Care Quality Commission

Anchor Trust

Norton House

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

We carried out this unannounced inspection on 24 and 25 January 2017. At our last inspection in November 2014 we rated this service "Good". At this inspection we found that the service remained "Good."

Norton House is a residential care service for up to 40 older people and people living with dementia. The service provides care over four floors, each of which has an accessible bathroom and shared living and dining room. On the ground floor there is a large communal dining room. On the first floor there is a short-term rehabilitation unit. At the time of our inspection there were 39 people using the service.

The service had a registered manager. 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 received personalised care through a detailed system of assessment and review, which ensured that people's wishes and preferences about their care were taken into consideration. People were supported to speak up, for example through regular residents' meetings, and through a yearly consultation to ensure people were happy with the service. Where people had made complaints, the provider had taken steps to ensure that these were appropriately investigated and responded to.

People had consented to their care and their choices were respected. The provider was meeting its responsibilities to assess people's capacity and to apply to the local authority when people may be deprived of their liberty. Managers did inform the Care Quality Commission when this had taken place.

People told us they found staff kind, helpful and caring, and that they were treated with dignity and respect. There were measures in place to ensure people received good nutrition and access to health services. There was a programme of training and supervision in place to ensure staff had the appropriate skills to carry out their roles.

Managers had systems of audit to ensure that the service was well-run. There were effective health and safety checks to ensure the building was safe, however the risk to people from using the stairs was not managed effectively. The provider had steps in place to safeguard people from abuse, and had risk management plans in place to mitigate risks to people, however in some cases these required revision. Medicines were safely managed and administered by staff with the skills to do so, and there were internal and external systems of checks to ensure this was carried out correctly.

We have made a recommendation about how the provider manages risks to people who use the service from using the stairs.

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 safe in all respects.

People were protected from abuse by safeguarding procedures. The provider had assessed the risk to people who used the service, however in some instances these risk assessments did not fully address these risks, and people may have been at risk from being able to access the staircase.

People received support from sufficient numbers of staff who were suitable for their roles.

Medicines were safely stored and administered, and there were measures to ensure staff were able to do this competently.

Is the service effective?

Good

The service was effective. Staff received suitable induction, training and supervision to enable them to carry out their roles.

People had consented to their care plans and the provider had assessed whether people had capacity to make decisions.

People received appropriate support with regards to maintaining their health and receiving appropriate nutrition.

The building was adapted to meet the needs of people living with dementia.

Is the service caring?

Good

The service was caring.

People told us their care workers were kind and caring and promoted their independence and dignity. Staff spoke of how they worked to promote people's dignity and privacy.

The provider supported people to speak up through the use of communication plans and residents' meetings.

Is the service responsive?

Good

The service was responsive.

Care plans were personalised to meet people's needs and contained detailed information on people's needs, wishes and life stories. Care plans were reviewed monthly by staff.

There was a varied activities programme in place, which people told us they enjoyed.

Complaints were appropriately recorded and investigated by the registered manager, who had apologised when appropriate.

Is the service well-led?

Good

The service was well led.

People told us they were asked for their views by managers, and staff told us managers were visible and supportive.

There were measures in place for ensuring the service was running well. This included an independent survey for people who used the service and care workers, a monthly system of checks by the registered manager and quarterly audits.

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Norton 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 24 and 25 January 2017 and was unannounced on the first day. On the second day the provider knew we would be returning.

The inspection was carried out by an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we carried out this inspection, we checked information we held about the service, including notifications about significant events which the provider is required to tell us about. We asked the provider to complete a Provider Information Return (PIR) prior to our inspection. The PIR is a report that providers send to us giving information about the service, how they met people's needs and any improvements they are planning to make. We contacted two local authority contracts officers for their views about the service, but did not hear back from them.

In carrying out this inspection we spoke with 10 people who used the service and three relatives who were visiting the service. We carried out observations of mealtimes and activities, and spoke with four care workers, a team leader, the registered manager, area manager and three visiting health professionals. We reviewed records of care relating to four people who used the service, five people's medicines records and five care workers' personnel files. We also reviewed records relating to the running to the service, including audits, records of training, engagement with people who used the service and rotas.

