Voyage 1 Limited

351 Maidstone Road

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 24 October 2018 and was announced.

351 Maidstone Road is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

351 Maidstone Road provides accommodation and or personal care for up to five people with a learning disability and/or autistic spectrum disorder. The accommodation is provided in a house with access to garden areas. At the time of our inspection four people were living at the service. People had complex care and communication needs and may present with challenging behaviours.

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. The service ethos is to enable people with learning disabilities and autism to live as ordinary a life as any citizen.

At our last inspection on 20 September 2017, we rated the service Good. We re-inspected this service earlier than planned due to concerns that had been raised about people's safety. At this inspection we found that the evidence continued to support the rating of Good.

There had been substantial disruption to the service from people displaying behaviours that challenged the service, staff and other people. The disruption had reduced from the beginning of October 2018 after a change in the number of people living at the service. At this inspection we found that people continued to receive safe care. Risks associated with people's care and support were managed safely. People's care needs were fully assessed and people were involved in the day to day planning of their care and making choices about their lives and routines.

Before this inspection allegations of abuse had been made about the service. We found that the registered manager and the provider had responded to these allegations by working with the local safeguarding team so that they were thoroughly investigated. At the time of this inspection there was no evidence or information that people in the service were at risks of harm.

The environment had been badly damaged by people displaying challenging behaviours. The decoration had suffered from damage and dilapidation. At this inspection the risks of continued damage had stopped. A maintenance team were in the process of repairing and redecorating the service.

Staff continued to minimise cross infection risks by following infection control guidance.

Behavioural management plans and interventions were based on the use of Positive Behavioural Support

(PBS). PBS is recognised as one of the best way of supporting people who display, or are at risk of displaying, behaviour which challenges care services. Staff recognised that harmful behaviours were also a form of communication. Staff received specialist training to enable them to respond appropriately to potentially harmful behaviours. This work was supported by a behaviours specialist employed by the provider.

Staff understand people's communication styles, using objects of reference, people's moods, facial expressions and body language. The registered manager had plans in place to ensure that people who may not understand what to do would be individually supported by a member of staff if there was an emergency. Staff had received training about protecting people from abuse. The management team had access to and understood the safeguarding policies of the local authority and followed the safeguarding processes.

There was a learning culture from incidents and accidents. These were recorded, investigated and checked by the registered manager and the provider to see what steps could be taken to prevent them happening again.

There were policies and procedures in place, based on nationally recognised good practice for the safe administration of medicines. Staff followed these policies and had been trained to administer medicines safely. People had sufficient amounts to eat and drink. People had access to GPs and other health care professionals such as the learning disability team. People's health and wellbeing was supported by prompt referrals and access to medical care if they became unwell.

End of life choices formed part of the care planning process, but end of life care was not being provided at the time of this inspection.

A policy about how to make complaints about the service was in place.

There were sufficient numbers of staff, who had been recruited safely, to support people's needs. Safe recruitment practices had been followed before staff started working at the service. New staff and existing staff were given extensive induction and on-going training which included information specific to learning disability services. Agency staff were not being used at the time of this inspection. However, appropriate agency staff checking systems were in place should they need to be used.

We observed a service that was welcoming and friendly. Staff provided friendly compassionate care and support. Staff we spoke with and observed were kind and calm at all times. We observed staff giving people choices about what activities or routines they wanted to follow. Staff were deployed to enable people to participate in community life, both within the service and in the wider community.

People, their relatives and healthcare professionals were encouraged to share their opinions about the quality of the service, to ensure planned improvements focused on people's experiences. The registered manager and provider regularly assessed and monitored the quality of care to ensure standards were met and maintained. Good practice information was shared by managers meeting and networking with management colleagues. Business development plans were based on improving people's experiences of the service.

The registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

The registered manager understood the requirements of their registration with CQC. The registered manager had sent statutory notifications to CQC when required. The CQC rating from our last inspection had been displayed.

Further information is in the detailed findings below.

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.

The registered manager and staff were committed to preventing abuse.

Responses to incidents reduced the risk of harm. Risk management systems covered individual and general risk.

Staff consistently worked to protect people from harming themselves or others and to minimise the risk of harm.

Staff were recruited safely. People's safety was maintained through the consistent deployment of the right numbers of staff based on the levels of risk.

Infection control practice minimised the risks of cross infection. Medicines were administered safely by competent staff.

Is the service effective?

Good

The service was effective.

People were provided with care based on an assessment of their needs.

People were cared for by staff who knew their needs well.

Staff encouraged people to eat and drink enough.

