Solor Care (South West) Ltd

Wey House Nursing Home

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

This unannounced inspection was carried on 25 September 2018.

Wey House Nursing Home 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.

Wey House provides care for up to 31 people with complex neurological conditions, acquired brain injuries and/or other physical disabilities. People who live at Wey House have complex nursing and other support needs and many of them are unable to communicate verbally. At the time of the inspection there were 28 people living at the home.

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

At this inspection we found the service remained Good.

Why the service is rated Good

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. People and staff commented positively about the registered manager.

Staff were aware of the risks relating to people, although not all of these had been formally assessed and recorded. Staff told us there was a culture of learning from incidents.

People's care plans were detailed and although some aspects of them were not fully up to date, staff were aware of people's needs. The registered manager was in the process of reviewing all of the care plans and transferring them onto a new electronic system.

People's consent to care was in the main sought in line with legislation and guidance.

Staff knew how to recognise and report abuse and were confident any concerns would be investigated. People received safe care and support from adequate numbers of staff who had the skills and experience to meet their needs.

There were systems in place to minimise the risks of the spread of infection in the home. There were a range of checks in place to ensure the environment remained safe. The environment was suitable to meet people's needs.

People's health was monitored by trained nurses and they had access to other healthcare professionals to meet their individual needs. People received their medicines safely.

People's nutritional needs were assessed and people's weights were monitored. Where aspects of people's care required monitoring, records were consistently completed.

People were cared for by staff who were kind and caring. One person told us, "You get to know them, you trust them." We observed positive interactions between people and staff.

People were treated as individuals and staff supported people to make choices about their day to day lives. Staff knew people well and provided care that was personalised to their wishes and needs.

People knew how to raise concerns and could be confident these would be responded to. There were systems in place to share information and seek people's views about their care and the running of the home.

The service was well led by a registered manager who had the right skills and knowledge to undertake their role. There was a management structure in the home, which provided clear lines of responsibility and accountability.

The quality assurance systems in place were effective at identifying shortfalls in the service and ensuring action points were completed.

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? The service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Wey House Nursing 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 was an unannounced comprehensive inspection and took place on 25 September 2018. It was carried out by two inspectors 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.

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

During the inspection we spoke with four people who lived at the home and two visitors. We also spoke with seven members of staff including the registered manager, agency nurses, care staff and the cook.

Some people in the service were not able to tell us about their experiences. We therefore spent time observing the care and support practices in the home. We 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.

During the day we were able to view the premises and observe care practices and interactions in communal areas. We observed lunch being served in the dining rooms. We looked at a selection of records, which related to individual care and the running of the home. These included seven care and support plans, four staff files, records of compliments, medication records and quality monitoring records. Following the inspection we received feedback from one visiting professional.

Good

Is the service safe?

Our findings

There were sufficient numbers of staff employed to keep people safe and to meet their needs. During the inspection we saw requests for assistance were responded to promptly and people were supported in an unhurried manner. One person told us, "There are always lots of staff here, night and day." A staff member said, "Oh yes, there's always enough staff. It's never an issue here." Staff were visible throughout the building for the duration of the inspection. The service used agency staff to cover some of their vacant nursing shifts, the registered manager confirmed they used the same agency staff to ensure consistency.

People told us they felt safe living at Wey House. One person told us, "There's continuity [in staff] and trust." The risks of abuse to people were minimised because the provider had systems and processes which minimised risks. These systems included a recruitment process and training for staff. Recruitment records showed that new staff did not begin work until appropriate checks had been carried out to make sure they were safe to work with vulnerable people.

Staff knew how to recognise and report concerns and all felt any concerns reported would be fully investigated to make sure people were kept safe. Agency nurses were also familiar with the provider's safeguarding policy. Both of the agency nurses we spoke with demonstrated they knew how to report any concerns about abuse or harm. One agency nurse said, "If the care staff tell me someone has got a bruise, I document it, complete an incident form, and tell [registered manager]. If it was at the weekend or during the evening, I would contact the on-call person." They also said, "If I was worried about poor care I would go straight to [registered manager]. I know [they] would listen and would take action."

Although in the majority of care plans we looked at people had been assessed for the risks of harm, not all had. One person had sustained a self-inflicted injury. Staff had documented this as "Self-harm" and it was also written on the handover sheet that the person had "Threatened to self-harm." Although staff were aware of the risk of the person hurting themselves again, there was no risk assessment in place to show how the service was managing this. We discussed this with the registered manager who said they would implement this immediately. Following the inspection the registered manager provided evidence this was completed.