Requires Improvement

Is the service safe?

Our findings

People who used the service and their relatives told us they felt safe. Comments included "Yes I do feel safe, the staff are lovely" and "The carers make me feel safe here."

Staff had received training in safeguarding adults and told us about the possible signs of abuse and understood their responsibility to report any concerns. Staff were very clear with us that managers would act on their concerns, comments included "Of course they take it seriously" and "They're so hot on this." Where abuse was suspected, the provider had met their responsibilities to notify the local authority and the Care Quality Commission (CQC), and had carried out an investigation.

The building had a front desk which was staffed during the day time. Staff told us that they covered the front desk as needed, and that they had an alarm system to notify them when the door was opened. The provider told us that they had requested that CCTV was put in place following an incident where a person had left the building without staff being aware. The provider carried out a series of health and safety checks, which included carrying out weekly checks of water temperatures and window closers, and flushing disused water outlets. There were monthly checks carried out of safety pendants, wheelchairs and safety equipment, with a schedule in place to ensure these checks were carried out.

However, some staff raised concerns about the doors which opened out into the stairwell at either end of each floor. These were unlocked and did not make a noise when opened, which meant there was a possibility that people who could not use the stairs safely could walk out to the staircase, and in the event of a fall may not be able to call out for help. A team leader told us "We try to discourage people from using the stairs, if they have to they inform staff, if they fall it's deadly." The provider told us that most people did not use the stairs, and where necessary there was a risk assessment in place for people who walked around the building, including checking on certain individuals every 15 minutes. Care workers confirmed that this was the case, but added that they felt concerned that people may still use the stairs unnoticed. Comments included "I feel so worried when they use the stairs, we need to be vigilant" and "it worries me all the time." In response to our concerns the provider told us they intended to fit locks to these doors and to provide a code to people who could use the stairs, and that people would still be able to use the lifts independently.

We recommend the provider take advice from a reputable source on how best to manage the risk of people using the stairs whilst ensuring that people's rights are not restricted.

There was an emergency evacuation plan displayed throughout the service, and evacuation equipment in place on the stairwell. Each person had a personal emergency evacuation plan (PEEP) in place on their file, which was reviewed monthly and clearly indicated whether the person was able to self-evacuate at present; a summary of these was kept up to date and stored in the main office. The provider carried out fire drills three times a year and carried out a series of fire safety checks, including daily checks on escape routes, emergency lights and firefighting equipment, and weekly checks of fire call points.

When people moved into the service, the provider carried out a detailed assessment of people's mobility

needs, including assessing for each area of function, whether the person required mobility aids, whether they required assistance and the number of staff required to do this. This included assessing people who did not usually use a hoist in cas one was required to get up from the floor in the event of a fall. There was a detailed falls procedure in place for staff to follow, which included checking for injuries and supporting people to get up in the event they were not injured, which reduced the risk of staff calling an ambulance unnecessarily. The provider had carried out falls risk assessments for people who used the service, and scored the risk based on factors such as whether the person had fallen in the last year, if they became agitated or confused, had visual difficulties or required support to stand up or mobilise. If people were identified as being at risk of falls, the provider completed a falls prevention plan, which included addressing relevant medical factors, the person's clothing and environment. Staff had recorded what action had been taken to manage the risk. In one case, we saw that a person required two staff to carry out personal care. Care workers and the registered manager told us that this was taking place, however staff had not always signed to record that two staff had supported this person.

Where incidents had taken place, including falls, these were recorded by staff, including what events had led to the incident and what outcomes had taken place, and staff had taken appropriate action in addressing falls. The provider used this information to complete a monthly falls monitoring report, which included an analysis of risks and trends and any people who may be at particular risk, including the location and time of day. This reported any action taken, including whether the risk assessment had been updated and reviewed in response.

