Scio Healthcare Limited

The Elms Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

The Elms Nursing Home is registered to provide accommodation for up to 48 People. The home provides both personal and nursing care support to older people including those living with dementia. The home also provides short term rehabilitation support for up to five people. At the time of the inspection the home accommodated a total of 45 people.

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.

The inspection was unannounced and was carried out on the 03 and 05 November 2015.

There were appropriate systems in place for the management of medicines. However, there was no

Summary of findings

guidance to support staff with the administration of 'when required' (PRN) medicine. We pointed this out to the registered manager and by end of our inspection this guidance was included in people's care plans.

Care plans were generic in style and focussed on people's clinical needs. However, they did not identify how staff should support people on an individual basis.

People and their families told us they felt the home was safe. Staff and the registered manager had received safeguarding training and were able to demonstrate an understanding of the provider's safeguarding policy and explain the action they would take if they identified any concerns.

The risks relating to people's health and welfare were assessed and these were recorded along with actions identified to reduce those risks in the least restrictive way. They were personalised and provided enough information to allow staff to protect people whilst promoting their independence.

People were supported by staff who had received the appropriate training and professional development to enable them to meet their individual needs. There were enough staff to meet people's needs and to enable them to engage with people in a relaxed and unhurried manner.

Staff sought verbal consent from people before providing care and when appropriate followed legislation designed to protect people's rights and ensure decisions taken on behalf of people were made in their best interests. We found the home was meeting the requirements of the Deprivation of Liberty Safeguards.

Staff developed caring and positive relationships with people, were sensitive to their individual choices and treated them with dignity and respect. People were encouraged to maintain their family relationships. People, and where appropriate their families, were involved in discussions about their care planning, which reflected their assessed needs.

People were supported to have enough to eat and drink. Mealtimes were a social event and staff supported people in a patient and friendly manner.

There was an opportunity for people using the service and their relatives to become involved in developing the service and they were encouraged to provide feedback on the service provided. They were also supported to raise complaints should they wish to.

People and their families told us they felt the service was well-led and were positive about the registered manager who understood the responsibilities of their role. The providers were fully engaged in the development of the home and had developed links with external organisations and professionals to enhance the quality of the service provided. Staff were aware of the provider's vision and values, how they related to their work and spoke positively about the culture and management of the service.

There were systems in place to monitor quality and safety of the service provided. Accidents and incidents were monitored, analysed and remedial actions identified to reduce the risk of reoccurrence.

Summary of findings

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.

Medicines were managed appropriately. However, there was a lack of guidance to support staff administering 'as required' medicines.

The registered manager had assessed individual risks to people. They had taken action to minimise the likelihood of harm in the least restrictive way.

People's families felt their relatives were safe and staff were aware of their responsibilities to safeguard people.

There were enough staff to meet people's needs and recruiting practices ensured that all appropriate checks had been completed.

Is the service effective?

Good

The service was effective.

Both management and care staff understood their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

People were involved in decisions about their care and support and were supported to have enough to eat and drink. They had access to health professionals and other specialists if they needed them.

Staff received an appropriate induction and ongoing training to enable them to meet the needs of people using the service.

Is the service caring?

Good

The service was caring.

Staff developed caring and positive relationships with people and treated them with dignity and respect.

People and their relatives were involved in planning their care. Staff respected people's preferences and views.

Staff understood the importance of respecting people's choice and their privacy.

People's bedrooms were individualised to reflect their preferences.

Is the service responsive?

Requires improvement

The service was not always responsive

Care plans were detailed but did not always reflect how best to support people's individual needs.

People told us the staff were responsive to their needs.

Summary of findings

The provider sought feedback from people or their families and had arrangements in place to deal with complaints.	
Is the service well-led? The service was well-led. The providers' values were clear and understood by staff. The management team adopted an open and inclusive style of leadership. People, their representatives and staff had the opportunity to become involved in developing the service. There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment.	**Good**

The Elms Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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.

The inspection was unannounced and was carried out on 03 and 05 November 2015. The inspection team consisted of two inspectors and a specialist advisor. The specialist advisor was someone who has clinical experience and knowledge of working in the field of frail older people and in particular those living with dementia and people with end of life care needs.

Before this inspection, we reviewed the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the provider is required to send to us by law.

We spoke with the 13 people using the service and four relatives. We also spoke with four visiting professionals. We observed care and support being delivered in communal areas of the home. We carried out pathway tracking of two people using the service, which meant we observed them and how staff interacted with them, looked at their care records and spoke with them and members of their family. We spoke with 11 members of the care staff, three nurses, the administrator, the catering manager, the training manager, the registered manager and four directors.