Care plans contained risk assessments for areas such as skin integrity, malnutrition and mobility. When risks were identified the plans provided guidance for staff on how to reduce the risk of harm to people. For example, when staff needed to use equipment to move people safely, hoist and sling details were recorded. When people had been assessed as being at risk of pressure sores, the plans guided staff on any pressure relieving equipment in use, such as air mattresses. There was a process in place to check air mattresses and all of the mattresses we looked at were at the correct setting. Some people needed staff support to have their position changed regularly. Position change charts informed staff of the required frequency and charts we looked at showed that people's positions were regularly changed.

Staff told us there was a culture of learning from incidents. One staff member said, "We do learn from incidents and try to prevent them." Staff completed an accident or incident form for each event which

occurred; these were entered onto the provider's computer system. All incidents were analysed by the provider's behavioural specialist who responded by offering suggestions and comments for staff to help improve their practice. This ensured that each incident was recorded and reviewed.

Medicines were managed safely. Staff had been assessed as competent to administer medicines and competencies had been regularly reviewed. We looked at some of the medicine administration records (MARs). All had been signed to indicate that people received their medicines as prescribed. There were up to date photographs in place of people and people's preferences for how they liked to have their medicines was recorded. For example, "Will usually pop all [their] tablets straight from hand to mouth."

Some people had been prescribed additional medicines such as pain relief on a PRN (as required) basis. In these instances PRN protocols provided clear information to nurses on when and why people might require them. Protocols for the use of medicine to relief signs of agitation were detailed and informed staff of the signs people might display and the steps staff should take before resorting to the use of medicine.

Medicines were stored safely. People's medicines were kept in locked cupboards in their bedrooms. Regular stock checks were carried out as well as additional random stock checks. The temperatures of the medicine cupboards, clinical rooms and the medicine fridges were monitored and were all seen to be at safe levels. Medicines that were no longer required were disposed of safely. Records of the latest pharmacist advice visit dated April 2018 included the comment, "Good meds management."

One person was self-administering their medicines. They had been assessed as competent to do this and were regularly reassessed.

People lived in a clean and fresh environment. There was a dedicated housekeeping team and all staff received training in good infection control practices. There were adequate hand washing facilities around the home and staff used personal protective equipment, such as disposable gloves and aprons, where appropriate. This helped to minimise the risks of the spread of infection in the home.

There were a range of checks in place to ensure the environment and equipment in the home was safe. These included a fire risk assessment, testing of the fire alarm system, and water temperature checks. Each person had a personal emergency evacuation plan, detailing the support required if they needed to be evacuated in an emergency.

Good

Is the service effective?

Our findings

People's needs were assessed prior to moving to the service. This helped to make sure it was the right place to meet their needs and expectations. The information from the initial assessment formed the basis of care plans to identify how people wanted to be cared for.

People's nutritional needs were assessed and people's weights were monitored. When people lost weight, advice was sought from the GP. People's food and drink preferences were documented. When required, specialist advice was sought. For example, some people had difficulties swallowing and had been reviewed by the speech and language therapy team (SALT).

Although in the main, the information for staff in relation to specialist dietary needs was clear, this was not seen consistently. For example, in one person's care plan it was documented that they needed to have "Stage 3 thickened fluids." In the same person's choking plan, it was documented they needed to have "Stage 2 fluids." On 21 August 2018, staff had documented a discussion with the GP as, "Some choking on Stage 1 fluids. SALT referral." The information documented in the plan was therefore contradictory. We discussed this with the registered manager and the agency nurse on duty. The outcome of the latest SALT review was checked by the nurse and this confirmed the person needed to have stage 3 thickened fluids. The information on the handover sheet was correct and staff were aware of amount of thickener to use. The choking care plan was amended during our inspection to reflect the latest guidance.

We saw in another person's daily records that they had been refusing food. Staff had documented this alongside information which showed they had offered alternatives and tried again at later times during the day. The agency nurse on duty told us the person had been refusing food for nearly a month. However, the care plan for this person was limited to, "Normal diet and fluids." Staff had informed the GP the person was refusing to eat, but the plan had not been updated to reflect the person's altered eating habits and provided no guidance for staff on how to try and ensure the person received some nutritional intake. The agency nurse told us they would update the persons care plan.

Some people were having their food and fluid intake monitored. All of the charts we looked at had been completed in full and showed what food and drink people had been offered and what they had eaten. Fluid intake was totalled each day and records showed people had enough to drink.

People commented positively about the food and the choices of meals. One person told us, "You get three choices of meal and they are very good. The food is good." Another commented, "They are alright. I think it's a good choice."

