HC-One Oval Limited

Meadow Bank Care Home

Inspection report

Meadow Lane
Bamber Bridge
Preston
Lancashire
PR5 8LN

Tel: 01772626363

Date of inspection visit:
05 March 2018
06 March 2018
07 March 2018

Date of publication:
25 April 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Meadow Bank Care Home is registered to provide care for up to 110 older people including people living with dementia and people who require nursing care in four single storey units. Accommodation is in single fully furnished bedrooms and each unit has assisted bathing facilities, dining and lounge areas. The laundry services and kitchen facilities are centrally located within the administration block and main reception area.

This inspection took place on 05, 06 and 07 March 2018, and the first day was unannounced. It was the first inspection of the home since a change in ownership took place in December 2017.

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Meadow Bank is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, both of which we looked at during this inspection

There was no registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. However, we saw evidence the manager at Meadow Bank was in the process of registering.

The manager and staff worked hard to understand people's backgrounds, preferences to care and how they liked to be supported. Care records we reviewed included their life histories to help employees gain a better awareness of each person.

People and staff said they felt the management team was visible about the home and the new manager was experienced and had good leadership skills. We saw records demonstrated action had been taken when the provider's wide-ranging quality assurance systems identified issues.

People we spoke with told us they felt safe and comfortable at the home. Staff had safeguarding training to enhance their skills to protect people from potential abuse, inappropriate support or poor care.

We reviewed rotas and found staffing levels and skill mixes were sufficient to help people with a timely approach. The manager checked staff learning with competency testing and question sessions, which covered multiple areas including personal care, infection control and the Mental Capacity Act. .

We noted staff gave people their medicines with a safe and patient approach. All the staff who administered medication received training and competency testing to underpin their skill and knowledge. One person said, "The staff are very effective, good with your medication."

Staff promoted lunch as a sociable occasion and ensured a welcoming atmosphere during mealtimes. They documented people's preferences and special diets, whilst frequently checking their weights and

monitoring their health against any potential concerns.

During our inspection, we saw staff continuously asked people's permission before they undertook any tasks. Staff had training and understood the principles of the Mental Capacity Act 2005 (MCA) and associated Deprivation of Liberty Safeguards (DoLS).

When we discussed the principles of good care, staff demonstrated a good level of awareness. This was enhanced by clear involvement of people and their relatives in their care planning. One person who lived at Meadow Bank told us, "Very nice staff. Yes, they're kind and compassionate."

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.

There were sufficient numbers of staff to care for people in a safe way. Recruitment processes included checks so that only suitable staff were employed.

The service was clean and working practices were in place to minimise the spread of any infection.

Staff knew how to recognise any potential abuse to keep people safe.

Potential risks to people were identified and measures were in place to minimise them.

People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

We found the building was spacious and appropriate for the care and support provided, including for those who lived with dementia.

People told us they enjoyed their meals and had a variety of food options.

The manager and staff ensured good standards in obtaining and recording people's consent to their care. We saw staff observed the principles of the MCA and DoLS and did not limit people's movement about the home.

Staff files we reviewed evidenced staff received a range of training to support them in their roles.

Is the service caring?

Good

The service was caring.

Staff encouraged people and their representatives to be involved

in their care planning.

Staff reviewed and documented people's diverse needs and assisted them to maintain their different requirements.

We saw they protected each person's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

The staff had a good understanding of people's end of life care needs through good care planning and training.

People and relatives said the home had a sociable atmosphere and they had good opportunities to keep occupied.

The manager developed good care plans which were reviewed, and this ensured a personalised approach to meet each individual's different requirements.

Is the service well-led?

Good

The service was well-led.

People we spoke with told us the new manager was caring and led the home well.

Staff commented they felt the manager and management team were supportive to them in their work.

Those who lived and worked at the home had several opportunities to feed back about the quality of the service, including satisfaction surveys.

We found the manager had an extensive system to assess the quality of the service provided. Where issues were identified, we saw evidence where the manager acted to address them.

