Wellhead Lane Limited

Wellhead Lane

Inspection report

16 Wellhead Lane
Westbury
Wiltshire
BA13 3PW

Tel: 01373303248

Date of inspection visit:
28 January 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Wellhead Lane is a small care home supporting young adults with a learning disability to live their lives as independently as possible. At the time of our inspection two people were using the service.

A registered manager was employed by the service. 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's needs were assessed and care plans developed to identify the care and support people required. Relatives said they were involved in planning their family member's care and were happy to express their views or raise concerns. Some of the wording used to describe how to support people in the care plans was inappropriate and the registered manager assured us this would be addressed and rectified. There was no evidence of staff talking in this way to people during our inspection.

There were systems in place to protect people from the risk of abuse and potential harm. Staff were aware of their responsibility to report any concerns they had about people's safety and welfare.

There were enough staff deployed to fully meet people's health and social care needs. The registered manager and provider had systems in place to ensure safe recruitment practices were followed.

The service was supporting people with medicines in a safe manner, and helping people to access healthcare services to maintain and support good health, however the medicines policy in place contained no guidance on PRN medicines (as required). We saw for one person who was receiving a homely remedy that no protocol had been put in place to guide staff when this should be offered and the processes around this.

People's relatives spoke positively of the care their loved ones received and praised the staff for their compassion and commitment. One comment from a relative was "They are very good, very caring and loving; they understand X and are consistent".

The registered manager had systems in place to monitor the quality of service provided. One notification

concerning police involvement had not been received by CQC. We raised this with the manager and it was actioned during our inspection and has since been received by CQC.

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

This service was safe.

People were protected from the risks of harm or potential abuse. Staff had a good knowledge of safeguarding and were confident in reporting any concerns they had.
Risks to the health, safety or well-being of people who used the service were assessed and addressed in people's care plans.

There were safe recruitment procedures to help ensure people received their care and support from suitable staff.

Safe medicine management was observed and self-administrating of medicines encouraged, however the service did not have PRN guidance within its medicines policy. A homely remedy had been provided without a protocol in place to guide staff.

Is the service effective?

Good

This service was effective.

People were cared for by staff who had received appropriate training to meet their individual needs. There were arrangements in place to ensure staff received regular supervision, appraisal and training.

Staff had an understanding of the Mental Capacity Act 2005 and supported people to make decisions regarding their daily living.

Staff recognised when people's health care needs were changing and supported them to access healthcare services when required.

Is the service caring?

Good

This service was caring.

Relatives spoke positively about the care and support their family member received. We observed staff were attentive, respectful and genuinely interested in people's well-being.

People's privacy and dignity were respected and they were involved in making decisions. Staff told us how they aimed to provide care in a respectful way whilst promoting people's independence.

Is the service responsive?

Requires Improvement

This service was mostly responsive.

Care plans were in place which detailed people's care and support needs. However the wording used was at times inappropriate. A treat was recorded as being used to encourage a person with getting up and washing.

People's needs were regularly reviewed and care provided in line with these needs. Families were kept informed of matters relating to their relative and took part in these reviews.

No formal complaints had been made but systems were in place to manage complaints. Everyone we spoke with was confident that any concerns raised regarding the service would be listened to and acted upon. One frequent concern raised by a person using the service had not been logged as an informal complaint.

Is the service well-led?

Good

This service was well-led.

There was a registered manager in post who provided strong leadership, demonstrating values, which were person focused. Staff had a good understanding of the aims and values of the service and had opportunities to express their views.

The registered manager carried out regular audits to monitor the quality of the service.

Staff were aware of their responsibilities and spoke positively about the support they received from the management team.

Wellhead Lane

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.

The inspection took place on 28 January 2016. This was an announced inspection which meant the provider had short notice that we would be visiting. This was because the location is a small service and we wanted to make sure the manager would be available to support our inspection, or someone who could act on their behalf. The inspection was carried out by one inspector. This service had not been previously inspected.