Staff met with their managers to discuss their work performance and each member of staff had attained the skills they required to carry out their role.

The Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were understood by the provider and staff received training about this.

Is the service caring?

Good

The service was caring.

People were treated as individuals and able to make choices about their care.

People were involved in planning their care through a person centred approach and their views were taken into account.

People experienced care from staff who respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People were cared for by staff who understood their communication styles and needs.

People accessed routine and urgent medical attention or referrals to health care specialists when needed.

People's preferences, likes and dislikes were understood by the staff from the person's point of view.

People were supported to maintain relationships that were important to them and to engage within their local community.

There were appropriate systems in place to deal with complaints.

Is the service well-led?

Good

The service was well led.

The aims and values of the organisation were shared by staff.

People and their relatives were asked about the quality of the service they experienced.

The registered manager operated systems and policies that were focused on managing risks and the quality of service delivery.

There were clear structures in place to monitor and review the risks that may present themselves as the service was delivered.

The service worked with other organisations to manage people's care.

351 Maidstone Road

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 24 October 2018 and was announced. We gave the service 18 hours' notice of the inspection visit so that the risks of people with complex needs becoming anxious when we arrived was minimised. The inspection visit was carried out by one inspector, one assistant inspector and one 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. This inspection was in response to concerning information we had received about safeguarding incidents involving challenging behaviours that exposed people to potential harm. Due to these concerns, we brought the inspection date forward.

Due to technical problems, the provider was not able to complete a 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. We took this into account when we inspected the service and made the judgements in this report. Before the inspection we looked at previous inspection reports and notifications about important events that had taken place at the service, which the provider is required to tell us by law.

People who lived at the service had complex communication needs. We spoke in depth to one person who used the service about their experiences. Other people did not engage verbally, however, we gathered information about the care received by observing how people responded to staff when care was delivered. We met and spoke with a relative. We spoke with six staff members which included the registered manager, deputy manager, the providers area manager, two senior support workers and one support worker. We asked three external health and social care professionals for feedback about the service.

We looked at two people's records to see how their care and treatment was planned and delivered. We reviewed four staff files to check staff were recruited safely and were trained to deliver the care and support people required. We also looked at records relating to the running of the service including staff training

records, quality assurance audits, complaints, accidents and incident records.

Good

Is the service safe?

Our findings

We observed safe care throughout our inspection. One person said, "Yes I feel safe here. There can be awkward situations with the people living here, but it is okay. I worry about my Mum but the staff cheer me up and take my mind off my worries."

A relative told us they felt their loved one was safe at the service.

Before our inspection there had been concerns raised about people and staff being exposed to harm from challenging behaviours. At this inspection the risk of harm from challenging behaviours had reduced. People causing potential harm were no longer living at the service. We found that the registered manager understood how to protect people by reporting concerns they had to the local authority and training staff to minimise harm. Staff had access to the provider's safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse.

We received an allegation that an incident of potential harm had taken place and had not been reported and investigated. Staff we spoke with were not aware of any unreported incidents. This allegation had been investigated in line with local safeguarding protocols; no evidence had been found that it had taken place. Staff understood how they reported concerns in line with the provider's safeguarding policy if they suspected or saw abuse taking place. Staff gave us examples of the tell-tale signs they would look out for that would cause them concern. For example, bruising or mood changes.

People were safeguarded by appropriate monitoring and responses to incidents and accidents. The registered manager followed policies about dealing with incidents and accidents. Should any incidents occur they were fully investigated by the registered manager. Actions needed to reduce the risks of incidents re-occurring were recorded and were checked by the registered manager to make sure that responses were effective. Staff gave us examples of changes to people's care after incidents and we saw these changes in people's care plans. The management actions following incidents minimised risks across the service and meant that safe working practices were followed by staff.

The risk to people's health and wellbeing from health condition's were assessed and safely managed. For example, where people had epilepsy.

People were protected by safe recruitment practices, minimising the risk of receiving care from unsuitable staff. Recently appointed staff gave a detailed account of how they had been recruited in line with the provider's recruitment policy. Applicants for jobs had completed applications and been interviewed for roles within the service. All new staff had been checked against the disclosure and barring service (DBS) records. Staff confirmed they had applied, been interviewed and DBS checked for their roles. No agency staff were working at the service. However, if they were used, agency staff had to provide full employment and DBS information before they could work at the service. This would highlight any issues there may be about new staff having previous criminal convictions or if they were barred from working with people who needed

safeguarding.

Staffing levels were planned to keep people safe. At the time of this inspection there were no staff vacancies. We observed and records confirmed that staff were deployed in appropriate numbers to meet people's assessed needs within the service and in the community.