Meadow Bank Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 05, 06 and 07 March 2018, and the first day was unannounced. The inspection team consisted of one adult social care inspector, a Specialist Advisor and two experts by experience. An adult social care inspection manager undertook a quality assurance visit on day 1 and 3 of the inspection.

A Specialist Advisor (SpA) offers particular professional knowledge and expertise to inspections when this is needed. They are health and social care professionals and clinicians drawn from a range of disciplines. In this instance, the SpA was a nurse with expertise in working with older adults.

An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts by experience for this inspection had experience of caring for people who lived with dementia in a care home setting.

Before our unannounced inspection, we checked the information we held about the home. This included notifications the provider sent us about incidents that affect the health, safety and welfare of people who lived at the home. We also contacted other health and social care organisations such as the commissioning department at the local authority. This helped us to gain a balanced overview of what people experienced living at the home.

We looked at the Provider Information Return (PIR) the provider had sent us. 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.

We spoke with a range of individuals about this home. They included 15 people who lived at the home, 11 staff members, 5 visiting relatives, three visiting healthcare professionals, three members of the management team and the manager and the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We observed care and support in communal areas and looked around the building to check environmental safety and cleanliness. This enabled us to determine if people received the care and support they needed in an appropriate environment.

We also spent time reviewing records. We examined care records of nine people who lived at the home. This process is called pathway tracking and enables us to judge how well staff at the home understand and plan to meet people's care needs, and manage any risks to people's health and wellbeing. We checked the recruitment, training and support documents in relation to five staff members. We also looked at records related to the management and safety of the home.

Good

Is the service safe?

Our findings

Some people could not effectively express their views. To help us understand their experiences of living in the home, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Throughout our inspection we did not observe anything that gave us cause for concern around how people were treated. We observed positive staff interaction and people were seen to be comfortable, content and happy in staff presence. Visiting relatives expressed their satisfaction with how their relatives were looked after and supported.

However, some relatives and people living at the home had mixed views as to the staffing levels. Some said that they thought there weren't enough staff on duty, and others thought that the staff were slow to respond to call bells. The deployment of staff was assessed, monitored and reviewed by the manager on a weekly using a dependency tool, where staffing levels were determined in line with the assessed needs of the people living at the home. There was a point during the lunchtime period on one unit, when the dining experience appeared to be disorganised.

The manager explained that the usual process before meals was for the staff to meet, in order to discuss the allocation of tasks. On this occasion, due to some staff being involved in telephone calls and personal care, this allocation meeting had not been completed. The manager explained that senior staff had been reminded of the need to ensure the correct deployment of colleagues in order to ensure that the dining experience was pleasant and person centred. Rotas showed that there were always enough competent staff on duty who had the right mix of skills to make sure that practice was safe and so that they could respond to unforeseen events or changes in the assessed needs of the people living at the home.

Our observations, the records and audits showed that staff stored medicines correctly, disposed of them safely and kept good records. People were assured that they received their medicines as prescribed. Where appropriate, the staff involved people in the regular review and risk assessment of their medicines and supported them to be as independent as possible. Staff spoke knowledgeably regarding medicines management. They confirmed that they were trained appropriately, had the necessary assistance from management and were competency checked regularly.

Correct procedures such as ensuring regular discussions with GPs and Social Workers took place, and that decisions relating to medicines were appropriately recorded. To reduce the risk of errors, staff talked with each other, their managers and other agencies and carers, who shared the responsibility for giving medicines.

We noted that some people were in receipt to medicines covertly (without the person knowing). When covert administration of medicines is considered, there should be a 'best interests' meeting. The purpose of this meeting is to agree whether administering medicines covertly is in the person's best interests.

Although the records showed that the proper decision making process had been followed, we found some of the information was disjointed, and a clear recording of who was involved in the decision making process was needed. The manager explained that as the home was moving from one type of recording system to another, this information would be more clearly captured and recorded in a more concise manner.