People had skin integrity plans in place, based on the Waterlow score. The Waterlow score gives an estimated risk for the development of a pressure sore in a given person. These included clear guidelines for staff, such as what equipment was in place and whether the person needed to be repositioned regularly. However, one person's assessment showed that they needed to be repositioned every three hours, but their pressure sore had healed and this was no longer taking place; the provider told us that this risk assessment needed updating. A monthly pressure ulcer audit was carried out, including a summary of which tasks were carried out by the district nurse for each person. The provider carried out competency assessments for all staff, which required care workers to demonstrate their knowledge of when a person may be vulnerable to pressure sores, when a care plan was needed and when care workers needed to consult with health professionals.

Where people were at risk of choking, this was clearly identified in the care plan and measures were put in place with the support of health professionals, including supervising people when eating and providing people with a soft food diet and using thickeners in drinks. Staff we spoke with knew which people were at risk of choking and understood these measures, and were able to demonstrate how they would respond if a person choked, including administering immediate first aid and calling for help. Risk assessments covered risks to particular individuals. For example, where one person was at risk of falling out of bed, this had been documented along with control measures such as ensuring the bed was as low as possible, the person was checked during the night and that crash mats were placed appropriately.

Each floor had a shared bathroom with a lifting bath, which had been serviced recently and contained a built in temperature setting. There were thermometers in place for staff to check the water temperature before bathing people and a clear process to follow, and staff had documented that they had carried out these checks. This meant that people were protected from the risk of scalding.

People who used the service and care workers told us they thought there were enough staff on duty. People had call bells in their rooms and told us that staff came promptly when they called. Comments included, "Quick response", and "They do come when I call the bell, the response is fast." Call bells were checked

regularly at night when night checks took place, and staff told us they were able to call for assistance from colleagues without leaving the room due to having a system of cordless phones. The provider had carried out an assessment of dependency and determined they required two staff on each unit, and one at night. We reviewed rotas for a three week period and saw that this was in place daily, with no use of agency staff.

The provider had measures in place to ensure that staff were suitable for their roles. This included obtaining references from previous employers, valid identification such as a passport and proof of the person's right to work. Before starting work, staff were checked with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, in order to help providers make safer recruitment decisions.

Where people were supported to take medicines, we saw that these were recorded and stored safely. Medicines were stored in locked cupboards on each floor, and staff recorded the temperature of these rooms to ensure they were safe. We checked medicines recording charts (MRCs) for five people over a three month period, and saw that medicines were accurately recorded throughout. MRCs were checked on each daily handover, and monthly audits of medicines were carried out, which were used to check stock levels against what was delivered, what was administered and what remained. These did not reveal any discrepancies, however in some units they did not take place in November and December. The provider told us that this was due to staff absences. In addition to these audits, an external audit was carried out by a pharmacist twice yearly. Where recommendations were made, such as the need to carry out regular quantity checks or to ensure that variable doses were recorded on MRCs, we saw that these had been implemented.

The provider had carried out risk assessments relating to people's medicines, these included recording possible side effects from certain medicines and highlighting which creams were flammable and recording measures to address the risks from these. Risk assessments also included home remedies and medicines which people self-administered, including whether they were stored safely. However, in one instance we saw that a person regularly drank alcohol and self-administered painkillers, which was not addressed by the medicines risk assessment. Care plans outlined the role of staff in administering medicines and the role of external professions such as district nurses, who administered insulin and controlled drugs.

Prior to administering medicines care workers received training in the care of medicines, and managers carried out assessments of staff competency to carry this out. This included the need for hygiene, safe storage, demonstrating that they were able to confirm medicines were given to the right person and recorded safely, and ensured staff knew what to do in cases where people self-administered their medicines or refused medicines. Staff had answered these in detail. The provider's policy was for staff to be observed at least five times administering medicines, however although all staff had been observed doing this, in some cases this was only done once or twice.

Good

Is the service effective?

Our findings

People received care from staff who had received appropriate training and supervision to carry out their roles. The provider maintained an up to date list which showed that over 90% of staff were fully up to date with mandatory training. This included safeguarding adults, personal planning, nutrition and hydration, moving and handling, mental capacity, food safety, health and safety, fire safety, equality and diversity, dementia awareness and infection control.

