Oakfield Psychological Services Limited

Wellfield

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The published date on this report is the date that the report was republished due to changes that needed to be made. There are no changes to the narrative of the report which still reflects CQCs findings at the time of inspection.

About the service
Wellfield is a residential placement for young people aged 13-17-years with complex emotional, mental health and behavioural needs, as well as neuro-developmental disorders that require specialist psychological therapy and intervention. The provider can accommodate two young people at a time. The provider is currently registered with the Care Quality Commission (CQC) as a care home, for the regulated activities of 'accommodation for persons requiring nursing or personal care' (ANPC) (a regulated activity relating to adults aged 18 years and over) and 'treatment of disease, disorder or injury' (TDDI). Wellfield does not provide a service for adults, it is a service 'wholly or mainly for children', and functions as a children's home. As such, the regulation of accommodation and care provided by Wellfield is the responsibility of Ofsted, as the regulator for children's homes.
At the time of our inspection there were two young people using the service.

People's experience of using this service and what we found
Young people were treated with kindness, compassion and respect by staff. We observed positive interaction between staff and young people, which supported dignity and respect.

Environmental risk assessments were individualised and incorporated into young people's care plans.

Staff supported young people to explore and embrace their identity and provided care that was sensitive to equality and diversity.

Young people received thorough and detailed assessments, plans and interventions that were individualised to their needs and risks.

All staff at Wellfield were trained in minimum level 2 safeguarding children eLearning, with all leaders and staff involved in care planning trained to level 3. Each level required the successful completion of an assessment for the staff member to be signed off as competent. This level of training was compliant with Intercollegiate Guidance (2019).

Staff had all received accredited training in positive behaviour support and restraint at advanced level before carrying out any direct work with young people.

Young people living quarters were maintained to a good standard or repaired in a timely manner when damage occurred. They had choice and control over the décor of their accommodation.

The management and organisation of most record keeping in Wellfield was good. Recording of medicines administration and the disposal of medicines was not always completed in line with the service's own guidance and protocol. For example, we saw instances where only one staff member had signed to confirm administration and disposal of medicines, limiting the assurance that young people received their prescribed medicines in a safe, and effective manner; and also not preventing the misuse of unused drugs.

Incidents were not always notified to CQC in accordance with regulatory registration. We found an example where a member of staff had been removed for professional misconduct whilst at work and several examples where notifications were not completed in a timely manner.

We expect health and social care providers to guarantee autistic young people and young people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The provider was able to demonstrate how they would meet the underpinning principles of Right support, right care, right culture:

Right support: Model of care and setting maximises young people's choice, control and independence. The provider adopted the least restrictive practices underpinned by a positive behaviour approach. Right care: Care is person-centred and promotes young people's dignity, privacy and human rights. Staff knew young people well and responded to them appropriately and sensitively. Young people took part in activities and pursued interests tailored to them. They gave young people opportunities to try new activities. Staff acted appropriately as advocates for young people when they were best placed to do so.
Right culture: Ethos, values, attitudes and behaviours of leaders and staff ensure young people accessing facilities lead confident, inclusive and empowered lives. Staff understood young people well. They got to know them and considered this a key element of personal care.

Young people were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Any courts orders depriving them of their liberty were adhered to.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this provider was requires improvement (published 11 March 2021) but was not in breach of regulations.
At our last inspection whilst improvements had been made, the provider was not yet able to demonstrate over a sustained period that management and leadership was consistent, or that staff practice led to good outcomes for young people.
There was no registered manager in post. We were assured that staff would continue to receive oversight from the provider and other members of the senior management team until another manager was appointed.
At this inspection we found management and leadership was much improved with a registered manager now in post.

Why we inspected

We undertook a full inspection of this provider prompted by a review of the information we held about this it.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Wellfield on our website at www.cqc.org.uk.

Enforcement

We have identified breaches at this inspection and have issued a requirement notice

You can see the actions we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was effective. Details are in our effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our responsive findings below	**Good**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below	**Requires Improvement**

Wellfield

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
This inspection visit was carried out by two inspectors from the Care Quality Commission.

Service and service type
Wellfield is a residential children's home that provides therapeutic psychological support to children and young people with mental ill health and neuro-developmental disorders.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced which means that that the provider was unaware of the inspection until we arrived on site.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke to staff members, including managers, as well as members of the senior leadership team. We also spoke to external stakeholders who were involved in the care that was being delivered to the young people living at Wellfield.

We did not speak to young people as they we at school or did not wish to speak with us.