We found that staff received training in safeguarding vulnerable adults, and our discussions with staff showed that the service had well established relationships with the local safeguarding team operated by the Local Authority. Staff were aware of how to report safeguarding issues and concerns, and had a good understanding of potential abuse which helped to make sure that they could recognise signs and symptoms of abuse.

The manager was found to investigate (when asked by the Local Authority) and review incidents in an open and transparent way. Whistleblowing procedures were in place, and staff knew how to use them. Evidence held within the service records showed that incidents, accidents and safeguarding concerns were reported promptly, and, where required, thoroughly investigated.

We found documentary evidence to show recruitment systems were robust and made sure that the right staff were recruited to keep people safe. All the proper pre-employment checks were seen to be carried out in a timely manner, and new staff were shadowed whilst on induction.

Proper checks had been completed before staff began working for the service. These included the receipt of a full employment history, an identification check, written references from previous employers, a physical and mental health declaration and a Disclosure and Barring Service (DBS) check. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Regular checks on the registration status and fitness to practice of all nursing staff had been completed. We noted when agency nursing and care staff were sometimes used to cover shifts the home had received confirmation from the agency that they were fit and safe to work in the home.

Risk assessments and risk management strategies were in place for all people living at the home. These were regularly reviewed, and if changes were needed then these were swiftly implemented in order to ensure people's safety was promoted and protected. Staff understood how to minimise risks and there was a good track record on safety and risk management. Risk assessments provided staff with guidance on how to manage risks in a consistent manner and included for example moving and handling, use of bed rails, tissue viability, nutrition and falls.

A recognised risk assessment tool for the monitoring of malnutrition and skin integrity was in use and where an increase in risk was identified, we saw that appropriate action had been taken. This included for example the provision of specialist equipment such as an air mattress to minimise the risk of developing a pressure ulcer, or referral to an external agency for advice.

There were strategies in place to make sure that risks were anticipated, identified and managed. Where the service was responsible it kept equipment serviced and well maintained. The staff and management team took action to reduce the risk of injury caused by the environment people lived in and looked for ways to improve safety.

Environmental risk assessments and health and safety checks were completed and kept under review. These included for example, regular checks in relation to fire, health and safety and infection control.

Emergency evacuation plans were also in place including a personal emergency evacuation plan (PEEP) for each person living in the home.

Restrictions were minimised so that people felt safe but also had the most freedom possible – regardless of disability or other needs. Staff explained that they gave people information about risks and actively supported them in their choices so they had as much control and independence as possible. Risk assessments were found to be proportionate and centred round the needs of the person. There was a key pad access to leave the home and visitors were asked to sign in and out of the home. This helped to keep people safe.

People were assessed to see if they were safe to be given the code for the keypad. If it were determined that the person would be unsafe, then appropriate measures were in place to ensure this restriction was properly recorded and authorised. The service regularly reviewed people's needs and took note of any changes, incorporating these into care pans and risk assessments in order to enable people to live as independently as possible.

The staff explained how they managed the control and prevention of infection. Staff followed policies and procedures that meet current and relevant guidance. Staff understood their role and responsibilities for maintaining high standards of cleanliness and hygiene. People who used the service said that they had no concerns relating to food hygiene or general hygiene issues.

Staff told us that there was a culture of learning from mistakes and an open approach. There were specific examples of learning from incidents such as falls and medication errors when processes had been modified to prevent further re-occurrences of issues.

Good

Is the service effective?

Our findings

During our inspection, we observed lunchtime was a friendly occasion and people enjoyed their meals. One person told us, "The food is nutritious and on the whole mealtimes are enjoyable." Another person commented, "The chef is excellent. There's always a choice of meals." A third person stated, "The food is very nice actually."

People were involved in choosing food from a rotating weekly menu. Lunch time was observed both in the dining room and in people's own rooms; although this was found to be a relaxed and pleasant experience for people using the service, on one unit, there was a period of time when it felt a little disorganised. Following discussion with staff and the manager, it was clear that this was not down to insufficient staffing levels, but rather, the effective deployment of staff.

