Orchard House Nursing Home Limited

# Orchard House Care Home

## Inspection report

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Date of inspection visit:
10 May 2016

Date of publication:
11 July 2016

## 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

We inspected Orchard House Care Home on 10 May 2016. This was an unannounced inspection. The service provides care and support for up to 52 people. When we undertook our inspection there were 48 people living at the home.

People living at the home were of mixed ages. Some people required more assistance either because of physical illnesses or because they were experiencing difficulties coping with everyday tasks due to memory loss. The home also provided end of life care.

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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to restrict their freedom in some way, usually to protect themselves. At the time of our inspection there was no one subject to such an authorisation.

We found that there were sufficient staff to meet the needs of people using the service. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period. There was a dedicated wing for those with memory problems. This was staffed separately to the main building for continuity of care for people living in that area.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan for each person. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

Staff had taken care in finding out what people wanted from their lives and had supported them in their choices. They had used family and friends as guides to obtain information and accessed a number of different resources within the community.

People had a choice of meals, snacks and drinks. Meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those that required it. Some people helped with setting tables for meals.

The provider used safe systems when new staff were recruited. All new staff completed induction training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

People had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements. Since our last inspection the provider had updated and refurbished many parts of the home.

## 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.

Checks were made to ensure the home was a safe place to live.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored safely. Record keeping and stock control of medicines was good.

### Is the service effective?

Good

The service was effective.

Staff ensured people had enough to eat and drink to maintain their health and wellbeing.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

### Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

### Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with

them.

Detailed care planning had taken place to ensure people's wishes were adhered to, no matter how long this took. Staff accessed a variety of resources in the community.

Activities were planned into each day and people told us how staff helped them spend their time.

People knew how to make concerns known and felt assured anything raised would be investigated.

## Is the service well-led?

Good

The service was well-led.

People were relaxed in the company of staff and told us staff were approachable.

Audits were undertaken to measure the delivery of care, treatment and support given to people against current guidance.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

# Orchard House Care Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 10 May 2016 and was unannounced.

The inspection was undertaken by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using services or caring for someone who requires this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

We also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We also spoke with health professionals both before and during the inspection.

During our inspection, we spoke with eight people who lived at the service, five relatives, four members of the care staff, two trained nurses, the quality care manager, the receptionist, the activities co-ordinator and the day care activities coordinator, the housekeeper, the cook, the provider and the registered manager. We also observed how care and support was provided to people.

In the wing designated for those with memory problems we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who

could not talk with us.

We looked at eight people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, audit reports and questionnaires which had been sent to people who used the service and relatives.

Good

# Is the service safe?

## Our findings

People and relatives told us they felt safe living at the home and leaving their family member in the care of staff. One person said, "We are all very safe in this home." Another person said, "All the outside doors are always locked to keep us safe." When talking about safety and security a relative told us, "It puts your mind at rest."

Staff had received training in how to maintain the safety of people and were able to explain what constituted abuse and how to report incidents should they occur. They knew the processes which were followed by other agencies and told us they felt confident the senior staff would take the right action to safeguard people. This ensured people could be safe living in the home.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns on a monthly basis. This ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to staff. Staff told us they were informed through shift handover periods when actions needed to be revised and also with one to one meetings with the registered manager or quality care manager.

To ensure people's safety was maintained a number of risk assessments were completed and people had been supported to take risks. For example, where people had a history of falls. A falls analysis had been completed monthly. We saw the one for dates ending in April 2016. Staff had recorded when they had observed people walking at different times of the day and when they required more help to walk. We observed staff walking with people, giving them encouragement to take steps and ensuring they were using their walking aids correctly and were wearing suitable footwear. Staff had ensured other health care professionals had been involved in the assessment of equipment to assist people to walk such as a walking frame. People had signed to say they had agreed to the course of actions described.

Staff had assessed people to see if they were capable of going out to local shops and events on their own. At the time of our inspection no one was capable of doing this, but we observed staff asking people if they would like to go out. Staff ensured wheelchairs were fit to use by checking tyres and that footplates were in place. Staff gave people advice about suitable clothing and footwear, to ensure they were dressed for the weather conditions.

