Care UK Community Partnerships Ltd

Snowdrop House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on 14 May 2018 and was unannounced. This inspection was brought forward due to some concerns we received from staff members working in the home as well as from members of the public. We shared the concerns with the provider who sent us a plan to tell us how they were going to address the issues. In this inspection we checked if the provider had implemented the changes they told us they were going to do. The concerns were related to lack of support for staff and not enough staff at times to meet people`s needs in a timely way.

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

Snowdrop House is registered for a maximum of 70 people. The home opened in September 2017 and had only 35 people living in the home at the time of this inspection. Services provided included residential and nursing care, short-term respite care and specialist care for people who may live with dementia, have a physical disability or require mental health support. This was the first inspection of the service since it registered with the CQC on 20 September 2017.

People were accommodated in a purpose-built environment over three floors which was clean and well maintained. Bedrooms were personalised and had en-suite facilities whilst still providing specialist bathroom facilities, several communal areas, dining rooms, coffee shop, hairdresser room, quiet lounges so people could choose where they wanted to spend their time.

There was a manager in post who registered with the Care Quality Commission. 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 and associated Regulations about how the service is run.

People told us they felt safe at the home. People had mixed views about staffing levels in the home. People who lived on the ground floor told us they felt there were enough staff, although people on the first floor told us they at times waited longer for their calls to be answered. Staff told us on occasions they worked short staff and some of the managers on the units didn't help much on the floor.

Staff received training and were knowledgeable in how to safeguard people from any risks of abuse. They could describe what constitutes abuse and the reporting procedure they would follow to raise their concerns. Every staff member employed went through a comprehensive training programme to ensure they could effectively meet people`s needs. Not every staff member we spoke with felt a valued member of the team and they felt that managers did not always listen to their concerns.

People signed consent forms to agree to their photograph to be taken or for their records to be shared with

relevant professionals, however people told us they did not know what was in their care plan. The provider had electronic care planning in place and all the care plans were in electronic format. However, we found that care plans needed further developing to ensure that they were personalised to the individual and not generalised.

People told us staff were kind and caring towards them and they respected their privacy and dignity. People told us they had confidence that if they reported concerns to staff these would be addressed.

Activities provided to people were varied and based on people`s preferences. People told us they enjoyed the opportunities to socialise and pursue their hobbies and interests.

People`s medicines were administered by trained staff who had a good understanding of safe medicine management practices. The provider was using an electronic medicine administration records system developed by a pharmacy they worked with. This needed developing further to ensure that senior managers could easily identify the reasons if medicines were not administered. People told us they were seen by their GP regularly and staff were prompt in requesting a GP visit if they were in need.

People told us the quality of the meals they received improved greatly in the last couple of weeks and they were happy with the choices on offer. Staff monitored people`s weight and ensured that if people were identified at risk of malnutrition or dehydration they were referred to dieticians and received fortified diets.

The registered manager used a range of audits to ensure they monitored the quality and the safety of the care provided. We found that recently the provider introduced regular audits they carried out in response to concerns raised by staff that they did not feel listened and supported by the management in the home. There were regular opportunities given to staff to meet with representatives from the provider to share their concerns.

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.

People and staff told us that at times there were short staff and it was a delay in people having their needs met.

Staff could tell us how they were safeguarding people form abuse. They were knowledgeable about reporting under the whistleblowing procedure to local authorities or the Care Quality Commission.

Risk to people`s health and wellbeing was identified and measures were in place to mitigate these, however these needed further developing.

People`s medicines were managed by staff who had been trained and had their competencies monitored by the provider. The electronic medicine administration record system needed further developing to ensure it was effective.

Is the service effective?

Good

People felt staff were skilled and knowledgeable enough to meet their needs effectively.

Staff received regular supervision and training however not every staff member we spoke with felt supported in their role by the management team.

People were asked to consent before staff delivered care.

People were provided with a varied menu and encouraged to have a healthy balanced diet. GP and Dietician's involvement was requested by staff if people had been identified as losing weight.