We looked at care plans and associated records for 11 people using the service, staff duty records, four staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records.

The home was last inspected in January 2014 when no issues were identified.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said they felt safe because the staff helped them with their mobility, they added, "The staff are careful". Another person told us that staff, "listen and know what to do". A relative told us, "I know if I can't get here, [my relative] is safe and well looked after". Another relative said their mother was safe and added "I have no doubt about it". A visiting professional told us, "Yes, people are safe here. I have never had an issue; if I did I would raise it and raise a safeguarding".

We looked at all the Medicines Administration Records (MARs) relating to all of the people living at the service. We found the MARs were fully completed and up to date. However we identified some issues that did not reflect best practice. The National Institute for Health and Care Excellence (NICE) guidance "Managing medicines in care homes" March 2014 identifies the need for guidance for administering 'when required' (PRN) medicines. This should include the reason for giving the medicine, how much should be given, what the medicine is expected to do, the minimum time between doses if the first dose has not worked and the recording PRN medicines in the person's care plan. There was no PRN guidance in either the care plans or MAR charts to support staff with the administration of PRN medication. We pointed this out to the registered manager and by the second day of our inspection we saw PRN guidance was being included in people's care plans.

There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. The provider had a medicine stock management system in place to ensure medicines were stored according to the manufacturer's instructions. There was a process in place for the ordering of repeat prescriptions and disposal of unwanted medicines.

The registered manager had assessed the risks in respect of providing care and support for each person using the service; these were recorded along with actions identified to mitigate those risks. They were written in enough detail to protect people from harm whilst promoting their independence. For example, one person had a risk assessment in place in relation to their choice to propel themselves in their wheel chair using their feet. Staff were able to explain the risks relating to this person and the action they would take to help reduce the risk from occurring. The registered manager had also identified risks relating to the environment, such as the use of oxygen, slips and trips on stairways, the use of electrical appliances and activities in the garden. Where an incident or accident had occurred, there was a clear record of this and an analysis of how the event had occurred and what action could be taken to prevent a recurrence. People's care records and risk assessments were updated when they had been subject of a fall or other incident.

There were enough staff to meet people's needs. The provider told us that staffing levels were based on the needs of people using the service. They explained they had assessed staffing in line with a national guidance produced by a specialist company, who are an independent organisation providing information and market intelligence to the independent health and community care sectors. For homes, such as The Elms Nursing Home, providing nursing care the suggested benchmarks is 38 hours per person per week, inclusive of both care and nursing provision. The provider was able to demonstrate the home was consistently providing staffing in excess of the benchmarked hours. There was a duty roster system, which detailed the planned cover for the service, with short term absences being managed through the use of overtime or staff from one of the other homes owned by the provider. The registered manager was also available to provide support when appropriate. A relative said, "There is definitely enough staff working, people are never left on their own; Staff are always watching out for people". A visiting professional told us, "One of the things I like is the matron [the registered manager] wears a uniform and will go out and support staff when she can".

The provider had a safe and effective recruitment process in place to help ensure that staff who were recruited were suitable to work with the people they supported. All of the appropriate checks, including Disclosure and Barring Service (DBS) checks were completed on all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

Staff had the knowledge necessary to enable them to respond appropriately to concerns about people. All staff

Good

Is the service safe?

and the registered manager had received safeguarding training, understood the different types of abuse and knew what they would do if concerns were raised or observed in line with the provider's policy.

There were arrangements in place to deal with foreseeable emergencies. There was also a fire safety plan for the home. Staff were aware of the plan and were able to tell us the action they would take to protect people if the fire alarm went off.

Good

Is the service effective?

Our findings

People and visitors told us they felt the service was effective and that staff understood their needs and had the skills to meet them. One person said, "Staff know what they are doing; I trust them" They told us they felt confident with them. A relative said staff knew, "how [my relative] likes to be looked after. They don't just look after the patient; they look after the whole family". People told us that staff asked them for their consent when they were supporting them. They said staff encouraged them to make decisions and supported their choices. People's consent to aspects of their care had been recorded in their care plans. One person told us, "Staff check if I want a wash, if I say no, it's okay and they say they'll do it later; They are very sympathetic to my needs".

People's ability to make decisions was assessed in line with 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. People told us that staff asked them for their consent when they were supporting them. The providers, registered manager and staff understood their responsibilities in relation to the MCA. A relative told us, "My [relative] had capacity when they came in but does not have capacity anymore. I am now involved in discussions about their care planning and any decisions".

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had applied for DoLS authorisations where appropriate in respect of people, whose liberty was restricted and were subject to constant supervision at the home. Staff understood how the DoLS applied to people in the home and the need to support them and keep them safe in the least restrictive way.