We reviewed information during the visit, such as policies, procedures and personal records. The provider also sent us information following the inspection visit.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Young people at Wellfield were cared for by staff who had access to a range of policies, procedures and guidelines to support them in their practice. Staff knew what policies were available to them and how to access them.
- Young people at Wellfield were protected by robust and bespoke environmental risk assessments that considered immediate and future risk. Each young person had complex but diverse needs and risks that staff understood well, and the risk assessments were personalised to their individual requirements. This ensured that their safety was central to the planning and arrangement of the accommodation.
- All staff at Wellfield were trained in minimum level 2 safeguarding children eLearning, with all leaders and staff involved in care planning trained to level 3. Each level required the successful completion of an assessment for the staff member to be signed off as competent. This level of training was compliant with Intercollegiate Guidance (2019).
- We saw evidence of staff awareness regarding the risks from internet use, including sexual exploitation. There was a signed agreement between the provider and young person, stipulating restrictions on the use of technology to maximise e-safety.

Assessing risk, safety monitoring and management

- Environmental risk assessments were individualised and incorporated into young people's care plans. When risks of injury were identified from fixtures, fittings and furniture being used as weapons or for self-harm, appropriate and timely action was taken. There were ligature points noted throughout the building, and these had been appropriately assessed as low risk for the young people living at Wellfield at the time of our inspection. This demonstrated a commitment to identifying and mitigating risks to keep young people and staff safe.
- Fire risk assessments were up to date and safety equipment such as fire extinguishers were available. Fire safety signs were in the buildings and staff we spoke with knew what actions to take in the event of fire.
- 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 MCA 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.

Young people over 16 can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In certain homes, this is usually

through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a young person of their liberty. Conditions related to DoLS authorisations were being met.

Staffing and recruitment

● Staff at Wellfield were recruited in line with safer recruitment principles. Processes included checks with the disclosure and barring scheme (DBS), reference checks, induction and appraisal conversations that provided the opportunity for reflection and challenge. Not all staff were aware whether they had signed up for DBS auto-renewal, but this was the expectation. None of the staff employed at the time of the inspection were due to have a repeat DBS check as required every three years.

● Staff were well supported to do the right thing by clear guidance and training. In addition to a range of formal policies, there were systems and processes in place. The introduction of 'resilience workshops' gave staff a safe space to share the emotional challenges they faced through undertaking such challenging and demanding work.

● The staff at Wellfield cared for young people with complex emotional, mental health and behavioural needs. They had all received accredited training in positive behaviour support and restraint at advanced level before carrying out any direct work with young people. The training was certified under Restraint Reduction Training Standards and taught staff how to ensure the least restrictive form of safe intervention was used, this included offering support through sensory items and beanbags, for example.

● Staffing rotas were published in line with the ratios stipulated in young people's court orders and individual care plans as agreed with the multi-agency teams. Furthermore, there was a senior manager on call 24 hours a day.

Using medicines safely

● The safety of the young people at Wellfield was supported through clear and detailed medicines management processes and guidance. All medicines were externally prescribed and reviewed.

● Medicines were stored in a locked cupboard away from the young people's accommodation. Medicines management and reconciliation records were comprehensive and when completed, ensured enough oversight and assurance that medicines were maintained and monitored appropriately.

● There was a clear process for recording and learning from administration errors, although there had not been any errors at the time leading up to the inspection. Such robust processes supported staff to practice in a safe manner.

● Processes were clear and understood by staff, however, adherence to these procedures was inconsistent. The medicines management records pertaining to the young person in the 'Pines' part of Wellfield were fully completed.

● Conversely, we could not be assured that the records for the young person in the 'Acorns' were accurate or consistently completed in accordance with the service's medicine's management policy and accompanying guidance. For example, we saw instances where only one staff member had signed to confirm administration, disposal or stock take of medicines. This had previously been highlighted by the registered mental health nurse (RMN) who completes regular medicines audits for the provider.

● We also observed one staff member dispose of medicines incorrectly, against the provider's clear protocols.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of young people and others, as the provider could not ensure staff followed their policies.
This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

● There were effective arrangements for the prevention and control of infection. Staff had access to infection prevention and control (IPC) policies and training, and leaders had completed monthly health and safety and IPC audits.

● All communal areas of the home were visibly clean. This included the lounge, dining room and kitchen areas. Appropriate cleaning equipment was available for staff to use and this was kept securely to keep young people safe.

Learning lessons when things go wrong

● Wellfield had an effective Comments, Compliments and Complaints Policy which included a system for recording and acting upon complaints. There had been no complaints made by young people or their families since the last inspection so we could not assess if the system was effective.

● Incident reports had informed discussions at weekly staff and manager meetings. Alternative management options were explored to identify learning and actions to further improve practice.

Good

Is the service effective?

Our findings

Our findings
Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating has changed to Good.

This meant young people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments and care plans completed by staff at Wellfield were comprehensive, holistic and dynamic. We saw in our review of records, how they were completed, developed and updated collaboratively with young people, families, multi-disciplinary and multi-agency professionals.
● Plans clearly articulated young people's short, medium and long-term goals and aspirations. These included for example, preparation for adulthood by promoting skills and independence through retaining control and responsibility, with support, for the living environment.