The environment was purpose built and fit for the type of services offered to people.

Is the service caring?

Good

The service was caring.

People were treated with kindness and respect by staff.

People told us their relatives were welcome to visit any time.

People told us they could influence the care they received, however this was not always documented.

People's dignity and privacy was promoted.

Is the service responsive?

Good

The service was not always responsive.

People`s care plans needed developing more to contain personalised information and capture peoples` likes, dislikes and preferences.

People were provided with a range of activities which enabled them to pursue their hobbies and interests.

People had their needs met by staff who knew their likes, dislikes and their preferences regarding the support they required.

People told us they could raise their concerns and complaints and these were investigated and responded by the provider or the manager.

Is the service well-led?

Requires Improvement

The service was not always well- led.

Staff had mixed views about them being listened and valued by the management team.

Staff told us that there was not always team work in the home and at times they were not supported by the managers.

There were systems used to quality assure the service, however the home had less than half occupancy. Systems and processes were still developing to ensure these identified shortfalls.

People and their relatives gave mixed views about how well the service was run.

The provider had submitted notifications to the Care Quality Commission for incidents as they are required to.

Snowdrop House

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 made the necessary improvements and was meeting the legal requirements and regulations associated with the Health and Social Care Act 2012.

The inspection was carried out on 14 May 2018 and was unannounced. The inspection team consisted of one inspector and an expert by experience.An expert by experience is a person who has experience of using this type of service or supporting a person using this type of service.

Before the inspection, we didn't ask the provider to complete a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us by law.

We carried out observations in communal lounges and dining rooms and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to their complex health needs.

During the inspection we spoke with nine people, five relatives, nine members of staff, the clinical manager and the registered manager. Prior to the inspection we contacted an additional four staff members to ask questions about work arrangements and support given to them to help understand and carry out their roles effectively. We looked at care records relating to five people and other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Snowdrop House. One person said, "I am very happy here, I have company and there is always someone to look after me." Another person said, "I am safe here because they are always here to help me." Relatives we spoke with told us staff delivered care and support to people in a safe way.

Staff we spoke with told us they had safeguarding training and they knew how to recognise and report their concerns to managers. They were also confident to contact outside agencies like the local safeguarding authority or CQC to report their concerns under the whistleblowing procedure. For example, prior to the inspection staff members reported under anonymity to CQC that there was not enough staff and they were not supported by the managers and the provider.

Every person we spoke with had a call bell pendant worn around their neck as well as call bells on the side tables so they could summon assistance when they needed. However, people had mixed views about how quickly staff answered their call bells.

On the ground floor people told us that call bells were answered promptly unless there was a particularly busy period. One person told us, "They [staff] are usually quick to come when I need something. We can wait a long while, 15 minutes, at busy times." Another person said, "Even at night they come quickly and nothing is too much trouble." A third person said, "I was up twice last night, the carers always come quite quickly."

On the first floor people told us they had to wait longer for their bells to be answered. One person said, "Sometimes there is a long wait." Another person told us, "There aren't enough staff and there aren't enough machines (hoists)." A relative who was present at the time when we spoke with this person suggested that it was staff shortage not the equipment. The person than replied, "Well whatever it is I have to wait a long time a lot of the time." A third person said, "They [staff] say to me 'we will be back in quarter of an hour but then they don't come back." A relative said, "Staff are good here but there aren't enough all the time."

Staff had mixed views as well when we asked if there was enough staff. One staff member said, "If everyone turns up for their shift it`s okay. But if not, then managers are not helping on the floor and if there is staff shortage downstairs they [managers] will take staff from upstairs and then it`s hard." Another staff member said, "I think it is enough staff but the problem is that it is a new team still and we are not used to each other. It's no teamwork."

The registered manager and the provider told us they were constantly recruiting to ensure that as people were moving into the home they had staff available to support them. They told us they were re-deploying staff in case some staff members didn't turn up for their shift, however based on the dependency assessment they carried out they considered that there was sufficient staff. They told us they would be monitoring staffing levels to ensure people`s needs were met. This was an area that required improvement to ensure people had their call bells answered in a timely way.