There were arrangements in place to ensure staff received an effective induction into their role. Each member of staff had undertaken an induction programme based on the principles of the care certificate which is a set of standards that health and social care workers adhere to in their daily working life. Each new member of staff was allocated a mentor to provide ongoing support, advice and guidance. They spent time shadowing more experienced staff, working alongside them until they are competent and confident to work independently. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as, fire safety, infection control, manual handling and safeguarding vulnerable adults. Staff had access to other training focused on the specific needs of people using the service, such as, dementia awareness, diabetes awareness and palliative care. Staff were also supported to achieve a vocational qualification in care. The provider had also arranged for all staff to be given a series of 'Key Information cards' detailing information about areas such as the Mental Capacity Act, infection control, dementia, the fundamental standards and the provider's values. Staff were able to demonstrate an understanding of the training they had received and how to apply it; for example, how they would respond if they had concerns regarding people's safety.

Staff members had access to supervision an annual appraisal. However, for some staff these were sporadic. Supervisions and appraisals provided an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and learning opportunities to help them develop. Staff said they felt supported, and the registered manager had an open door policy and they could raise any concerns straight away. We raised this with the provider's representative who took action to ensure supervisions were completed in a structured way.

People were supported to have enough to eat and drink. They were complimentary about the food and told us they could eat what they liked. One person said, "The food is all right" and added "You can always ask for more". Another person, who was registered blind, told us, "When staff give me my dinner they tell me what it is and ask me if I want it cut up. If I ask for extras like more gravy they get it for me. Nothing is too much trouble". They added "When I have mashed potatoes my daughter brings in special butter which they use for me". A relative told us, "There is plenty to

Good

Is the service effective?

eat; it is always very good". Another relative said, "The food here is so good I came here for my Christmas dinner". They told us that their relative's weight was checked regularly and "if she doesn't eat they let me know".

The catering manager provided a link between the nursing staff and the kitchen staff. They told us people's dietary needs were assessed before admission or by the nursing staff and then monitored. When appropriate, guidance was obtained from the Speech and Language Therapy Team (SALT) and the hospital. The catering manager had a system in place to monitor people's nutritional and hydration needs and was able to put in place additional interventions when nutritional issues were identified. One person told us "I had a lady come and see me today because I was losing weight and asked me if there was anything specific I would like to eat".

The kitchen staff were aware of people's likes and dislikes, allergies, preferences and special dietary requirements. Both the catering manager and the cook were aware of the new regulations in respect of the management of food allergens. These regulations require organisations to display information about the top 14 food allergens, such as nuts or wheat, and list any menu items which may contain any of those allergens

People were offered a choice of what they wanted to eat. We observed that people were asked in advance about their preferences but could change their decisions at meal times. During lunch we saw that people's choices had been taken into account and a variety of combinations of foods were provided for the main course. A dessert trolley was used at lunchtime to allow people to choose which pudding they preferred. These included a hot pudding and alternatives such as yoghurts, fruit or ice cream. Staff continually monitored people to check whether they were eating and offering people alternatives. Drinks of water and juices were offered throughout the meal and hot drinks were available after it.

To check arrangements were in place to provide people with the individual support they needed to eat at mealtimes we observed the provision of food at lunchtime. Staff told us how they were organised to ensure each person had help during the lunch period. The staff were consistent and clear about arrangements to ensure each person was individually supported. We saw that ten care staff and the hospitality staff were involved in delivering food to people in the three dining rooms on both floors, one person in the lounge and people eating in their rooms. Staff told us thought there were enough of them to support people in each area.

People had the choice of where they wanted to eat their meals which were managed on an individual basis. When the person had finished their main course their plate was cleared and the dessert trolley was brought out. They did not have to wait for everyone else to finish, so everyone could eat at their own pace without feeling rushed.

Where people were identified as being at risk and required a food and fluid chart to monitor their intake, these were detailed and completed fully. Staff recorded the amount people ate and drank diligently after each meal and throughout the day. For example, one person was subject to a restricted fluid intake. The fluid chart in their care record contained up to date details of the person's fluid input and output. People were weighed on a regular basis and the catering manager monitored the results to identify any developing trends or concerns.

People were supported to maintain good health and had access to appropriate healthcare services. Their records showed they had regular appointments to be seen by health professionals, such as chiropodists, opticians, dentists and GPs. All appointments with health professionals and the outcomes were recorded in detail. A family member told us their relative "wasn't well this morning so they called the doctor in. They call them in for the slightest thing if they are concerned". Another relative told us they had "raised a concern with [the registered manager] that their [relative] was having trouble hearing. [The registered manager] arranged for them to be included in the regular GP round and had their ears syringed which solved the problem".