Environmental risks and potential hazards were assessed. There was guidance and procedures for staff about what actions to take in relation to health and safety. Fire systems were maintained and tested. Each person had a personal emergency evacuation plan (PEEP) with detailed information about their ability to escape fire and the support they needed from staff to do this safely. Fire evacuation practice demonstrated that the registered manager monitored how staff responded to people's PEEP's to maintain people's safety.

The premises had been damaged by a person displaying behaviours that could harm themselves and others. For example, the plaster and decoration had been affected. Wear and tear on furniture and in the kitchen, had increased through behaviours that challenged. However, at the time of this inspection the damage was being repaired and the service was being redecorated. People had already been involved in choosing the colours they would like internally. The providers area manager confirmed that the maintenance plan included the replacement of the kitchen unit doors.

The service was clean and free from odours. The risks of infection and cross contamination were minimised by health and safety control measures based on an up to date infection control policy. These controls included the use of gloves by staff and the testing of water systems for legionella bacteria, water outlet flushing and temperature monitoring, infection control training for staff, safe systems of cleaning, and the provision of personal protective equipment. For example, daily, weekly and monthly cleaning schedules were followed by staff. These safe systems of work protected people from potential infection.

Staff followed the provider's medicines policy which was based on guidance issued by the National Institute for Health and Care Excellence. The registered manager checked that staff remained competent by checking staff knowledge and practice when they administered medicines. Staff administering medicines were provided with training so that they understood the broader principals of medicines safety and record keeping. Staff we talked with gave us details of how they supported people safely when dealing with medicines.

People were protected by staff who understood their responsibility to record the administration of medicines. The medicine administration record (MAR) sheets showed that people received their medicines at the right times and as prescribed. The registered manager confirmed there was a policy regarding the safe management of 'As and When Required Medicines' (PRN), for example paracetamol. Records showed that PRN management was effective. The system of medicine administration records (MAR) allowed for the checking and recording of medicines, which showed that the medicine had been administered and signed for by the staff. MAR sheets and these were being completed correctly by staff. Medicines were audited monthly by the registered manager.

The provider had a 'business continuity' policy which was being reviewed. This gave information to staff about how people's care should continue safely immediately after an emergency, and the arrangements that had been made to minimise disruption to staffing levels during periods of severe weather.

Good

Is the service effective?

Our findings

One person said, "I go to the dentist when my teeth hurt." And, "The staff do a good job. They understand me. I try and cook certain foods, I like to eat spaghetti bolognaise."

People were assisted to access other healthcare services to maintain their health and well-being if needed. People had been seen by a variety of healthcare professionals, including a GP, nurse and dentist. Referrals had also been made to other healthcare professionals, such as Speech and Language Therapy and Psychology. Having input from a wide range of professionals gave staff the information they needed to meet people's needs. We saw that the registered manager kept people informed of services that would promote their health. For example, staff were aware of an initiative called, 'Get Better Health Care' which was aimed at people with learning disabilities in getting better outcomes from local GP services.

People's needs were assessed in line with recognised guidance and practice for learning disability services. For example, The British Institute of Learning Disabilities, (BILD). This provided information about good practice that staff could use when supporting people with complex needs. For example, how to champion rights, ensure excellent support and continually improve practice. Staff told us that when they supported people they were mindful that they needed to explore any behaviours that indicated people may have different cultural needs or choose different lifestyles, such as sexuality.

Members of staff were aware of people's dietary needs and food intolerances. Staff used observations to assess if people enjoyed or left their food to build up a picture of people's individual food and dietary preferences. People were encouraged to make their own drinks and foods. People had storage areas in the kitchen for foods that they preferred to eat. One person said, "I have drinks in between meals, tea or coffee or fruit juice."

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

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. The provider had an up to date policy in place covering mental capacity. Staff had received training in relation to protecting people's rights. People were restricted by DoLS authorisations. For example, people could not leave the service on their own. However, records showed that these restrictions were operated lawfully.

Decisions about placing restrictions on people followed best interest practice. One person had met an external best interest assessor the day before our inspection. People could access advocacy services outside of the staff team if needed. Advocacy services worked on people's behalf to make important decisions. For example, about important medical treatments. DoLS restrictions were kept under review and their renewal dates were kept by the manager to prompt new applications to be made within the principals of the MCA 2005. This protected people's rights.

Staff learning was provided in a number of ways, including by e-learning, distance learning courses and face to face training and this was supported by records we checked. Additional training was provided in relation to person centred care planning for people with learning disabilities and managing people's behaviours if they may harm themselves or others.