People were supported to have access to ongoing healthcare. There was a book where staff wrote when and why people needed to be reviewed by the GP each week. The outcome of these reviews was also documented. There was a physiotherapy assistant in post and records showed people had regular sessions with them. People had access to a hydrotherapy pool for both exercise and leisure.

People were supported to attend appointments where necessary and hospital passports were in place. These are documents which provide information to hospital staff which isn't just health related and includes information about people's communication needs, and their preferences. This helps to make sure people receive appropriate support when away from their home setting.

The environment was suitable to meet people's needs. The home was spacious and corridors were wide to enable people using a wheelchair to move freely and without obstruction. Accommodation for people was arranged over two floors with a passenger lift between which enabled all areas to be accessed by people with all levels of mobility. All bedrooms were used for single occupancy and people had been able to personalise their rooms to suit their tastes and needs. There were various lounges and communal spaces where people could choose to spend their time. There was also a sensory room for people to use. A sensory room is a room designed to develop a person's sense, usually through special lighting, music, and objects. It can be used as a therapy room for people with limited communication.

The home also had an area called the 'Coach House' where there was the physiotherapists room, a hydrotherapy pool, and a kitchen area with height adjustable side boards to enable people who used wheelchairs to use the facilities. The registered manager told us the kitchen area was used to support people to be involved in cooking and baking. One person told us, "I go to the Coach House two or three days a week. It's like a Bake Off [in the OT kitchen] and there's an adjustable table."

There was also an assessable outdoor space with a pond and poly tunnel where people had been involved in growing vegetables. The registered manager told us there were further plans to develop the garden area to make it fully assessable. Some areas of the home appeared to require redecoration and the registered manager told us there was a programme of ongoing refurbishment.

People were supported by staff who had the right skills and knowledge to carry out their role.
Staff received an induction when they started working at the home. The induction included a period of 'shadowing' experienced staff, attending training, familiarising themselves with the home and reading people's care records. The induction programme was linked to the Care Certificate. The Care Certificate standards are recognised nationally to ensure staff have the relevant skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff also received ongoing training and commented positively about the opportunities they had to gain recognised qualifications. One staff member said, "The training is good here, [name of registered manager] supports staff to develop." The registered manager demonstrated staff training statistics for mandatory training was 97% completion. Staff told us they had formal supervision (meetings with their line manager to discuss their work) to support them in their professional development. Records demonstrated staff were receiving regular supervision.

People were able to make most of their own day to day decisions as long as they were given the right information in the right way and had sufficient time to decide. However, there were some decisions people were not able to make for themselves and we therefore looked at how the Mental Capacity Act 2005 (MCA) was being applied.

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.

In the main, consent to care was sought in line with legislation and guidance. People had been assessed for their capacity to consent to aspects of their care. When people lacked mental capacity, best interest decisions were made. Records of these decisions were clear and showed who had been involved in the decision and how the decision had been reached. Independent mental capacity advocates (IMCA's) had been utilised.

We looked at the plan for one person who chose to make what could be viewed as an unwise decision. Staff told us due to safety the person had restricted to access to a certain item, this was documented in the person's care plan. However, there was no capacity assessment in place which meant it was not clear if the person had consented to staff keeping the item or not. We discussed this with the registered manager who said they would complete a capacity assessment with the person. Following the inspection the registered manager demonstrated the capacity assessment and best interest decision had been made.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager confirmed referrals had been made for people to be lawfully deprived of their liberty where they needed this level of protection to keep them safe and lacked the mental capacity to fully agree to aspects of their care. We saw DoLS applications had been agreed for five people living at the home and the other 21 applications were pending assessment from the local authority.

Good

Is the service caring?

Our findings

People were cared for by staff who were kind and caring. One person told us, "You get to know them, you trust them." Other comments included, "Nice staff", "They are alright. They talk to you, do things" and "It's alright. I like the place. I like the fact you are cared for, they care about you. You can have a joke and a laugh with the staff."

We observed positive interactions between people and staff. People appeared relaxed around staff; they were smiling and talking to them. Throughout the inspection we saw staff interacted with people in a kind and patient way. Staff chatted to people in a friendly manner and took time to listen to people's responses even when people had difficulties communicating.

On one occasion we saw a member of staff walk into one of the lounges. They saw that one person was leaning over in their chair and didn't look comfortable. They went over to the person who was sleeping and gently touched their hand, trying to wake them. They crouched down to the person's level and said, "Would you like to go and lie on your bed for a while? You don't look very comfy there and you seem a bit tired." The person agreed and the staff member supported them to their room.