Before we visited we looked at notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the Provider Information Return (PIR) from the service. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with the registered manager, five members of staff, three relatives and a health professional. We were able to speak in length with one person who was being supported by the home. We looked at documents relating to people's care and support and the management of the service. We reviewed a range of records which included two care and support plans, five staff files, staff training records, policies and procedures and quality monitoring documents.

Good

Our findings

People felt safe living at the home. One person told us "I feel safe; I'm not worried about that". We spoke with three relatives of the people using the service who had no concerns about the service. Comments included "X is safe here" and "Without a doubt X is safe, the carers are very good".

Staff were proactive in helping people understand the importance of keeping safe. One person was currently being helped to understand road safety and we viewed documentary evidence that conversations around this had taken place. People's care plans contained a vulnerabilities profile, which summarised any difficulties there may be for an individual in keeping safe. For one person it was recorded that because of communication difficulties they may be unlikely to be able to call for help in an emergency. This meant staff were aware of their responsibilities in ensuring the safety of the people they supported.

People were protected from avoidable harm and potential abuse. Safeguarding policies and procedures were in place which provided guidance and information to staff. Staff were aware of their responsibilities to report any suspicion or allegation of abuse, and had completed safeguarding training as part of their induction. They felt confident any concerns raised would be taken seriously by the registered manager and where necessary acted upon. Staff were knowledgeable on recognising changes in people's behaviour, who may be unable to verbally communicate concerns. Comments from staff included "I would look at changes in behaviour, if someone was withdrawn, agitated or frustrated, and look at their responses to individual people" and "If someone's behaviour was different from what is a normal pattern for them, this may indicate concerns".

Assessments were undertaken to identify risks to people who used the service. When risks were identified appropriate guidance was in place to minimise potential risks. For example it was noted in one person's care plan that on trips out in the car they sometimes attempted to distract the driver. Preventative measures had been put in place which advised of seating arrangements and the provision of additional staff to sit with the person. This had been regularly reviewed.
We saw risk assessments in place relating to the service location as well as for individuals. The home had set up and agreed emergency evacuation places; they could use either the sports hall situated behind the property, or the hotel at the end of the road. Health and safety checks had been completed for the home, including legionella water testing (bacterial disease) and PAT testing (portable appliance testing). The home had recently received a fire safety check, however during our visit we saw there were no carbon monoxide detectors in place. The registered manager raised this with the director directly after our visit who has since purchased carbon monoxide detectors with plans to install them with immediate effect.

We reviewed the accident and incident log book and saw events had been recorded appropriately detailing the nature of the incident and subsequent resolution. Where required a body map had been completed for the person which recorded any injuries sustained. These were then passed on to the manager for review and for action to be taken if needed.

The service was fully staffed to meet the needs of the people currently being supported. This included two staff for two people and the provision of extra staff according to what activities each person had chosen for that week. This was because one person needed two members of staff when accessing the community due to the level of support required and identified risks.

During the night there was one staff member on duty. Two bank staff were also employed to cover sickness and holidays. For all shift changes the manager had allowed a fifteen minute crossover period for a handover to be given to the staff coming onto shift. One staff member told us "there is enough staff; we have enough time to support people". A relative also commented saying "The home has enough staff, its spot on".

The service followed safe recruitment practices. Staff files included application forms, records of interviews and appropriate references. Records showed checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. The manager informed us that no one was allowed to even shadow an experienced member of staff until their DBS was in place.

Peoples' medicines were managed and administered safely. One person was able to self-administer their medicines with the support from staff. An alarm had been set up to remind the person when it was time to take their medicine so they could retain their independence in managing this. Even though this person was self-administering there was guidance in their care plan relating to their medicine, so staff could access this information if they needed to assist the person at any time.
We saw one person was occasionally using a homely remedy and although advice from a health professional had been sought there was no protocol guidance in place. We reviewed the service's medicine policy and saw there was no information around PRN medicine (medicine that is taken 'as needed'). We raised this with the registered manager who was going to ensure protocols were put in place so staff have access to the appropriate information when supporting people with their medicines. There had been no medicine errors within the home at the time of our inspection.