Staff we spoke with were complementary about their training and the way this was monitored by managers. Comments included "The trainings are useful", "We have enough training", and "If you don't do your training they will remove your name from the shift." We spoke with staff about their inductions, and they told us that this included a tour of the building, including health and safety issues, and online training such as dementia awareness. Staff told us that they were happy with the support they received from managers and their colleagues on joining the service. New staff were required to undertake the Care Certificate which is the new minimum standards that should be covered as part of induction training of new care workers and was developed jointly by Skills for Care, Health Education England and Skills for Health.

All staff had a nominated supervisor, although we found that the frequency of supervision varied based on team leader. For example, some staff received supervision six times per year, whereas others had received three in the year, which was in line with the provider's requirements. Care workers told us they were happy with the level of supervision they received. All staff also received an annual appraisal, which was used to review care worker's performance and to identify training and development needs.

The provider was meeting its requirements under the Mental Capacity Act 2005 (MCA). The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

As part of the assessment carried out when people moved into the service, the provider assessed whether people had the capacity to consent to their care and if they were subject to any legal orders or had a lasting power of attorney (LPA) in place. The provider had recorded when people had consented to their care plans, and where it was not clear whether people had capacity, they had undertaken a mental capacity assessment.

The provider told us that only one person at present was subject to DoLS. The provider had applied to the local authority where it was thought people's care may place restrictions on their movement and had notified the Care Quality Commission (CQC) when these applications had been granted.
People had nutritional care plans in place, and where people had nutritional needs the provider had

recorded what these were, whether they had consulted with a dietitian, put a diet plan in place and notified the chef. The provider used the Malnutrition Universal Screening Tool (MUST) to assess when people might be at risk of malnutrition, and people's weights were recorded weekly when this was the case, and recorded and reviewed measures in place to manage this risk. Care plans also included detailed information about people's needs and preferences, for example what they liked to have for breakfast, how they liked drinks prepared and where they preferred to eat.

People told us they liked the food and felt well supported in this area. Comments included, "The food is alright, I like it", "They know what I like and dislike, this just makes everything easier" and "I get enough drinks during the day."

We saw that drinks were available at all times around the building and in people's rooms. People were given a choice of what soft drinks they wanted. There was a varied and nutritional menu in place, which was checked for any specific dietary requirements. We observed lunchtime, and saw that care workers offered people choice based on this menu, but also allowed people to order other items and whether they chose to eat in their rooms, the communal areas upstairs or the main dining room. We saw staff offering patient encouragement to people to eat by themselves or to provide assistance when necessary. The food was of a good quality and attractively presented, and people we spoke with enjoyed their meals.

On admission to the service, people were assessed for health needs, including allergies, past and present conditions and swallowing difficulties. On arrival staff completed baseline observations promptly in most cases, and these included height and weight, MUST and Waterlow scores. They recorded whether the person had a do not attempt cardio-pulmonary resuscitation (DNACPR) order in place and what their end of life wishes were. The provider kept detailed logs of when people had received medical attention, such as contacting the GP when people felt unwell or contacting a dietitian when people were losing weight. There was evidence that health professionals were involved in planning people's care, this included dietitians and speech and language therapists.

The design of the building was suitable to meet the needs of people who used the service. For example, floors were colour-coded to aid people's navigation around the building, and the provider had installed a dementia friendly lift. This provided information about what floor the person was on, what was on each floor, and provided a chair, clock and calendar to enable people to remain orientated. Areas of the building such as the lobby and transition unit had been recently refurbished. The registered manager told us "We have tried to make it more homely, it was quite medical previously". The provider had also created lounges and dining areas for people to sit and relax, on each floor. There was unobtrusive music playing softly in communal areas.

Good

Is the service caring?

Our findings

People we spoke with were very positive about their care workers. Comments included, "They are lovely", "They are really good, respectful and kind", and "I think they are great and really caring." Visiting professionals told us, "They seem quite helpful in general", and "Staff are very friendly and approachable." All staff were wearing name badges and uniforms.