The manager explained that senior staff had been reminded of the need to ensure the correct deployment of colleagues in order to ensure that the dining experience was pleasant and person centred. People told us they enjoyed the food and they were able to eat at a time that suited them. Where people required assistance from staff, this was provided discreetly and in an unhurried manner. Where people did not want an item on the menu, alternatives were offered. Staff were aware of people's likes and dislikes, and the catering staff were aware of people who required a specialised diet, and ensured this was provided through nutritional assessment and planning.

People's needs were assessed before they moved into the home. Where assessments were not able to be fully completed due to a lack of information, additional measures were put in place to ensure prompt support was available to help with any concerns that may arise. The manager explained that she made sure that the needs of people were met consistently by staff who had the right competencies, knowledge, qualifications, skills, experience and attitudes.

We saw records that showed that staff had a thorough induction that gave them the skills and confidence to carry out their role and responsibilities effectively. The service had a proactive approach to staff members' learning and development. Staff files we reviewed evidenced staff received a range of training to support them in their roles. This included safeguarding, person-centred care, dementia awareness, environmental and fire safety, manual handling, basic life support and food hygiene. The manager followed this up with competency testing and question sessions, which covered multiple areas including personal care, infection control and the MCA. Staff we spoke with said the provider supported them with a range of courses. One staff member told us, "The manager will get us on as much training as possible."

We found evidence staff received regular supervision to underpin their roles and responsibilities. Supervision was a one-to-one support meeting between individual staff and their line manager to review their role and responsibilities. The two-way discussion covered, for instance, a review of previous sessions, work performance, training and personal issues. The manager explained staff were asked questions around equality and diversity during their supervision and appraisals, and this was documented in the staff files.

The home was accessible to people and pleasantly decorated, and had some adaptations to meet people's current needs. There were grab rails, ramps and mobility aids. Appropriate signage was placed around the units to help people orientate around the building and on specific units.
People were supported to maintain their health and emotional wellbeing through access to preventative healthcare, for example GP visits, dental checks, opticians and chiropodists and had annual health checks and medicines reviews. Staff knew people's routine and specialised health needs and preferences, and the records showed that these were consistently kept them under review. Appropriate referrals were made to other health and social care services as and when required. The records showed that people's needs were regularly monitored and reviewed and relevant professionals and people using the service were actively involved in this.

Consent was always sought before care was provided, and when decisions were made on behalf of or about individuals, then this was appropriately documented. We saw that people, and their relatives (where appropriate) had been involved, consulted with and had agreed with the level of care and treatment provided. We saw that consent to care and treatment within care records had been signed by people with the appropriate legal authority. This meant that people's rights were being protected.

The principles of the Mental Capacity Act (MCA) were now embedded in practice within the home, and all the relevant documentation is now completed in line the MCA. Staff understood and had a good working knowledge of the key requirements of the MCA. They put these into practice effectively, and ensured people's rights were respected.

Staff always considered people's capacity to take particular decisions and knew what they need to do to make sure decisions were taken in people's best interests and involved the right professionals. Where people did not have the capacity to make decisions they were given the information they needed in an accessible format. When best interests meetings are needs, the new recording system would show who attended the meeting eg care home staff, relevant health professionals and a person who can communicate the views and interests of the person (this could be a family member, friend or independent mental capacity advocate). If the person had an attorney appointed under the Mental Capacity Act for health and welfare decisions, then this person would also be present at the meeting, and their views recorded.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedure for this in care homes is called the deprivation of liberty safeguards (DoLS). Appropriate applications had been submitted to the local authority for authorisation where required.

Good

Is the service caring?

Our findings

People received care and support from staff who knew and understand their history, likes, preferences and needs. The relationships between staff and people receiving support were described by service users as "positive", "respectful" and "dignified." One person said, "The staff are kind and compassionate." Another person added, "Yes, staff treat you with respect and they are kind." A third individual stated, "We get looked after in here. If you are upset they come and try to help."