People had plans in place to support them in case of an emergency. These gave details of how people would respond to a fire alarm and what support they required. For example, ensuring people were not frightened when the fire alarm sounded or needed help with walking due to poor mobility. Each person's plan had been colour coded. The same codes were used on other documents and bedroom doors so staff and others, such as a fire and rescue officer, could see who was most at risk. Red being for the person who would need the most help in the event of an evacuation. A plan identified to staff what they should do if utilities and other equipment failed. Staff knew how to access this document in the event of an emergency.

A lot of refurbishment of the environment had occurred since our last visit and areas looked clean and well maintained. We were invited into eight people's bedrooms to see how they had been decorated. People told us of their involvement in the layout of the room and how they had been involved in choosing the colour scheme. One person said, "It looks just like my original home." Some areas of the garden were still being developed. We pointed out to the registered manager where there were some possible trip hazards and a damaged wall. This was taped off during our inspection.

People in one area of the home had their own secluded garden which was set out with tubs of flowers and chairs. The bedrooms and communal rooms leading to the garden had directional signs displayed so people could find their way around. Notices in words and pictures told people what was behind closed doors; such as toilets and bathrooms.

People told us their needs were being met and there was sufficient staff available each day. One person said, "Yes there are enough staff here." Another person said, "Everything I want doing, they do."

Staff told us there were adequate staff on duty to meet people's needs. One member of staff said, "There are sufficient staff. It's hard work, we are on the go, but we have the right skill mix." Another staff member said, "Management cannot help it if staff go off sick or on holiday, but they always get cover." Another staff member said, "There is a different range of skill mixes here, but staffing feels alright."

The registered manager told us how they had calculated the numbers of staff required, which depended on people's needs and daily requirements. The provider was having on-going discussions with the commissioners of services so that the care packages reflected what had been agreed for each person, which was documented in care plans. Staff were aware of people's increasing health care needs as they got older and also if their needs changed. They were happy to discuss the flexibility of staffing with the registered manager and quality care manager. Staff felt their opinions on staffing levels were valued.

We looked at three personal files of staff. Checks had been made to ensure they were safe to work with people at this location. The files contained details of their initial interview and the job offered to them. The registered manager explained they were fortunate in the long service of the majority of staff, but would recruit when necessary. As the home employed registered nurses the registered manager showed us evidence of when each nurse's qualifications had been checked with the Nursing and Midwifery Council (NMC). All held valid registrations with the NMC.

People told us they received their medicines at the same time each day and understood why they had been prescribed them. This had been explained by GPs' and staff within the home. This was recorded in people's care plans. Staff were observed giving advice to people about their medicines. Staff knew which medicines people had been prescribed and when they were due to be taken. A procedure was in place for people to take medicines out with them if they left the home.

Medicines were kept in a locked area. There was good stock control. Records about people's medicines were accurately completed. Medicines audits we saw were completed regularly by staff at the home and also by the local pharmacy. We saw the audits for April 2016. Any actions had been signed as completed. The provider was currently in discussion with their local pharmacy supplier to ensure when requests were made the turnaround time for delivery was shorter. This was to ensure people did not run out of medicines which were prescribed to them.

We observed medicines being administered at lunchtime and noted appropriate checks were carried out and the administration records were completed. Staff stayed with each person until they had taken their

medicines. We also observed throughout the day staff giving medicines to people who told them they were in pain or discomfort. Staff ensured each person could have the medicine they had requested before administering the medicine. Staff who administered medicines had received training. Reference material was available in the storage area and staff told us they also used the internet for more detailed information about particular medicines and how it affected people's conditions.

Good

# Is the service effective?

## Our findings

People we spoke with and relatives told us they thought staff were trained to be able to meet their needs or their family members' needs.

Two members of staff we spoke with had been recruited within the last year. The retention level of staff was very good and the registered manager very rarely had to recruit new staff. However, the two staff members told us about the introductory training process they had undertaken. This included assessments to test their skills in such tasks as manual handling and helping people with complex needs. They told us the programme had suited their particular needs. This provided the skills they needed to meet people's needs safely. Details of the induction process were in the staff training files. Staff told us they were interested in completing the new care certificate as this would give everyone a new base line of information and training. The care certificate is a set of common induction standards set up to ensure all care staff have the same level of introductory training.