Staff employed at the home had gone through thorough pre-employments checks which included a criminal history check, two references and a full employment history. This ensured that staff working at the service were of good character and had the right to work in a care facility.

Risks to people's wellbeing were assessed and risk assessments were in place to mitigate these. Staff knew people well and they told us how they ensured that risks to people`s well-being were minimised. However, risk assessments needed developing further to document in detail what measures were in place to mitigate risks. For example, we found that people who had regular falls had sensor mats in place to alert staff when they needed help. However, this was not always recorded in the risk assessments. There was no evidence that the risk assessments were reviewed after each fall the person had and other measures were considered in addition to the sensor mat. Moving and handling assessments needed to be developed to detail the size of sling and the loops staff should use when hoisting people. Lessons learned after complaints or incidents were shared and discussed at handovers, team meetings, supervisions or as needed.

People were supported to take their medicines as prescribed. Electronic medicine administration records (MAR) had been completed when people took their medicines. We found that the electronic medicine management system had not been used effectively. For example, were people were not given their medicines the system was not been set up to alert managers that medicines were not given. This happened because staff who were administering medicines were recording an explanation on the system as to why people`s medicines were not administered. This increased the risk of managers not identifying in a timely way if they had to take action like alert people`s GP or pharmacist because people missed a dose of their medicines. We discussed this with the registered manager and the provider. They confirmed following the inspection that the system had been up-graded to create the alerts in case people had not received their medicines.

We also found discrepancies when we counted medicines for people and the clinical manager explained that this was because the dose of the medicine changed, however when they updated the system with the new dose of medicines they could not remove the old instructions which we found confusing and hard to identify which instructions needed to be followed. This was an area in need of improvement.

We spoke with staff about fire drills and fire procedures in the home. Staff told us they received training, however some staff could not remember the last time they participated in a drill. One staff member said, "I couldn't tell you the last time we had one (a drill). Maybe there has been one when I was off." Another staff member said, "There is a fire panel which would tell us where the fire is and the doors would shut automatically. Everyone has a PEEP (personal emergency evacuation procedure) and there are little dots at the top of each door showing whether the person is red, amber or green." We recommended to the registered manager to ensure all staff members take part in regular fire drills.

People had personal emergency evacuation procedures (PEEP) in place where it was indicated if they were low, medium, or high risk in case there had to be an evacuation. On people`s bedroom doors there were red, amber or green stickers for staff to identify easily the level of risk involved when they had to evacuate people.

People were protected from the risk of infections by staff who used personal protective clothing when delivering personal care to people. We saw staff washing hands before they prepared drinks or food for people.

Good

Is the service effective?

Our findings

People spoken with told us that staff were suitably trained and experienced to support them. One person told us, "Staff is good. And they know how to help me."

Staff spoken with confirmed they had received an induction when they started to work at Snowdrop House. We saw that staff received the training considered necessary by the provider which included manual handing, infection control, safeguarding and other areas to help them understand their role. Additional training included dementia, diabetes and care planning. The home only opened eight months before this inspection and staff told us they were not required to attend any refresher training yet.

Staff told us they had supervision with their line managers. Not every staff member we spoke with felt well supported by the registered manager and the provider. They told us that management presence on the floor was not sufficient and they had to find managers in their office if they needed support which was not practical at times. We discussed this with the registered manager and the regional manager and found that there were plans to address this.

Throughout our inspection we saw that staff sought to establish people's wishes and obtain their consent before providing care and support. One person told us, "They ask me if it`s ok to do this or that and I can choose when I go to bed and when I get up. I went at 10.30 last night." Another person commented, "I can do as I choose here – it's up to me. They ask if they can help which is nice."

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.