Good

Is the service caring?

Our findings

Staff developed caring and positive relationships with people. People and relatives told us they did not have any concerns over the level of care provided or how it was delivered. One person said they thought the home was "lovely" and added "I was really against coming here but now I am here I love it. They are all so lovely to me. They treat me with respect and dignity". Other people's comments included that the staff were "very good", "lovely, I get on with them all" and "excellent, friendly, kind and caring". A relative said, "The way they look after [my relative] is brilliant. I have seen an improvement since he has been here. He will have a laugh now". Another relative told us, "I am in every day. Everyone is so friendly and they really care. It is like one big family".

People were cared for with dignity and respect. Staff spoke to people with kindness and warmth and were observed laughing and joking with them. Staff responded promptly to people who required assistance. One person told us "One thing does stand out for me. I had a bad dream recently and woke up very frightened. I rang my bell and the carer came in and sat with me. She made me a cup of tea and just sat talking to me until I fell back to sleep". Another person said the person in the next room shouted a lot and "staff are so nice to her and caring, speaking to her gently until she calms down".

People, and when appropriate their families, were involved in developing their care plans. We saw that people's preferences and views were respected. One person said, "It's a nice place, there are no restrictions, like when I go to bed. I can watch TV 24 hours a day if I wanted to". A family member, whose relative was living with dementia said, "When [my relative] came into the home, I was invited to a meeting where they asked me information about what [my relative] liked and disliked and how he liked to be looked after". After the meeting they sent me the minutes and the plan of what they were going to do". Staff used the information contained in people's care plans to ensure they were aware of people's needs and preferences.

Staff had good knowledge of the individual likes and dislikes of people and understood the importance of respecting people's choice, and privacy. They spoke with us about how they cared for people and we observed that personal care was provided in a discreet and private way. Staff knocked on people's doors and waited before entering. There were signs on people's rooms which staff used when they were supporting people with their personal care so they would not be interrupted.

Staff were very respectful of people's privacy and were able to speak with people privately. There were also rooms available for people to meet privately with friends and family should they wish. The movement of the people at the home was unrestricted and they were able to choose where they spent their time. We spoke with some people who chose to spend their time in their own rooms. They said the staff respected this and offered them opportunities to join others if they wished.

People were supported to maintain friendships and important relationships; their care records included details of their circle of support. Family members confirmed that the home supported their relatives to maintain the relationships. Staff supported people to maintain links with the local community. One family member, whose relative was living with dementia, told us, "We have always been church people. So it was really welcome when they arranged for a prayer meeting at harvest festival. [My relative] was able to say the Lord's Prayer by himself. I can't fault it, they go the extra mile".

A visiting professional told us that the staff took an individual approach to meeting people's needs. They added staff showed a good understanding of individuals and were consistent in their approach. People's bedrooms were individualised and reflected people's preferences with photographs, pictures and other possessions of the person's choosing.

People had access to information in a way and at a time they wanted it. Notices and pictures providing information for people were displayed in the communal areas of the home.

Requires improvement

Is the service responsive?

Our findings

People and relatives told us staff were responsive to their needs. One person said, "Sometimes I ask [staff] not to check on me through the night and sometimes I change my mind and ask them to do it. They are very good and don't mind. If I am having a bad time I may need supporting nine times during a night but they never moan". A relative told us that staff knew their relative "very well" and they were "kept updated with what was happening and whether there are any concerns". Another relative told us their family member was able to do what they wanted and staff were supportive and understood their needs. A visiting professional told us the staff were "excellent, knowledgeable and responsive to people's needs".

Care plans were detailed and reviewed on a regular basis. They included areas such as, maintaining a safe environment, personal hygiene, behaviour, communication and breathing. Although care plans were detailed and had a clinical focus, they were not personalised and did not reflect the individuals' specific needs. Care records were generic and pre-typed with gaps to insert people's names, with the same care plan mirrored across all of the care records we reviewed. For example, the care plan for one person included 'Ensure eye test every two years or if there is a deterioration in sight'. This did not reflect the needs of the person, who was registered blind'. Another person experienced delusional episodes relating to their family. However, there was no specific information in their care record to help staff to understand how to support them at these times. The care plan of a third person, who was at risk of chest infections, stated 'staff to monitor and report any changes in breathing to the nurse on duty'. However, it did not identify what normal looked like for this person to aid staff in understanding when a change had occurred. Although the care plans were not personalised, staff were knowledgeable about the people they supported and were able to tell us in detail about their preferences, backgrounds, medical conditions and behaviours. We raised the lack of a personalised care plan with the providers who recognised it was an area for improvement and by the end of our inspection they had put in place an action plan to update all of the care plans to ensure they were personalised and in line with best practice guidelines.