Staff also told us that they received supervision and felt supported in their roles. Records showed that when new staff started they would begin training using the Care Certificate Standards. These are nationally recognised training and competency standards for adult social care services. Records showed that supervision meetings with staff were held with senior members of staff. One member of staff told us, "At supervisions I am asked how I am getting on, we talk about the team and we talk about anything we feel could be improved." Staff also told us about situations where the registered manager used additional supervisions to discuss how their work could be improved. This meant that staff were supported to enable them to provide care to a good standard.

Records showed that staff had an annual appraisal. Staff told us that they could request additional training to develop their skills and careers. One member of staff had recently been promoted within the team. They told they had been on specific management training, for example how to carry out formal staff supervision.

The design and layout of the service met people's needs. People could access the communal areas, their bedroom and the outside spaces. There was a large garden which we observed people using for recreation.

Staff had specialised behaviour intervention training to maintain people's safety. Enough staff were deployed to enable people's individual needs to be met and for care to be delivered safely in the service and in the community. For example, staff explained how they minimised risks to individuals by understanding their behavioural triggers and avoiding them. One member of staff said, "We work out the triggers. We are very good with crisis situations." Another member of staff said, "We use MAPA (Management of Actual or Potential Aggression) to verbally re-focus and disengage people to prevent challenging behaviours."

Good

Is the service caring?

Our findings

People using the service indicated to us that the staff treated them with care, respect and kindness. One person said, "The staff make me feel good about myself. They are kind. They help me with my washing." And, "I make my own decisions about what I do. The staff encourage me to clean my room. The staff usually knock on my bedroom door before coming in. I am treated with respect." We observed that people were supported by caring staff who were sensitive in manner and approach, people looked relaxed, comfortable and at ease in the company of staff.

A relative said, "Some of the staff are caring. The staff usually involve me in decisions regarding my family member's care."

Staff actively engaged with people and interacted with them positively. Staff understood how to support people to make everyday choices. Staff gave people options and explained information in a way they could understand, people communicated with staff by showing them what they wanted. For example, by leading the member of staff to food in the kitchen.

There was a person-centred culture at the service. We observed people having fun with staff, laughing and entertaining interactions were taking place. People were respected, valued and treated as individuals. Staff knew and understood each person's needs very well. Staff knew people's names and they spoke to them and about them in a caring and affectionate way. Staff understood the importance of respecting people's individual rights and choices. Staff showed interest in what people were doing. For example, by asking questions of people or making encouraging comments. Staff promoted people's interests by involving them in decisions in the service. For example, people made choices about how their bedrooms were personalised and had recently chosen the colours of the paint for the lounge and other communal areas in the service.

Staff used various methods to support people to communicate their needs, for example staff used sign language, and a system which used signs and pictures. People were provided with information in ways that helped them to make decisions about their care, for example in a pictorial format. They were also supported to access advocacy services, which help people by enabling them to explore and voice their opinions. People were supported to have as much choice and control over their lives as possible.

People were encouraged to live an ordinary and least restrictive life as possible. They were encouraged to participate in planning and participating in community activities, for example, using public transport. Staff encouraged people to learn some household tasks such as cleaning and tidying. People were supported to maintain important relationships and have visitors whenever they wished. Staff had been able to gain information about people's preferences and relationships through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person.

People's care records included an assessment of their needs in relation to equality and diversity. The provider's policies were inclusive and assessments included information about people's sexuality. Staff understood the importance of maintaining people's privacy and human rights. People chose where they

spent their time, such as in their own room or in communal areas and moved freely around the service. Throughout the day, staff demonstrated they respected people's privacy and dignity. They announced their arrival when coming on shift and knocked on people's bedroom doors before entering.

Staff were aware of confidentiality regarding information sharing. Records were kept securely so that personal information about people was protected.

Good

Is the service responsive?

Our findings

People told us that they were happy living at the service. One person said, "I do lots of things here. I like bowling, going to the cinema. I go and visit my mother for the day. I go with staff. Sometimes I go out on the bus. I like gaming. I have a video games box. I like board games. I made a complaint about people keeping me awake at night. It was dealt with and is okay now."

The registered manager was aware of the Accessible Information Standard (AIS) and its requirements. AIS is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information. The service was working according to the framework.

People had hospital passports to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital which included their likes, dislikes, preferred ways of communicating and religion. People had health action plans. These would assist people to maintain their health and wellbeing through consistent health appointments and health monitoring.