The pharmacy the home used did not supply medicine administration records (MAR) to the service and the manager had previously questioned the pharmacy in regard to this. The manager had put in place their own version of MAR's and staff signed these for people they assisted, prompted or observed taking medicines. We saw there were no gaps in the recordings of these charts and people were receiving their medicines in line with the medical guidance supplied.

Good

Our findings

People received individualised care from staff who had the skills, knowledge and understanding needed to carry out their roles. One relative told us "Staff are well trained to meet people's needs". A member of staff commented "We have a really good staff team with a good knowledge of autism".

We spoke with staff about their training opportunities and viewed the training records which confirmed staff received training on a range of subjects including, mental capacity and deprivation of liberty and safeguards, positive behaviour management and safe medicines management. Staff told us further training was then provided to meet people's specific needs such as learning disability awareness, and the diabetes nurse had provided training around managing diabetes. Part of the induction process also included communications and sensory processing training, which was provided by an educational psychologist trainer.

The manager spoke to us about the importance of staff receiving equality and diversity training commenting "We are surrounded by different backgrounds and people, we have reflective practice on equality and diversity, and do work with residents to be accepting of each other, and we demonstrate respectfulness to each other".
New staff were supported to complete an induction programme before working on their own and shadowed experienced members of staff. Staff comments included "New people always shadow, and come in and meet people first", "Shadowing periods depend on what that staff member needs, we tailor it to the person and their confidence and previous experience" and "I met people before I started, and felt it prepared me for my role".

Staff received regular supervision meetings in which they were able to discuss training and development opportunities and other matters relating to the provision of care for people living in the home. Staff told us "Supervisions are regular, it's a two way process, we talk and plan the way forward to meet every ones needs" and "Supervisions are very useful to talk about things your unhappy or happy about".

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. The DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. They aim to make sure that

people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Review meetings had been held with people's representatives and health and social care professionals to discuss what might be needed in each person's best interest. We saw in people's care plans that where needed standard authorisations for DoLS had been applied for following the correct procedures. For one person a DoLS had been requested because measures were in place that restricted freedom of movement. A door sensor had been fitted to a bedroom door to alert staff to the person's whereabouts when they chose to move around during the night. The person was aware of the sensor and understood the reasons it was in place. During the day these restrictions did not extend to the person, and we saw them freely accessing the garden. This person also enjoyed time away from the home in the company of their family. This person's relative told us "X struggles with being supervised, but staff talk to X and they understand". The manager told us "Applying for a DoLS is not the end result, it will be reviewed regularly and there have been no incidents so we are hoping to reduce this restriction in the near future".

Staff understood the importance of enabling people to make their own decisions and told us "We give information to people so they can make informed choices, we establish understanding by giving the information in a way they understand, pictures or flow diagrams", "People constantly make choices", "We always adapt to the individual and offer choice" and "We have conversations with one person, on why we assist them in the community".

People were supported to have a meal of their choice by organised and attentive staff. Each week staff would sit with people individually and complete a food menu of what that person wanted to eat. Staff would then assist the person to go shopping and buy the ingredients needed for that week. A staff choice was also included on the weekly menu to encourage people to try new foods and appreciate, in other settings such as shared living, there is compromise around sharing choices. If there was something on the menu a person did not wish to eat however they were able to choose something else.

People living in the home were expected to take part in food preparation and cooking, to learn life skills and take steps towards future independent living. Staff told us people had access to the kitchen at all times and made their own sandwiches at lunchtime. One staff commented "People make their own sandwich, it doesn't matter how long it takes". Another staff said "It's their house, their home, and everything in the cupboards is theirs". One person told us "I can eat and drink what I like; I say what I want to eat, I like fish and puddings. I get enough food and drink here. I go food shopping, I'm going today". We saw in people's care plans that individual food likes and dislikes preferences had been recorded. We observed at mealtimes staff sat and ate their meals alongside people, and chatted easily. Relatives could join people for meals if they chose, and during our inspection we heard one person's family being invited for tea.