Staff said they had completed training in topics such as nutrition and hydration, manual handling and falls prevention and first aid. They told us training was always on offer and it helped them understand people's needs better. The training records supported their comments. Staff had completed training in particular topics such as blood borne diseases, diabetes awareness and catheterisation. This ensured the staff had the relevant training to meet people's specific needs at this time. We saw the training planner for 2016. This gave grades of staff and which departments they worked within, when training was planned and when topics were due for updating.

Staff told us a system was in place to test their competences and if required they would receive supervision. For those staff that were to supervise others, they had undertaken a team leaders course and some had also completed a business and administration certificate course. Staff told us this helped them have a better understanding of how they could help others achieve their potential. The records showed when supervision sessions had taken place and there was a planner on display showing when the next formal sessions were due. The trained nurses who were employed and who held a current registration with the Nursing and Midwifery Council (NMC) had time set aside to complete training and update their records for revalidation with the NMC.

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 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person on their liberty

were being met. We found the provider had followed the requirements.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. Staff had recorded the times best interest meetings had been held and assessments completed to test their mental capacity and ability. The registered manager kept a list of when DoLS applications had been applied for and when other information was required to support an application. This ensured tight timescales were adhered to and ensured each person's needs were being monitored.

To help staff to understand the needs of those people who required support to make decisions some staff had attended courses in topics such as dementia awareness, how to become a dementia friend, the Mental Capacity Act 2005 and dignity champions course.

People told us that the food was good and they could have drinks when they wanted them. One person said, "The food is very good." Another person said, "You can have anything you like for breakfast."

The staff we talked with knew which people were on special diets and those who needed support with eating and drinking. Staff had recorded people's dietary needs in the care plans such as when a person required a special diet. We saw staff had asked for the assistance of the hospital dietary team in sorting out people's dietary needs. People's likes and dislikes had been recorded.

We saw in the care plans when staff had discussed the dietary needs with each person in the home. This was recorded in people's care plans. This ensured people felt included in the menu planning and their specific needs were taken into consideration. Menus were only on display in written format, but the registered manager told us they were looking for alternatives for people who could not read or did not understand written English. Full sets of menus were available within the kitchen area, which staff had access to all the time. There were summer and winter menus. There was little interaction between people and staff at the lunchtime meal. One person's lunch was delayed by the visit of a health professional but the person told us, "The carer made sure my lunch was kept warm for me, the staff are fantastic here."

We observed staff attending to the needs of people throughout the day and testing out the effectiveness of treatment. For example, one person was being encouraged to sit out of bed after treatment in hospital and another person was being encouraged to walk unaided. We heard staff speaking with relatives about hospital appointments and home visits, after obtaining people's permission if they were not the people's spokesperson. This was to ensure those who looked after the interests of their family members' knew what arrangements had been made.

People told us staff obtained the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people's behaviours had changed and when they required health checks such as attending a diabetic clinic. We also saw in the records when people had visited the opticians and dentist. Several of the people had hospital appointments which they had attended. Staff had recorded outcomes of those visits. Staff told us they had a good rapport with other health professionals and felt supported by them when they required assistance. Health care professionals told us staff knew the people they looked after well and they could be relied upon to follow instructions.

Good

# Is the service caring?

## Our findings

People told us they liked the staff and they were confident staff would look after them. Staff were described as polite, respectful and protected their privacy. One person said, "[Named staff member] is so kind to me." Another person said, "If we are sat on our own, carers come and talk to you." A relative told us, "You wouldn't get a better dementia suite."

The people we spoke with told us they were supported to make choices and their preferences were listened to. One person said, "The carers keep me involved, they are [used swear word] marvellous here."

People told us they had been involved in the refurbishment programme. They told us they had been asked about colours of the walls. One person said, "Staff are always asking how we like things done and what is happening with redecoration." Another person told us, "A sitting room is out of action at the moment, but we've got a new area to sit in, it's lovely. We are asked where we would like to sit and be in each day."