Care plans included detailed assessments, considered people's physical, mental, emotional and social needs. Some parts of the care plans presented information using pictures so that they were more accessible to the people concerned. Care plans were reviewed and updated if any changes had been identified. A relative told us they were invited to attend review meetings and were kept informed about their family member's changing needs. Relevant health and social care professionals were involved where required. Health professionals' advice was listened to and acted upon by staff. There was a keyworker system in place which enabled people to have a named member of staff they met with on a regularly basis to talk about all aspects of their support, such as activities they had taken part in, their wellbeing and important relationships.

Each person had detailed care plans that identified how their assessed needs were to be met. Care plans included information on their background, hobbies and interests and likes and dislikes. Using pictures, people pointed to the picture indicating that staff helped them participate in activities they enjoyed. Care plans covered end of life wishes, but no end of life care was being provided at the time of this inspection.

The activities people were involved in were tailored to their choice and lifestyle to encourage participation and reduce social isolation. We observed staff encouraging activity, for example playing board games. Staffing was provided based on the assessment of risks the activity to be undertaken may have. Activities were introduced to people slowly so that staff could learn by the behaviours the person demonstrated if they were comfortable with the activity.

People's care plans included a meaningful engagement plan, looking at activities and goals. This included an environmental assessment. This considered the look of the environment, shapes or colours that may upset/offend people and limit their participation. There was a sensory room in the service. This gave people

opportunities to relax with sounds, mood lighting and texture touching experiences. Each person had a sensory assessment for their likes and dislikes. This included, body awareness, recognising others, and how people were affected by lights and weather, for example sunny days and other potential distractions.

Staff enabled people to have the personal space they required. Positive relationships had developed between people who used the service and the staff. Staff knew people well and there was laughter and conversation, which engaged people during the inspection. Staff were calm, reassuring and individually responsive to people at all times. Staff communicated with people using eye contact and appropriate language. Staff understood how to maintain a calm and relaxed atmosphere for people.

Staff were aware of what was important to people and were knowledgeable about their preferences, hobbies and interests. They had been able to gain information through talking with people and their relatives. This information enabled staff to provide care in a way that was appropriate to the person.

Information about making complaints was available and shared with people and relatives. There had not been any complaints since our last inspection.

Good

Is the service well-led?

Our findings

The service was well-led. People indicated to us that the registered manager was friendly and approachable. One person said, "I think the staff are happy here because they like everyone who lives here. X is the manager, we sometimes have meetings to discuss things. I think it is managed well. I would give it 9/10. I like it here because the staff are good to me and give me choices."

The provider employed a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service was well-led by a committed registered manager and senior management team who had the necessary skills and experience.

The registered manager and staff were working with a clear vision for the service which was based on ensuring people felt like the service was their home and promoting choice.

The provider proactively sought people's views and took action to improve their experiences. The provider's quality assurance system included asking people, relatives, staff and healthcare professionals about their experience of the service.

Records demonstrated that there were regular staff meetings at the service and hand over meetings between shifts. Staff continued to receive appropriate supervision and told us that the registered manager was supportive and that they were listened to. The registered manager ensured that staff received consistent training, supervision and appraisal so that they understood their roles and could gain more skills. Staff told us that the values and culture of 351 Maidstone Road were shared by staff and at the heart of the care they provided.

Policies and procedures governing the standards of care in the service were kept up to date, taking into account new legislation. For example, Medicines policies followed guidance issued by the National Institute for Health and Care Excellence.

People benefitted from a quality of service that was driven by the provider and staff's commitment to monitor and improve their performance. Systems were in place which continuously assessed risks and monitored the quality of the service. These included managing complaints, safeguarding concerns and incidents and accidents. Audits were also focused on learning about individuals and the outcomes expected from service delivery. For example, an audit action was 'To complete a support guideline that details the sensory requirements for a person with autism when participating in planned activities.' [Were there objects that may improve the person's participation]. This support guideline had been completed and was working. It was clearly evidenced in the records about the person's activities, in our discussions with the staff and in our observations of the person during the inspection, that the person participated more in activities if they could hold a football during the activity.

The registered manager also completed and audited an improvement plan for the service. This improvement plan included areas such as the effectiveness of care, paperwork and staff performance, training and staff competency. This meant that the registered manager consistently monitored the service against the provider's quality standards to improve people's experiences of care. There was on-going commitment from the management team and the provider to maintain consistently good levels of service for people at all times.

The registered manager continued to work closely with social workers, referral officers, and other health professionals. The registered manager was aware of when notifications had to be sent to the Care Quality Commission (CQC). These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that happened at the service. We used this information to monitor the service and to check how events had been handled. This demonstrated the registered manager understood their legal obligations.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed their rating at the service and on their website.