People had access to health and social care professionals. Records confirmed people had access to a GP and dentist and could attend appointments when required. One person had previously been nervous of health visits and staff had supported this person by bringing a blood pressure monitor into the home and encouraging the person to become comfortable and familiar with the process. We saw in this person's care plan many conversations had taken place around the health visit and staff had used pictorial aids to explain the appointment. We spoke with the relative of this person who told us "They help X with healthcare appointments, they get X to access doctors and dentists, they prepared X well, I'm in awe of how". The manager told us that "Good planning for these visits makes it easier for people and less distressing".
We saw people had 'Passport to hospital' forms in place, which provide a summary of their care needs and important information about the individual should they need to go into hospital, this enabled hospital staff to provide care in line with the person's needs. Staff told us there was good communication between the

home and the district nurses. One health professional commented "They are great, they have always been helpful, they hand over well, and know people well".

Good

Our findings

People received care and support from staff who had got to know them well. Staff knew, understood and responded to each person's diverse needs in a caring and compassionate way. One member of staff told us "We take things at peoples pace, and pick up on things that they have success at, we demonstrate how things can be done and allow them to do it on their own, we look at every opportunity as a learning experience without making it obvious".

Throughout the inspection we observed staff taking the time to explain things to people, and giving them the time and space to respond. People appeared relaxed and comfortable around staff and were choosing to do the things they wanted to do. One person we spoke with told us "I don't have a problem with the staff, I talk to staff and they know I'm not happy here I want my own flat in a city". Staff were currently working with this person to develop the life skills needed to enable them to hopefully move on to more independent living.

Relatives commented on the supportive care provided by staff saying "They are very good, very caring and loving, they understand X and are consistent", "We are really pleased it's so homely", "They think about putting the right people together" and "They took time to get to know X before they came to live at the home, so the transition was fantastic".

We observed people had their names on bedroom doors and pictures of their choosing if they wished. We did not look into people's bedrooms as this was their private space, but we viewed the two currently unoccupied rooms which looked inviting and nicely decorated. One of these rooms had its own en-suite and the other would share a bathroom with one other person. One person told us "I have my own things here; my room is nice and big".

Staff spoke about the people they supported in genuinely caring ways. One member of staff talked to us about occasions where one person would become frustrated, "It has been a period of getting used to each other, we reflect on it in team meetings, and look at historical situations that may be similar, we see what worked, what didn't, and discuss this with the family". Another staff member told us "You should reflect every day that you are meeting that person's needs". Other comments from staff included "Helping people, and seeing someone get on and flourish and be a part of that process is a privilege" and "Hopefully we make a difference, it's small, homely and welcoming". The manager also commented saying "We celebrate the individual".

Staff were aware of the importance of maintaining people's privacy and dignity. One Staff told us "We knock on peoples doors, and encourage them to lock their doors". Both people living at the service were able to lock their doors if they chose. One person did lock their door and the other person chose not to, but did lock their en-suite bathroom when showering.

People were encouraged to be as independent as possible. This included taking responsibility for cleaning their own rooms and the communal bathroom. One person told us "I do my own cleaning". A relative commented "The place is clean and tidy; they are really good they encourage X to clean up". We saw daily living sheets in people's care plans which recorded any independent living tasks that had been completed. Tasks included making beds, shopping, and health related tasks such as hair washing, cleaning teeth.

During our inspection we spoke to the manager about the support people receive in maintaining their independence. The manager told us one person was currently being supported with managing money, and they were assisting this person with opening a bank account. Staff comments included "We try and advise people to make informed decisions, and let people make mistakes safely", "I put myself in someone's place, guide them when needed, and support them to be as independent as possible", "We help build and develop peoples strengths", "We hope to improve people's wellbeing so they can move onto independent living" and "We want to support people to live their lives as we live ours".

We saw in people's support plans it stated who had been involved in preparing the plan and was signed by the person. An external health professional told us "The service are good at promoting independence, recognising what people need and supporting meeting their needs". One relative told us "X is helped to manage their self, especially for independent living". Another relative said "It's an amazing contrast, they are working towards independence".