Staff told us they thought the staffing had become considerably more stable in recent years, which enabled them to get to know people better. Comments included, "I always work on the same floor, our manager wants us to be well known" and "Most of the customers are very happy, we do chat with them a lot." One care worker told us that they had recently supported one person to attend a funeral, and said "They wanted to come with me to be close to me." Another care worker told us "There's always going to be something missing as it's not their home, but we try and do our best."

Most people we spoke with told us that they were asked for their opinions, particularly through a monthly residents' meeting. One person said "We have regular meetings so we can say what we think."

We observed a residents meeting which had been scheduled for the unannounced day of our inspection. We saw that people were given a choice about whether to attend or to remain in their rooms or lounges. The meeting was well-organised, and staff distributed a planned agenda to people and provided refreshments. We saw that people were able to discuss their views one by one and as a group discussion, and that everyone had the opportunity to speak up.

There was a board in the lounge which clearly displayed information from the previous meeting, including what people had said, and what managers had done in response. For example, in the previous meeting, people had said that they were not sure who was assigned to support them at mealtimes, and it was agreed that staff will introduce themselves to people at the start of their shifts. Minutes of previous meetings showed that people had spoken up about other concerns about the service, for example which activities were taking place and providing hot water for drinks, and that managers had taken steps to address these, for example by displaying activity timetables throughout the building. People had also requested a more pleasant area for sitting outside and for smoking, which had been provided, including chairs, tables and a gazebo, and we saw this in use during our visit.

We saw records including photographs of a cake making activity prior to Christmas, where people were given options on what type of Christmas cake they wanted, and were supported to cook and decorate this in line with their wishes. We also saw pictures of a person's recent 100th birthday party, which they had organised with their family and staff.

As part of the residents meeting, the provider also carried out a food tasting activity which we observed. As part of this, people were encouraged to try items from the upcoming menu and to give their views on the food. We saw that people seemed to enjoy this activity and there was good interaction between people and their care workers, although we observed that the food was all served on one plate and did not appear well

presented.

The provider also supported people to speak up by compiling personalised communication plans. These highlighted for staff the support people needed to communicate effectively, such as the use of hearing aids and glasses and highlighted when people were quiet talkers and required staff to listen particularly carefully.

People told us that staff respected their privacy and dignity and promoted their independence. Comments included, "Yes, they just help when we need it", "I get enough help, but they don't overdo it" and "They do respect my privacy and dignity, they always close the door and the curtain." Staff we spoke with gave examples of how they promoted people's privacy, for example by closing doors and ensuring nobody came into the room when giving personal care. Comments included, "Those who can do it themselves we remind them" and "We always give the opportunity to make choices."

Good

Is the service responsive?

Our findings

People who used the service told us that they were given choices about their care. Comments included, "Yes, at all times, if I want to stay in bed or not" and "One hundred percent." A relative told us "I am sure they are provided with choices at all times."

There was a thorough system of assessment and care planning which promoted personalised care. Comments from care workers included, "There's enough information on care plans to get to know people", and "I did one week of reading care plans." Care plans covered areas such as sleep and rest, emotional and psychological needs and religious and cultural needs. For example, the sleep and rest care plan gave detailed information on people's night-time routines, including how many pillows they needed, how they wanted their beds arranged, what time they wanted to go to bed and how often they wanted staff to check on them at night. Staff recorded that these checks were taking place and made observations on their wellbeing, and whether they had slept or were out of bed.

There was information about people's cultural needs, such as their religion and their level of involvement. This included whether people had needs relating to their diet or washing due to their religion, and whether they wanted to be supported to attend a religious service or to pray. Comments from staff included , "Here we are not biased" and "We have done LGBT [Lesbian, Gay, Bisexual and Transgender] training to make sure people have their views respected", and "This is their home, we have to make sure that they are comfortable here."

Care plans also documented records of discussions about people's wishes for the end of their lives, including whether they would like to stay in the service, whether they had made a will, whether they had any specific religious observations to be carried out at the time of their death and who should be contacted in the event of their death.

Care plans were reviewed monthly, and these recorded whether people's needs had changed, and whether there had been improvements in their conditions, and whether they felt more settled in the service.