We found that consent to care had been obtained from people in line with the Mental Capacity Act (MCA) 2005. People's capacity to make decisions had been assessed, determined and reviewed where necessary. For people who lacked capacity to take decisions these were made following best interest processes involving health and social care professionals and people's family members when this was appropriate.

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 manager had submitted deprivation of liberty applications to the local authorities for people who had limitations of their freedom in place to keep them safe.

People told us that the meals provided to them improved significantly recently. One person told us, "The new chef is great – the food wasn't so good before – but it is much better now." Another person said, "The food is ok, there's a reasonable choice and it's hot and usually quite good." A relative told us, "Well we saw

Sunday lunch last week and we will be booking in soon. It looked so good."

In the dining areas the tables were nicely set and menus were displayed. At meal times staff asked people what they wanted to eat and drink and there were positive social interactions in the dining room between people and staff. We observed staff sitting and having their lunch with people together and they gently encouraged people to finish their meals or to have more drinks. The atmosphere was calm and people appeared to be enjoying their meals.

Some people ate in their rooms by choice. We heard staff asking people what they would like to do and encouraging them to come to the dining room where practicable.

The services manager, who was responsible for overseeing the catering for the provider was on a scheduled visit to the home and told us that the chef had discretion about the menu and they could adapt these to suit the needs of the people living in the home. The chef told us they were passionate about their role and they demonstrated an in-depth knowledge about people`s dietary requirements, likes and dislikes. We observed the chef asking people for their feedback about the meals they provided. They told us they had started to adapt the menu to reflect people`s likes and dislikes.

People were weighed regularly and where weight loss was identified staff informed the person`s GP and a dietician which ensured they had specialist advice in meeting people`s nutritional needs. We saw however that every person who had their fluid intake monitored had a set target of 1600ml over 24 hours. Records evidenced consistently that some people were not able to meet this target. Staff told us they knew people well and they could identify when people were at risk of dehydration. However more clarity was needed around each person`s individual recommended fluid target over 24-hour period and guidance for staff around when they had to raise concerns if people were not meeting their targets.

People living in Snowdrop House were supported by a range of health professionals, including the GP, chiropodist, district nursing teams, dentist, dieticians and speech and language therapists. A person told us, "If I am not feeling well they take notice of me and they keep a check on me." Their relative told us, "They phone me [in case of concerns around people`s health]. It happened recently and they phoned me several times during the day to keep me up to date." The home had a visiting chiropodist and a GP surgery weekly as well as by request district nurses visited as well.

Good

Is the service caring?

Our findings

People and relatives praised the staff at the home. They told us that staff were kind, caring and had a respectful approach towards them. One person said, "They are very kind when I need help, they speak to me really nicely to help me." Another person told us, "The staff here are wonderful, really wonderful." Relatives told us they were happy with how people were looked after and they praised staff for their kindness. One relative said, "[Person] is well looked after and I am happy with the care."

People told us staff understood their needs and they respected people`s privacy and dignity. One person told us, "They are really good, they always make sure the curtains are drawn if they are helping me." We observed staff knocking on bedroom doors before entering and they addressed people in a respectful and dignifying way. For example, staff were asking people respectfully about what they wanted to do. One staff member told a person, "We could sit and have a coffee or would you like to go to the lounge?" We heard another staff member say, "Would you like me to help you into the garden later, it's a lovely day and we talked about it earlier?" This meant that staff were mindful about people`s feelings and they were tactfully reminding people conversations and decisions they took earlier but may already forgot.

We observed staff interacted and responded to people in a positive manner and spent time with them chatting. Staff were calm and got close to people when talking to them. Where needed staff repeated information over again until the person understood what was being said. We observed staff encouraging people to socialise together and form and maintain relationships. Visitors told us they could visit the home any time the person they visited was happy to see them. However, some people told us they struggled with constantly changing staffing group. One person told us, "I do know the main staff, but lots of them keep changing." Another person said, "They are different staff all the time, I mean all the time, you just get to know someone and on the next shift there's people you don't know again." However, the home only opened in September 2017 and were in the process of having new staff starting and people moving in every week. This had been planned by the provider and the registered manager as well as possible not to disrupt the daily life of people who already lived in Snowdrop House.