Staff support: induction, training, skills and experience
● Young people living at Wellfield had complex emotional, mental health and behavioural needs, as well as those displaying traits consistent with autism spectrum disorder. They were cared for by staff who had a variety of skills, experience, and training in order to deliver effective care and support.
● Staff were supported to learn through a comprehensive induction programme and mandatory training eLearning package. They had all received accredited training in positive behaviour support and restraint at advanced level before carrying out any direct work with young people.
● Some staff had received training at advanced level and the training was certified under Restraint Reduction Training Standards and taught staff how to ensure the least restrictive form of safe intervention was used, this included offering sensory support.
● Staff were well supported to do the right thing by clear guidance and training. In addition to a range of formal policies, there were systems in place. For example, 'The Golden Book' which broke down the expectations of each staff member on each shift, including handover, medicines management and individual responsibilities. Another example was the 'Boundary Document' for each young person. This highlighted statements the young person might make if they did not want to engage with something, and suggested responses for the staff members in order to increase engagement with minimal risk of escalation.

Supporting people to eat and drink enough to maintain a balanced diet
● Young people had access to their own kitchens at Wellfield. Staff considered cultural needs and encouraged healthier food choices when supporting young people to choose and shop for their own food.

Staff working with other agencies to provide consistent, effective, timely care
● There were strong working relationships between the staff and leaders at Wellfield and some multi-

disciplinary and multi-agency professionals who were external to the service. For example, we saw valuable information sharing and liaison with social workers and GPs.
● CAMHS (Child and Adolescent Mental Health Service) were less effective at engaging with Wellfield. Records (CAMHS tracker) demonstrated Wellfield's repeated attempts to engage with external professionals.

Adapting service, design, decoration to meet people's needs
● Young people at Wellfield had choice and control over the décor of their accommodation. Furniture, fixtures and fittings were bespoke to meet the differing needs of each young person. For example, where a young person had history of demonstrating behaviours that resulted in damage, weighted and reinforced furniture was sourced. Furthermore, sensory areas were provided to meet individual young people's needs.

Supporting people to live healthier lives, access healthcare services and support
● Young people were supported to access their GP, the dentist and hospital appointments when required.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. This is done by the Court of Protection for children and young people who are under 18 years of age.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Young people at Wellfield were lawfully deprived of their liberty through the issue of orders by a High Court Judge. Records confirmed how care was provided in accordance with the stipulations of the court orders.
● Despite court orders overriding the legal requirement for consent by the young people at Wellfield, records clearly demonstrated how young people and their families were positively involved in care planning. Young people had signed contracts agreeing to a range of situations and circumstances to keep them safe. These included time restrictions on internet use and the requirement to be always accompanied by staff when leaving Wellfield. This meant that young people understood the risks they faced and why interventions may be necessary to ensure safety.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection this was not rated. This key question has been rated Good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- We were told about, and saw evidence of, examples where staff supported young people to explore and embrace their identity and provided care that was sensitive to equality and diversity. For example, using the correct pronouns and chosen names, as well as exploring sexuality.
- Parents and carers spoke highly of staff. They felt that they had always been treated respectfully, had been listened to and supported in whatever way was possible.

Supporting people to express their views and be involved in making decisions about their care

- Wellfield operated a 'maintain scheme' which allowed the young person to accumulate points to gain a reward of their choice. They had responded well to this.
- Staff said that young people were enabled to make decisions about their care and treatment and were involved in all aspects of planning. This was evident in care plans which were child-focused, with some being written in the first person, as if the child had written the plans about themselves.

Respecting and promoting people's privacy, dignity and independence

- Young people were treated with kindness, compassion and respect by caring staff.
- Staff and leaders at Wellfield worked to get the balance right between ensuring young people's privacy with safety. Staff entered the living quarters with consent where possible, either for scheduled therapeutic intervention or in response to a request from the young person.
- There was a CCTV camera in the lounge/kitchen and communal areas, for which written consent had been obtained and stored in care records. This enabled staff to observe behaviours and respond quickly to escalating risks yet afforded privacy where appropriate such as the bedroom and bathroom. This also enhanced safety for young people and staff when incidents had occurred.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question was not rated. This key question has been rated as Good.

