes were made as a result. We discussed this with the manager and how they could capture this information in the future.

People told us there were no restrictions on their friends and family visiting and they told us they were made welcome at all times.

Good

Is the service well-led?

Our findings

At the last inspection 25 August 2015 we told the provider that improvement was needed in ensuring there was a registered manager in post and that audits were improved to ensure the safe and effective management of the service. At the time of this inspection there was a new manager in post and they had just started the process of applying for registration.

We saw that the provider had introduced audits that were more effective in highlighting areas that needed improvement. We saw that these had been carried out in areas such as people's care files, medicines, equipment and the general environment. We found that these were effective in highlighting ways to improve the service. For example as a result of the manager auditing falls improvements had been made in the deployment of staff and falls had been reduced significantly.

People and the relative spoken with said that they knew the manager well. The relative said, "I speak to her most days, she is always around and about, a lovely lady." We observed the manager several times during my time in the lounge talking with people. The manager introduced us to people using the service when we arrived and it was clear she knew them all well, and they knew her.

Staff also spoke positively of the manager. One staff member told us, "Things have improved since she has arrived." Another staff member said, "She has created an open culture and I feel supported by her."

There was a statement of purpose about what people could expect from the provider. This included details about how the provider would assess people's needs, the complaints procedure and facilities provided by the home. The manager and staff were able to describe this as well as the mission statement of the provider. This included ensuring people received the best care and have a good quality life.

Staff knew how to report poor practice of their colleagues should they have needed to. One staff member told us, "I'd speak to either someone at social service or CQC."

Staff had opportunities to give their suggestions about how to improve the service. For example, there were regular staff meetings that had included discussions on Christmas activities. The manager told us that as not all the staff attended team meetings due to shift patterns she often met with staff at different times to ensure they all received the same information. These meetings and who they had spoken with were reordered. When we spoke with staff about making suggestions they could not give examples but told us they did feel listened to by the new manager.

Feedback about the service had been sought by the provider. We saw that questionnaires had been sent in the last 12 months to people and their relatives about the quality of care offered to people. We saw that the results were in general very positive, with most people happy or very happy with the service. We did note there was one comment from a relative about a member of the night staff. As the results from the questionnaire had not been analysed it was unclear what action the manager had taken as a result of this comment. The manager told us they had spoken with the person and recorded it in the person's diary notes,

which we were shown. They told us they intended to send another questionnaire out in the next few months and would analyse this information to ensure they recorded any areas they needed to improve on.

Staff told us that as the manager often worked alongside them when providing care they felt supported and were able to discuss how to improve practice. One staff member told us, "I receive feedback from [manager], she observes me when we work together. I know how I am doing." Another staff member said, "If we have done something right she will tell us, she will thank us as she goes along." We saw that the manager took staff through the provider's disciplinary procedure as and when necessary. This ensured that the manager was aware of the culture of the staff team and dealt with any negative practice accordingly.

Staff also told us and records confirmed that they received their appraisals with the provider and they were able to discuss how they wanted to develop as well as make suggestions to improve the service.

The manager understood their legal responsibility for notifying the Care Quality Commission of deaths, incidents and injuries that occurred or affected people who used the service. There was a procedure for reporting and investigating incidents and accidents and staff members demonstrated their understanding of this.