People's daily records of care were up to date and showed care was being provided in accordance with people's needs. Handover meetings were held at the start of every shift, which provided the opportunity for staff to be made aware of any changes to the needs of the people they were supporting. Each person had an allocated keyworker, whose role was to be the focal point for that person and help them to plan and shape the support they need.

Staff were knowledgeable about people's right to choice. They were aware of the types of activities people liked to do. People had access to activities that were important to them. The home had an activities co-ordinator who organised group activities and individual activities for those people who stayed in their rooms. One person said, "There are activities all the time, which I can join in if I want and I can also go out with the activities coordinator, if I want to". A relative told us their relative "is often in the lounge doing activities when I visit. They are always asking him what he would like to do". Another relative told us there were "plenty of activities, including taking people out".

People, their relatives and friends were encouraged to provide feedback and were supported to raise complaints, if they were dissatisfied with the service provided at the home. The home arranged 'residents' meetings' to give people an opportunity to express their views about the service. A relative said, "We have monthly resident/ relatives' meetings where we can raise ideas or concerns. At a recent meeting we suggested swapping the lounge and the dining room round because it was bigger. They have and we are reviewing it at our next meeting". They added "We are listened to and if it is a good idea it is acted upon and if they can't they explain why".

The provider asked people and their relatives to complete satisfaction surveys twice a year. The provider analysed the responses to each survey and told us that if issues were identified they would use the information to help develop an improvement plan for the home. We looked at the result for the March 2015 survey and saw they were predominately positive. Where issues were raised action was taken to respond to the individual concerns.

There were arrangements in place to deal with complaints which included detailed information on the action people could take if they were not satisfied with the service being provided. The provider told us there had been two complaints during the year. We reviewed these and saw that they had been investigated and the result of that investigation fed back to the person concerned.

Good

Is the service well-led?

Our findings

People and relatives told us they felt the service was well-led. A relative told us, "I have no doubts about how the service is led. [The registered manager] is very approachable and [the provider] attends all of the meetings and is always approachable. Last week he was sat in the foyer chatting to everyone coming in. I have no doubt they want to interact with people". Another relative said, "I have been recommending The Elms to everyone, [the provider] comes in and takes part, everyone gets involved. It is really nice". A health and social care professional told us, "The service is definitely well-led; the registered manager has an open door policy so anyone can see her. If I raise an issue they sort it out straight away".

The providers were fully engaged in running the service and their vision and values were set out in the 'service user's guide'. There were posters reinforcing the provider's expectations with regard to people's experiences of the care displayed in the home. There was a clear management structure with a registered manager, heads of departments, nursing staff, care staff and administration staff. Staff understood the role each person played within this structure. There was the opportunity for people and their relatives to comment on the culture of the service and become involved in developing the service through regular feedback opportunities such as monthly resident meetings and the annual feedback survey. Positive feedback was also recorded through a compliments file.

Staff were aware of the provider's vision and values and how they related to their work. Regular staff meetings provided the potential for the management team to engage with staff and reinforce the provider's value and vision. They also provided the opportunity for staff to provide feedback and become involved in developing the culture of the service. There was an opportunity for staff to engage with the management team on a one to one basis through supervisions, although these were sporadic and informal conversations. Observations and feedback from staff showed the home had a positive and open culture. Staff spoke positively about the culture and management of the service. They said that they enjoyed their jobs and described management as supportive. Staff confirmed they were able to raise issues and make suggestions about the way the service was provided in one to one or staff meetings and these were taken seriously and discussed.

The provider had suitable arrangements in place to support the registered manager, for example regular meetings, which also formed part of their quality assurance process. There were systems in place to monitor the quality and safety of the service provided and to manage the maintenance of the buildings and equipment. These included regular audits of medicines, staff files, infection control, environmental health and safety, and fire safety. The registered manager also carried out an informal inspection of the home during a daily walk round. The provider carried out their own quality assurance process and provided documentary feedback of their findings to the registered manager. Where issues or concerns were identified an action plan was created and managed through the regular meeting processes.

The providers were responsive to new ideas and had developed links with external organisations and professionals to enhance the staff's and their own knowledge of best practice and drive forward improvements. For example one of the providers was a member of the local authority safeguarding board and the chairman of the Isle of Wight Registered Nursing Homes association.

The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.

Although, the provider and the registered the manager understood their responsibilities and were aware of the need to notify the Care Quality Commission (CQC) of significant events in line with the requirements of the provider's registration.