People we spoke with were generally complimentary about the activities programme. Comments included "I like to read and do singalongs, I don't think I get bored here" and "The activities co-ordinator is just great." One person said "Sometimes we need more." There was an activities programme for the month displayed in each floor. Weekly activities included singing and dancing, the hairdresser, a cinema night, dominoes and physical exercises, and there was a fortnightly Christian service which alternated between Catholic and Church of England services. There was also a fortnightly visit from a local animal charity which brought dogs to the service, and a local charity that organised a monthly cocktail party.

All people had a life story document, which included information about the person, including previous occupations, family life, their likes and dislikes and wishes for the future. In some cases, people had signs on their door relating to their previous occupation. The provider told us they were in the process of implementing a more detailed life story book, which contained pictures relevant to the person's life story,

family history and place of birth, and we saw that six of these had been completed so far.

Most people we spoke with told us that they had someone to advocate for them, such as a friend or family member, and those that did not told us they were confident they could get one if they asked. The provider told us that people subject to Deprivation of Liberty Safeguards (DoLS), had independent advocates, and that they had befrienders from Age Concern who worked with other people.

The provider had a system in place for recording and investigating complaints. Most people told us they knew how to complain and said they would speak to their family members or staff if they had concerns. Comments included, "I don't have any problems, and think it would be dealt with accordingly" and "I would speak to the manager." The registered manager had recorded when complaints had been received, together with a clear explanation of the investigation and outcome. This showed that complaints had been investigated appropriately, and had apologised when necessary. A care worker told us "Everything is discussed."

Good

Is the service well-led?

Our findings

People we spoke with told us that they were asked for their views by managers, although not everyone knew who the registered manager was. Staff were complimentary about the support they received from their managers. Comments included, "The manager is very calm, very competent", "The manager is always on the floor" and "If someone is in difficulty the team leader and manager come and help."

The provider commissioned a yearly satisfaction survey for people who used the service, which was carried out by an independent organisation. This showed that people were satisfied with the service, felt understood as individuals by staff and that staff were available and had time to speak with them. There was also a similar survey for staff, which showed people were satisfied with their jobs, had access to information they required and had the appropriate skills and knowledge. About a third of staff responded that they did not feel optimistic about their futures and did not feel consulted before changes were made. Staff told us they were happy in their jobs, with comments including, "I find this place good to work in" and "I enjoy working here." However, some staff told us they struggled with changes made by the provider with limited consultation.

Managers provided leadership through a weekly staff handover meeting, which was used to update staff on people's needs, to clarify staff responsibilities and to listen to staff concerns and suggestions. There was a daily handover in place for team leaders to share information relating to people who used the service, including appointments and to carry out checks of medicines. Additionally, the registered manager had recently introduced a "10-10" meeting, which was to be carried out mid-morning between senior staff in different departments, and was used to share information between units and departments, and to discuss any planned reviews, maintenance , housekeeping, training, activities and safeguarding matters. The registered manager told us these were to be carried out daily, although this was not taking place at present.

The provider had a clear statement of their values, which were displayed in the training room and in other parts of the building. This included personal accountability, reliability, respect, honesty and to be straightforward. The provider operated a Lesbian, Gay, Bisexual and Transgender network for staff, and there was an advert for the next meeting displayed on the front door.

Managers had tools in place to ensure the service was well-led. The registered manager completed a monthly checklist, which included carrying out checks of training, incidents and accidents, fire drills and checks of equipment including bedrails. Additionally, the provider had implemented a quarterly "excellence tool". This required the registered manager to complete a detailed audit of the service in terms of health and safety, catering, compliance with regulations, quality assurance, property, customer surveys and improvement. Managers were required to verify that 10% of personal plans were audited monthly and that complaints were appropriately dealt with and closed. This information was then corroborated by the district manager on a visit to the service, and signed off if correct. This meant that managers had a clear picture of the performance of the service.

Managers were meeting their responsibilities to inform the Care Quality Commission (CQC) of significant

events which affected the service, such as serious injuries and allegations of abuse.