All the staff approached people in a kind, patient and sensitive manner. They were patient with people when they were attending to their needs. For example, one person was worried about their next meal. So staff spoke quietly to them and explained the next meal time and reminded them of the choices available and what they had already chosen. The person appeared happier once they had a time to look forward to for lunch. Another person was asking the time their relative normally visited. They appeared reassured when they knew it was only a couple of hours hence.

Interaction between people living at the service and staff was not restricted to staff whose role was to give personal care to people. We observed staff from all departments having conversations with people. This included the domestic and laundry staff talking to people about their personal laundry and ways to clean bathrooms. The kitchen staff were observed asking people's opinions about the meal provided at lunchtime. Maintenance and administration staff had some in-depth conversations with people about the weather and people's well-being. Each member of staff had small pieces of information about each person which they could tell us about and also have conversations with the people.

In one area of the home where we were completing a SOFI we observed some people who were more anxious at times than others. Staff were immediately on hand to ease their anxiety by talking with them in a quiet, unhurried manner. In some cases staff were able to move onto another topic of conversation. This helped distract them from their anxiety, which was often repeated throughout the day, due to each person's different levels of memory loss. Staff exhibited a lot of understanding with some people as they repeated information many times throughout the day.

Throughout our inspection we saw that staff in the home were able to communicate with the people who lived there. The staff assumed that people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made. For example; one person wanted to stay in bed to rest that day. Staff listened to them, respected their wishes, but returned during the day to see if they had changed their

mind. We also observed staff knocking on bedroom doors before entering.

People told us staff treated them with dignity and respect at all times. One person said, "Staff respect my dignity when I have a bath, covering me up." Another person said, "Staff knock before coming into my bedroom." Staff told us about their roles as dignity champions and how the training they had undertaken had made them think of everyday tasks such as ensuring people were suitably dressed in communal areas. A dignity champion manifesto was on display. This outlined topics such as ways to show respect to people, engaging with family members and listening to people to help support them. Each staff member was then given the opportunity to write what being a dignity champion meant to them before signing the manifesto.

People told us they could have visitors whenever they wished. We saw several signatures in the visitors' book of when people had arrived at the home. Families visiting were offered refreshment and opportunity to speak with staff. This was recorded in the care plans. This ensured people could still have contact with their own families and they in turn had information about their family member. People told us staff would telephone their family members when they wanted to speak with them. A relative told us, "Weeks go by and we do not see [named family member], but we have no worries. The Bramley suite and staff are excellent."

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care could be supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display. There were no local advocates being used by people at the moment.

Good

# Is the service responsive?

## Our findings

The people we spoke with told us staff responded to their needs quickly. Some people could name the registered manager. One person said, "When I need them they are there." Another person said, "[Named staff member] offered to go with me to the hospital for my appointment, [Named staff member] didn't have to do that." Another person told us, "If I need a doctor or nurse they manage to get them to come here, which is better for me."

People told us staff had talked with them about their specific needs. This was in reviews about their care and questionnaires. They told us they were aware staff kept notes about them. People told us they were involved in the care plan process. This was confirmed in the care notes we reviewed. One person said, "My eyes aren't so good so staff will read notes to me." Staff knew the people they were caring for and supporting. They told us about people's likes and dislikes. For example, when they liked to go to bed and people's specific medical needs. This was confirmed in the care plans.

Staff also received a verbal handover of each person's needs each shift change so they could continue to monitor people's care. Staff told us this was an effective method of ensuring care needs of people were passed on and tasks not forgotten.

People told us staff had the skills and understanding to look after them and knew about their social and cultural diversity, values and beliefs. Staff knew how to meet people's preferences with suggestions for leading a full life. This means people have a sense of wellbeing and quality of life. Staff had used local resources in health and social care, plus the internet and information centres to ensure messages were received by people about health matters and local events.

People's care and support was planned in partnership with them. Staff used different ways of involving people so they felt consulted, empowered and listened to. People told us that staff took time each day to discuss their care and treatment. As well as the opportunity to speak with other health professionals.