People told us they could influence the care they received, however they were not knowledgeable about their care plans. People and where appropriate their relatives signed consent forms when people moved in the home to authorise staff to take their photograph and share their records with relevant professionals.

Private and confidential records relating to people's care and support were securely maintained in lockable offices and password protected electronic devices. Staff were able to demonstrate that they were aware of the need to protect people's private and personal information. This helped ensure that people's personal information was treated confidentially and respected.

Good

Is the service responsive?

Our findings

People and their relatives had been involved in developing people's care plans. People and their relatives told us they discussed care needs at the time of admission in the home and they communicated with staff daily about their care if there was a need for it. Monthly reviews of the care plans were documented, however there was no evidence that these reviews happened with people or their relatives being present. Care plans contained information for staff about how to meet people`s needs, such as maintaining safety, personal care, eating and drinking. The care plans lacked personalisation and had limited information about people's preferences, dislikes and preferred routines. We saw that at the time of the inspection this had not had an impact on people because there were only 35 people living in the home and staff had got to know them well, however care plans needed developing to ensure the information was always available for staff.

People were supported to follow their own pursuits and interests or to participate in wider events within the home. One person said," I go to everything, I join in whatever is going on." Another person said, "I really enjoy the activities, I like it that there are things going on."

A varied program of activities was delivered to people throughout the week and people received a weekly activity schedule to inform them on what was on offer. People if they wanted could deliver activities themselves to other people living in the home. For example, a person was leading on golf sessions. The activity coordinators encouraged everyone to join in the activities. They said to people, "Come along, everyone can join in, it doesn't matter if you are in a wheelchair there's lots of activities to do for everyone."

The activities coordinator was very focussed on communication and activities that encouraged fun and friendships. Each person was encouraged to fill in a life history book with headings such as 'My working life' and 'My family' and 'My life at Snowdrop House'. People were encouraged to use the life history book anyway they wanted and the activity coordinator help them putting pictures in it with the activities they enjoyed doing. Activities were based on the interests of the people as much as possible.

Staff developed strong community links and we saw that the local Brownies have come in to visit and were scheduled in to do an evening bingo session. There was a regular church service each week and the local school had been in for singing sessions. Hertfordshire Disability Cricket team was also visiting the home for a cricket session. The activity coordinator established links with the Creative Minds Project. This was a project using arts and craft to help people express their feelings.
They are waiting for a pet therapy dog and the ACs are going to set up a gardening group with the help of a resident who was a gardener

The service provided nursing care and at times they provided end of life care for people. The staff had been prepared for this by establishing links with a local hospice. Care plans showed that people were asked to think about their wishes in relation to end of life care and it was documented if they had any specific wishes or if they had declined to talk about this matter when they moved in to the home. Where people were nearing end of life action was taken to keep them as comfortable as possible and to remain at Snowdrop

House if this was their choice.

People told us they were able to attend regular meetings where they were able to freely discuss matters relating to the management of the home, concerns or compliments they may had. People and relatives told us they knew how to raise complaints and were confident that complaints would be answered. There was a complaint procedure in place and we found that where people raised complaints or concerns these were investigated and appropriately responded too.

Requires Improvement

Is the service well-led?

Our findings

People and relatives had mixed views about the management in the home. A person told us, "I live here and I still don't know who the [registered] manager is. I would go to whoever is in charge in the unit if I wanted anything." A relative told us, "I don't feel the [registered] manager keeps up to date at all. We hardly ever see them, sometimes in the corridor but [registered manager] doesn't come to people's rooms." Another relative told us, "I don't feel that the [registered] manager is good - you don't see them much at all, so I know who they are but that's all."

Prior to this inspection CQC received concerns from family members and staff regarding the management in the home. We contacted the provider to seek assurances that they would be investigating and support the registered manager to improve the quality of the care people received in the home.