On another occasion, one person was in the lounge sat in front of the television. A staff member came in, and said, "Hello [person's name]. Are you watching this or would you like me to change the channel for you?" The person replied that they were watching the programme and so the staff member left the television as it was.

Staff spoke positively about people and it was clear they had built strong and trusting relationships. When staff discussed people with us they were respectful and knowledgeable.

Agency nurses spoke highly of the care and support provided by staff. One said, "I keep coming to work here because I love it. The staff are wonderful. They know exactly what they're doing and know people really well." Another said, "The care here is very good. All of the residents seem happy."

Staff described how they respected people's privacy and made sure care was provided in a dignified and respectful way. One person told us, "They knock on the door when I have the door closed and I'm getting dressed." Another commented, "They knock on the door and they close the door."

People were involved in day to day decisions about their support. One person told us, "I am allowed to discover my own boundaries." Other comments included, "If you want to go to bed, you can" and "I like the fact you are free to do what you want." Staff described how they used people's individual communication methods to give people choice and control over their lives. We observed one person holding a staff members hand, the person was leading the staff member to where they wanted to go and the staff member stayed with them and respected their choices.

There was an open visiting policy which helped people to keep in touch with friends and family. One person

told us, "My sister comes. We go out to places, there's no restriction."

We reviewed feedback the home had received that described the staff as; "Very caring and supportive", "[Name of person] has been looked after so well, staff are sensitive to their needs and I can't thank them enough for their care and hard work" and when asked what works well at Wey House a relative commented, "The natural compassion of the staff, the atmosphere, their helpfulness and understanding."

Good

Is the service responsive?

Our findings

People received care that was responsive to their needs and preferences. Each person had a care plan that was personal to them. The quality of information within care plans was generally good. There was information about people's choices and preferences for how they wanted to be supported. Life histories were detailed and staff demonstrated they knew people well.

However, not all of the plans we looked at had been updated. For example, in one person's plan it was written, "Unable to access the community as [their] bespoke wheelchair is not licenced for use in Wey House transport." This contradicted what the registered manager had told us because the service had taken steps to ensure the person's wheelchair could be used on the transport. We discussed this with the registered manager who confirmed the plan had not been updated to reflect the changes made. In another person's records it had been documented that their mood had been "low" during the past few weeks, but there was no plan in place to inform staff how to support the person through this. The registered manager told us they were in the process of reviewing all of the care plans and transferring them onto a new system.

Other plans we reviewed provided clear guidance for staff. Plans in relation to people's health needs were clear and informative. Some people were at risk of having seizures and the plans informed staff of the signs of seizures and the actions they needed to take. Catheter care plans were clear and informed staff how to monitor for the signs of infection. Plans in relation to the behaviours some people displayed when they because anxious were detailed. For example, any triggers were listed and distraction and de-escalation techniques were documented.

Staff supported people in a way that promoted their independence and well-being. One person told us they thought their health and physical abilities had improved since they moved into Wey House. They demonstrated how they were able to stand and walk some steps, which they had not be able to do when they moved into the home. They also told us how they were now accessing college independently.

Care plans promoted people's independence. For example, in one person's plan, it was written that although they needed support with their personal hygiene, they were able to carry out some aspects of it by themselves. The plan stated, "Encourage to do as much as possible by [themselves]. Can wash own face and upper body. Can shave [themselves] using electric razor."

The service met the requirement of the Assessable Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Some people had sensory impairment and the plans detailed how staff could ensure people were able to communicate their needs. For example, in one person's plan it was documented that staff should, "Use simple, closed question, ensure only one person talking at a time to minimise any misunderstanding" and "Has a spelling board and will spell words to you." Other people had communication cards which they used with staff.

Documentation in general was of a high standard. Daily records were detailed and provided a clear picture

of what support people had received each day. All charts had been completed in full. Two members of staff told us, "We know how important the documentation is; we write in people's folders all the time throughout the day." One agency nurse said, "Care staff record keeping is very good here."

People and their relatives were invited to participate in care plan reviews. Records showed that people were asked for their input into whether the care plan was meeting their needs or if any changes were needed.

Although advanced care plans were in place, these were not routinely being used. The registered manager showed us a new document that was being trialled for one person who was approaching the end of their life. There was some information written about things that were important to the person, but not enough information to enable staff to fully understand how people wanted to be cared for at the end of their lives. However, one staff member told us how they had recently supported one person at the end of their life. They explained what was important to the person a this time and how the staff team provided care that reflected this.