Professionals' visits to the service say it was focused on providing person-centred care. On-going improvement is seen as essential by the management team and lessons learnt passed on to all staff. Social care professionals we had contact with before the inspection told us staff informed them quickly of any issues. They were confident staff had the knowledge to follow instructions and did so.

The service was flexible and responsive to people's individual needs and preferences, finding creative ways to enable people to live as full a life as possible. Arrangements were made for social activities. We observed a variety of activities during the inspection. This included a craft session where items were being made for a party in June to celebrate the Queen's birthday. The day had started with discussion about a newspaper called "The Daily Sparkle". This was a reminiscence session as well as discussing topics of the day. Notes to aid staff came with the paper. A number of people joined in and there was a lot of laughter and chatter. The day centre clients joined in some activities such as entertainments, which people told us they enjoyed.

Links were being made with the local community. Staff told us an outing was being arranged to a local social centre the following week to ensure people were not becoming isolated. People were given their mail during our inspection. Most could open and read their own. Where they could not do so staff read it for them, if that was what they wanted. However, we did bring to the registered manager's notice that we had observed a staff member reading a letter back to a person in a very loud voice, in a communal area. The registered manager took action with that staff member to remind them of the provider's policy on dignity.

People are actively encouraged to give their views and raise concerns or complaints. People's feedback is valued and concerns discussed in an open and transparent way. People told us they were happy to make a complaint if necessary and felt their views would be respected. Each person knew how to make a complaint. No-one we spoke with had made a formal complaint since their admission. People told us they felt any complaint would be thoroughly investigated. We saw the complaints process displayed and this was in word format, but the registered manager knew where to obtain other types of formats; such as different languages, quickly.

The complaints log detailed the formal complaints the manager had dealt with since our last visit. It recorded the details of the investigations and the outcomes for the complainant. Lessons learnt from the case had been passed to staff at their meetings in 2015.

Good

# Is the service well-led?

## Our findings

There was a registered manager in post. People told us they were well looked after, could express their views to the registered manager and felt their opinions were valued in the running of the home. One person said, "The manager will talk to anyone, she is very approachable." Another person said, "All the staff are friendly, but I do like the manager."

People who lived at the home and relatives completed questionnaires about the quality of service being received. People told us they had completed questionnaires. The last questionnaire had been in November 2015 for people who used the service. Each part of the questionnaire had positive outcomes.

Staff told us they worked well as a team. One staff member said, "I just still love working here." Another staff member said, "Everyone gets on so well." Staff told us they supported each other, but were supported by the registered manager, the quality care manager and other staff. They said the registered manager talked to them and they felt their opinions were valued.

Staff told us staff meetings were held occasionally. They said the meetings were used to keep them informed of the plans for the home and new ways of working. We saw the minutes of the staff meeting for April 2016. The meeting had a variety of topics which staff had discussed, such as; changes to daily evaluation records and other care records. This ensured staff were kept up to date with events. Staff told us they felt included in the running of the home. This was reflected in records seen. Feedback on the processes described in the early part of April 2016 were fed back in minutes we saw for later in April 2016 and May 2016.

The registered manager and quality care manager was seen walking around the home during our inspection, plus being in the office dealing with audits and answering the telephone. They talked with people who used the service and visitors. They could immediately recall items of information about each person. They gave support to staff when asked and checked on people's needs.

There was sufficient evidence to show the registered manager had completed audits to test the quality of the service. These included medicines, care plans, infection control and equipment. Where actions were required these had been clearly identified and signed when completed. Any changes of practice required by staff were highlighted in shift handovers so staff were aware if lessons had to be learnt. A complete policy review took place each year and staff were directed to those polices which had changed. The registered manager and provider also looked at national good practice guidance in areas such as dementia care so they could implement this within the home.

The registered manager, on different days throughout the year, completed an observation of staff interactions with people. This was recorded and we saw the details of the observation for February 2016. This covered when staff were helping people join in activities and staff attending to people's personal needs. Feedback was given verbally to staff after the observation. The registered manager told us this was a good way for her to observe staff interaction as she blended into the back ground and staff "got on with the job".

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The registered manager understood their responsibilities and knew of other resources they could use for advice, such as the internet and local multi-agencies.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The registered manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.