At this inspection we found that the provider had worked closely with the registered manager to ensure all areas of concerns they identified through their quality auditing were addressed. These were in addition to issues CQC reported to the provider. However, people and staff still reported that managers were not visible on the floor and they had to approach the managers in their office if they wanted support which was not practical for them to do. One staff member said, "The managers sit in the office most of the time. I don't know what they are doing there but we would like to see them out on the floor more. It would be nice to approach them outside their office." Another staff member said, "The managers worked on the floor once I think but that's not enough. They are all in the office and we need to struggle on our own." This was an area that required improvement.

The provider`s regional manager carried out weekly visits and audits in addition to other representatives from the provider`s quality team. Audits were comprehensive and looked at areas like safeguarding, accident, incident analysis, care planning, recruitment and other areas. However, we found that the audits had not always identified what we found in the inspection. For example, that care plans needed more personalisation.

In addition, the provider introduced a regular visit from human resources for staff to have a person independent from the home to share their concerns with. We spoke with staff who reported that their main concern was the lack of financial enhancements for overtime and they felt that there was not enough support from the management team in the home. Staff told us they were not listened by the managers and they were pressurised to accept to work extra hours even if they had no intention to do so. Staff also told us that managers were rarely visible around the home and they spent they days mainly in their office so they were not readily available to support people or staff on the units. We discussed these concerns with the registered manager and the regional manager and whilst we accepted that some of these concerns were historical there was a need for unit managers and the registered manager to be more visible around the units, establish and build relationships with people, relatives and staff.

The registered manager told us and we saw evidence that they had days in the week when staff could talk to them and share their concerns and the regional manager was visible weekly for staff to talk to them. They

recently held a staff meeting to give staff the opportunity to voice their concerns. The registered manager told us they had worked on the floor once and that the unit manager and clinical lead were working on the floor on a regular basis, however not every staff member we spoke with had the confidence that the improvements would be sustained.

We found that the staff team was still developing and newly employed staff members were constantly scheduled to start. This was because the home only opened in September 2017 and it was not at full capacity. Therefore, the staff team had not yet had the time to get to know each other well and work as a team. One staff member said, "It`s no teamwork. Staff comes and goes its constantly changing."

The registered manager told us they were opening the top floor the week following the inspection and were planning to move people from the ground floor who had nursing needs on the top floor. However, at the time of the inspection they had not yet communicated with people or their relatives about these plans. Staff however were informed and some staff told people they would have to move to the top floor. This caused some anxiety to some people. We asked the registered manager to ensure they clarified and discussed the move with one person who was extremely anxious about the move. The registered manager told us they will reassure the person and they would find a way to accommodate the person on the ground floor if it was in their best interest.

There were quality assurance systems in place and these were effective in identifying issues and what had to improve. However, we saw that where actions were identified for example one audit identified that care records for a person had to improve. The action to improve this had been completed, however it had not triggered a review of every person`s care records to ensure all were improved to the same standard. We also found that some care records needed further developing to ensure they were personalised to the individual. This was an area in need of improvement.

There was an internal service improvement plan which logged all actions needed to improve the quality of the care people received. Information that fed into this included accidents and incidents, staffing, training, maintenance or environmental issues, complaints and feedback from other agencies. We found that actions were clearly documented and addressed in a timely way.

There were regular residents and staff meetings at the home. These meetings gave people the opportunity to give feedback on the quality of the care they received. We saw that as a result actions were taken and improvements were made. For example, people complained about the quality of their meals. This was addressed and a new Chef started at the home two weeks prior of the inspection. People told us the quality of the meals had improved greatly and they were happy that the provider acted and resolved this issue. People also complained at times that there were longer waiting times for their bells to be answered, however this issue was reported to us as well by some people therefore it had not been resolved. We asked the provider and the registered manager to review their staffing levels and ensure their dependency calculations took account of the layout of the building and busy times when it was a possibility that more staff was required to ensure people could have their calls answered in a timely way.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.