People told us they were happy with, and aware of, the activities on offer and had the choice if they wanted to participate or not. One person told us, "There are opportunities to go out, trips and gardening. I've been to Paignton Zoo. I'm going to Minehead this afternoon. I went to an Elvis tribute night." Other comments included, "I sometimes use the sensory room" and "I enjoy the activities. I like going out in the garden, I find it very soothing."

The home had a beauty therapy room for people to access if they wished. The registered manager told us a beauty therapist attended the home weekly and staff supported people to access the room throughout the week.

Social activity plans were person centred. People's choices and preferences for how they liked to spend their time were clear and informative. The activities co-ordinator told us, "It can sometimes be trial and error finding out what people like to do, but we keep going." They told us, "One person prefers one to one time. So I took them out for a drive today" and "We're taking a few people for a walk along the sea front this afternoon and then to a café for tea and cake." They also told us they regularly took one person to visit their relatives. They said that while this was happening they would go out for lunch with two other people before picking up the other person on the way home. Staff described how they supported one person to attend their chosen meeting place to worship and said that a visiting priest attended the home on a monthly basis.

People felt confident to raise any concerns or make a complaint. One person told us, "I have made a complaint and it was sorted out." The provider had a complaints policy which made sure all complaints were investigated and responded to. There had been no formal complaints received by the service in the past year.

Good

Is the service well-led?

Our findings

The home was well led by a registered manager who spoke enthusiastically about working at Wey House, the progress they had made, the staff team and supporting the people living there. People spoke highly of the registered manager. One person told us, "If I have problems, I tell [name of registered manager]." Another commented, "[Name of registered manager] works hard and she's around. I have a lot of confidence in her."

Staff also spoke highly of the registered manager. Comments included, "[Registered manager] is very hands on. They are very good and really understand the work that is done here", "They are very approachable and make you feel valued" and "[Registered manager] is very supportive and always listens." A visiting professional told is they thought the home was, "Very well led" and described the registered manager as, "A great role model."

The registered manager told us they felt well supported by their managers and the organisation. The registered manager said they had regular supervision sessions and an annual appraisal. They told us they attended monthly management meetings with managers from some of the provider's other homes and undertook peer audits and observations at the other homes. They said, "We can bounce ideas off each other." They said they felt well supported by their line manager and had regular meetings and phone calls with them as well as feeling supported by other members of the senior management team.

The registered manager was trained to carry out their role. They told us they enjoyed learning and that they lead their own study. They said, "I've done my level five health and social care management and I'm hoping to do some project management training in the future. I also make sure I attend training specific to the people who live here. For example, I did some bariatric training a while ago."

In addition to the registered manager there was a deputy manager and there was always a trained nurse on duty. This helped to ensure there were clear lines of accountability and enabled people's care and support to be constantly monitored and treated according to their individual needs. The registered manager and deputy manager were visible in the home and worked alongside staff which enabled them to constantly monitor standards of care. One staff member told us, "[Name of registered manager] works alongside us, it's a good thing. They will put their hand to anything."

People lived in a home where staff morale was good which created a happy and relaxed atmosphere. Staff commented positively about working at Wey House. One staff member told us, "We all want people to have the best possible care and the team all work together, we are all on the same page." One person commented, "There's a good saying on the wall. 'This is our home', it makes you feel comfortable."

The registered manager spoke positively about the staff, they told us, "Staff here go above and beyond all the time. I have a brilliant care team. We're open and honest with clear lines of communication. We're also open to evolving. I go home at peace because the staff do the best they possibly can for people."

Staff meetings were held which were used to address any issues and communicate messages to staff. One staff member told us, "You can say what you think and are listened to." Records demonstrated items discussed during the meetings included health and safety, policies, record keeping and training.

There were systems in place to monitor and improve the safety and quality of the service. Audits covered areas such as, accidents and incidents, health and safety and medicines. The operations manager also completed an audit of the service and this resulted in an action plan being developed identifying areas for improvement.

There were systems in place to seek people's and their relatives views. These included an annual survey and regular residents meetings. One person told us, "We are asked our views. They are very good. We asked for the menu to be changed a couple of months ago. It's improved. There's more variety." We reviewed the action plan from the 2017 survey and saw that actions identified, were monitored for progress and noted when completed. For example, an action point had been for a porch to be added to the front door to prevent visitors from getting wet, this action had been completed.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

Significant incidents were recorded and where appropriate were reported to the local authority. We found the registered manager had not notified the Care Quality Commission of two incidents in line with their legal responsibility. It is important that CQC are notified of significant incidents to ensure the correct action has been taken. We noted the incidents were responded to appropriately. We discussed this with the registered manager who told us they would complete retrospective notifications and ensure we would be notified of all future incidents where required.