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Prior to admission an initial assessment was completed to make sure the placement was the best fit for the young person.
- Following admission young people received thorough and detailed assessments, plans and interventions that were individualised to their needs and risks. All assessments and plans we reviewed were comprehensive, dynamic and clearly articulated strategies to respond to a range of situations.
- They proactively identified, managed and minimised risks. This meant that young people received care and intervention that was appropriate to meet their needs and successfully improve outcomes. These were reviewed not only monthly but when a significant situation occurred.
- An alert disc discretely placed in the front window forewarned staff as they entered the building of the status and disposition of the young people. This meant they were prepared and able to respond appropriately.
- There was evidence of a clear vision by leaders to provide a therapeutic environment which was person centred, open, inclusive and empowering for the young people which gave positive outcomes. This could be seen by the progress they had made in managing their emotional dysregulation and subsequently attending education where previous placements had failed.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- At the time of our inspection there was no one living at the home who required information in an accessible format.
- Voice of the child was captured well within records and they were encouraged to word documentation in their own language before signing to confirm agreement and understanding.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Young people were supported to maintain relationships with their families. This was facilitated by pre-arranged telephone contact in line with court orders and face-to-face visits to Wellfield by social workers.

Staff were careful to gauge whether this contact was appropriate based on therapeutic and psychosocial factors.

● Young people were also supported to engage in activities in the community with assistance from staff. They were also encouraged to have pets and a kitten had recently been adopted. This brought with it responsibilities for care which the young person had embraced.

● One young person at Wellfield was in full-time education, and the other had an identified educational placement which offered vocational courses such as animal care, for young people who had previously experienced repeated educational placement breakdowns.

Improving care quality in response to complaints or concerns

● There was a system in place for recording and acting upon complaints. However, there had been no complaints made by young people or their families since the last inspection so we could not assess if the system was effective.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. The rating for this key question has remained Requires Improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Staff we spoke with felt well supported and valued in their work. This was reflected in their commitment and desire to provide the best provision for the young people .
- External professionals we spoke with described how the therapeutic relationships staff developed with young people had been integral in making positive differences to their lives.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The service had a duty of candour policy which reflected the legal duty to apply this when needed. There had been no incidents identified by the service in the last 12 months that had been identified as needing the duty of candour to be applied.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There was a thorough process for accurately and comprehensively reporting incidents internally, including the provision of regular incident analysis reports, which supported a learning and improvement culture.
- However, there was a lack of clarity to support incident reporting and sharing with CQC in line with regulatory registration. We found an example where a member of staff had been removed for professional misconduct whilst at work and several where notifications was not completed in a timely manner.

Processes had not been established to assess, monitor and mitigate the quality and safety of services provided in the carrying on of the regulated activity. Such processes must enable the registered person, in particular, to evaluate and improve their practice in respect the processing of information, namely incident reporting. This placed people at risk of harm. This was a breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Weekly management meetings had explored what was working well in the service as well as what needed to change in order to further manage and mitigate risks. These arrangements had demonstrated a commitment from leaders to continually monitor and improve the service.
- The staff at Wellfield had received regular management and clinical supervision. We saw evidence in staff

folders of learning through supervisory discussions, as well as the identification of further training needs. These arrangements were further strengthened through reflective and restorative 'circle of care' safeguarding team meetings which staff saw as safe space to explore relevant issues.

● At the time of the inspection a new operational manager had been in post for three weeks. Their role included daily on-site support for staff, quality assurance and ensuring of the safe general day to day running of the service. Staff welcomed this addition and told us they had already seen the benefit of having this manager working so closely with them.

● We saw evidence in daily care records of adequate staffing levels and skill mix.

● Record keeping at Wellfield was strong and standardised. All work was clearly documented in detail, and the single daily log captured all information related to the young person in a format suitable for sharing at the shift handovers.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff and leaders actively sought feedback from young people, families and external professionals to inform future developments of the service.

● Wellfield was an inclusive employer and staff we spoke with reported feeling supported and spoke positively about working in the service.

Continuous learning and improving care

● Staff and leaders at Wellfield demonstrated a shared goal for continuous improvement to achieve positive outcomes for young people. This was evident in the direct work undertaken as well as their receptiveness to our feedback throughout the inspection process.

Working in partnership with others

● Staff and leaders at Wellfield worked well with external partners. This included appropriate information sharing with health and multi-agency partners such as the local authority, hospitals and the police. This strengthened a partnership approach to meeting young people's needs.

● One young person had education, health and care plans which had been implemented by supporting local authorities. However, leaders informed us that the local authorities had not always involved Wellfield in the review process for these. This limited the opportunity for leaders to actively input into goals that had been set for the young person and also for the young person's care plans to reflect the goals set by them and the professionals involved in their education, health and care.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The management and organisation of most record keeping in Wellfield was good. Recording of medicines administration and the disposal of medicines was not always completed in line with the service's own guidance and protocol. For example, we saw instances where only one staff member had signed to confirm administration and disposal of medicines, limiting the assurance that young people received their prescribed medicines in a safe, and effective manner; and also not preventing the misuse of unused drugs. Incidents were not always notified to CQC in accordance with regulatory registration. We found an example where a member of staff had been removed for professional misconduct whilst at work and several examples where notifications were not completed in a timely manner.