Our findings

In one person's daily log there were guidelines to support staff with encouraging the person to get up and washed in the morning. It was recorded that staff used the person's 'favoured treat' as an encouragement for getting up and this would then be lost if the person did not get up and dressed. We spoke with the manager about the kind of message this was giving to the person and received reassurance from the manager that this was not done or said to the person anymore and would be immediately taken out of the care plan. We did not hear any staff speaking in this way during our visit.

We saw one person had a 'behaviour response plan' in place which identified early warning signs of the person becoming distressed, and what staff should do to help manage and alleviate it for that person. The plan contained wording such as 'reward' and 'praise', and we discussed the appropriateness of this with the registered manager. The manager explained this plan needed to be updated as it was no longer in use, and agreed it was inappropriate wording for young adults.

Staff knew people's individual communication skills, abilities and preferences. There was a range of aids used by the service to ensure people were able to communicate in ways that were appropriate for them. This included message boards which we saw around the home which had pictures and word captions for a range of feelings, experiences and emotions a person may wish to communicate to staff or for personal expression. There were visual and written prompts for people on doors and cupboards to help identify contents and purpose.

One person had been identified as experiencing diminished verbal communication during times of increased anxiety. Staff had put a whiteboard in place for this person during these times, and this method had been successful in refocusing person's attention so staff could continue to communicate with them. Staff explained how they wrote different outcomes on the whiteboard for the person to understand and choose which alleviated the distress in these situations before they escalated. One staff member told us "People sometimes use touch or eye contact to get your attention, or may choose to write the message down. It may take a while to unpick it, but we take the time".

The home used social stories to help explain situations to people. These stories are a series of pictures with a word underneath to enable people's understanding of a particular event. For example in one person's care plan a social story had been used to explain that personal information about that person will sometimes have to be shared. This document was then signed by the person to give permission and say they had understood. Another person had a social story to describe the fire alarm testing that would happen on a

regular basis.

The care plans differed slightly in the way they were completed and the manager told us this was something she was happy with as they reflected the differences in people and what was important for that person. The staff were very much involved in what information they needed available in the care plans, and what types of paperwork for recording information worked well and best reflected that person's needs.

People were able to choose what activities they took part in and completed a weekly planner where each individual decided what they wished to do for the following week. The two people currently supported by the service both had diverse interests, and were able to choose what they wanted to do independently of each other. One person told us "Staff will take me anywhere I want to go, it's my choice, I spend time in the garden, and I went to the cinema to see the new star wars". A staff member commented "People choose to do swimming, bowling, go to church, they are always going out". Another staff member told us "We attend activities with people based on shared interests, or our skill set and peoples preferences".

People's needs were reviewed regularly and as required. Where necessary the health and social care professionals were involved. We looked at the minutes of review meetings that had been held and saw they identified areas for support; the level of support needed, and agreed changes. People and their relatives took part in these reviews. One person had stated they did not wish to be present at their review meeting but had contributed a presentation to be shown so their feelings were still included. One relative commented "We have meetings here with the manager, and progress has been made". An external health professional told us "They are very proactive in bringing meetings forward".

The manager spoke to us about the importance of reviewing people's care and explained the home are hoping to reduce one person who needs two staff members when accessing the community down to one in the future. One staff member said "We all contribute to care plans; we all build into it, and feed in to the reviews as a team".

One person was currently adverse to living at the home because they wanted to live independently. Staff were supporting this person with learning independent living skills in order to manage independent living in the future. We saw that this person's feelings were recorded in the daily logs and spoke with the manager about recording it as an informal complaint. The manager had not previously done this but due to the frequency of the person's feelings was going to start doing this.

People's relatives praised the home for maintaining good contact with them. We saw in people's care plans family communication sheets and regular contact was made to update relatives. Relative comments included "They are good at ringing us, we are very happy they let us know", "They make us feel very welcome" and "They ring me, good at keeping me informed, can't fault them, constant communication twice a week".

Although no formal complaints have been raised to date, the service ensured people, their relatives and staff knew how to make a complaint and the procedure that would follow should they need too. We saw there was an easy to read complaints procedure on the notice board and a pictorial complaints procedure in care plans if a person needed it in this format. A visual guide was displayed highlighting the kind of things people may feel unhappy about and wish to complain around. Staff received a handbook when they joined the home and this contained the complaints policy and procedure.

The manager had prepared a feedback questionnaire and was planning to circulate this on a regular basis for staff and relatives. Relatives we spoke with told us they had not yet been asked to give feedback on the

service. For people living in the service there was a daily review sheet which was completed with staff at the end of each day if the person wanted to. One person had a pictorial version of this daily review which showed happy or upset faces and asked if it had been a good or bad day and what had made it good or bad. The person and the staff were then able to discuss this and consider what they could change so the person could have a better day next time. Another person had this review in a verbal discussion and then staff recorded it in a written format.

Good

Our findings

The service had a registered manager in post. A registered manager is a person who has registered with CQC to manage the service. The registered manager had a long background of working with people who have a learning disability and spoke passionately about the service and the people they support. The home had signed up to the social care commitment which is a commitment made to improve services, providing people who need care and support with high quality services and encouraging their staff. An external health professional we spoke with told us "Very approachable manager, always at the end of the phone". A relative also commented "The manager is always approachable".

The service promoted a positive culture and staff spoke to us about the supportive environment the service offered to them. Comments included "We have a good team, a supportive team, it's a small team so everyone supports each other", "It's a supportive team, and an approachable manager, can go to them about anything", "The manager is very approachable and supportive" and "I get enough support in my role, the manager is amazing, she's fully committed". The staff team comprised of team leaders, senior support workers and support workers so there were opportunities for staff progression within the service.

Staff attended regular team meetings and in-between face to face meetings the manager would create a virtual meeting. For a virtual meeting the manager would print out the meeting agenda and discussions and put on the staff noticeboard. Staff could then add any further issues for discussion and then the minutes would be typed up and staff would sign to say they had been read. Staff we spoke with told us how useful these team meetings were, saying "We have regular meetings and information share on what we find works, we listen to each other. I feel I'm worthwhile and part of a team" and "We have regular staff meetings, they're very useful and good to get people together". Staff told us the manager was at the home every day, and the manager herself said she covered shifts during holidays or sickness when required.

The manager felt supported by the service director and had regular supervisions with them and said she felt able to raise things at any time. The manager told us the director would visit every week and was familiar with people, their relatives and staff and would chat with them on visits. The manager described how the director had completed some shifts when the service first opened and in a crisis would be happy to provide cover.

Staff were aware of the organisations visions and values and told us they felt involved in the progression of the home. Comments from staff included "We have conversations on what we want the home to be", "The manager is open to us making suggestions, you feel that your ideas are valued, as a team we bounce off

each other", "We want to get more established and let people know what we are all about and continue to meet people's needs" and "It's a very individualised service, there's time to support people on their level, it feels more nurturing and ethical, an individualised way of working".

The registered manager spoke to us about the homes achievements in settling people into the home. The home was now looking to the future and the manager was hoping to fill the home to capacity. The manager also spoke about continuing to raise the home's profile in the local community, people regularly used the local shop so they were well known, and hoped in time it may open up work experience opportunities for people. The manager told us "I would like to create a model that people want to replicate, that they say Wellhead Lane got it right". An external health professional commented "I have every confidence in the service, they are brilliant".

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. We reviewed the quality assurance management schedule in place and saw daily checks were carried out on the building. Folder checks of care plans were completed weekly. The registered manager reported the quality assurance checks to the director on a monthly basis and would formulate an action plans from these audits. We saw there was also a fundamental standards quality audit in place which linked in with CQC's key line of enquiries that we use to inform our inspections. These had also been discussed with staff.

We saw that one notification of police involvement had not been reported to CQC. Registered managers have a responsibility to notify us of significant events and this information is used to monitor the service and ensure they respond appropriately to keep people safe. The manager was aware of her responsibilities in reporting notifications of events and described this as an oversight. The manager actioned this notification during our inspection and it has since been received by CQC.