However, some people believed some of the more established staff had more "time to talk" than some of the newer recruits. We explored this with three people in further detail. One person believed that some of the newer staff could be encouraged to "chat and talk about their day a little more", rather than just "undertaking the jobs they have to do." Another person said, "I appreciate that staff are busy, but I think sometimes, some of them could just take 2 mins out, and have a natter". The people we spoke with were clear, that these sentiments did not apply to all the staff at the home, but a few individuals who had recently been recruited.

We discussed this with the manager, and she was clear that she would be supporting the newer staff through training and supervision, to ensure that they were clear about their role, part of which was to interact with people and give people time.

The atmosphere on each unit in the home was calm and relaxed. Staff had a very good knowledge of the people they supported, including their life histories, the things they liked and didn't like and the people who were important to them. Relatives and friends were welcome to visit at any time and people were supported by staff to maintain relationships with friends and family outside of the home.

People said that they were proactively supported and encouraged to express their views and staff said that they gave people information and explanations they needed about their care so that they could make informed decisions. Staff were seen to enable people to take control of their daily routines, make decisions and maintain their independence as much as possible. This was evident throughout the inspection when staff consistently asked people for their thoughts and wishes.

Relatives told us they felt involved and had been asked about their family member's likes and dislikes, and personal history. The 'My Day, My Life' care documentation supported staff to better understand people's individual needs, choices and preferences and focused on the development of person centredcare plans.

Staff communicated effectively with every person using the service, no matter how complex their needs. We saw people were involved in 'residents forums' each month. Minutes of these meetings showed us people who used the service were provided with information and were asked their opinion about the menus and activities provided.

There were notice boards in the entrance with information the policy on smoking in the service, the food safety certificate and how to complain. We saw menus were provided in written and pictorial format.

We saw there were leaflets about advocacy services on display. Advocates are independent people who provide support for those who may require some assistance to express their views. Signposting people towards advocacy services helped to ensure people's rights to make decisions about their care and support were promoted.

We observed that staff treated people with dignity and respect and encouraged people to treat each other in the same way. We heard that when people had disagreements, staff would act as mediators to help them resolve their differences in a way that helped them to maintain respect for each other's views and opinions and hopefully reach a resolution. This was confirmed by a health professional who told us how staff had assisted a person they supported to resolve an issue with another person who lived at the home.

People told us that they trusted the staff that worked with them, and the staff we spoke with understood and respected people's confidentiality. Staff recognised the importance of not sharing information with people inappropriately, and the service had processes in place to deal with breaches in confidentiality.

Good

Is the service responsive?

Our findings

We looked at the arrangements in place to ensure people received care that had been appropriately assessed, planned and reviewed. People's support plans included information about all areas of their life and guidance for staff in how to provide the support they required. For example, their communication, eating and drinking, work, social and leisure needs, their health and emotional wellbeing and their goals and aspirations. They included information about people's end of life wishes where appropriate. Support plans included information on how to promote people's independence and choice.

Care plans for people living with dementia were supported by 'My life, My day'. This gave details of what was important in people's lives and how this can be achieved with staff support. The profile set out what was important to each person for example how they were dressed, personal care and how they could best be supported.

People's needs were recognised and addressed by the service and the level of support was adjusted to suit individual requirements. The provider had systems in place to ensure they could respond to people's changing needs. For example staff told us there was a handover meeting at the start and end of each shift. During the meeting staff discussed people's wellbeing and any concerns they had. This meant staff were kept well informed about the care of people living in the home.

Daily reports provided evidence to show people had received care and support in line with their care plan. We noted the records were detailed and people's needs were described in respectful and sensitive terms. We also noted charts were completed as necessary for people who required any aspect of their care monitoring, for example, personal hygiene, falls and behaviour.

People were able to keep in contact with families and friends. Visiting arrangements were flexible. Visitors we spoke with told us they were able to visit their relatives and friends at any time and were made to feel welcome. People's friends and family had been invited to join in with activities and were informed of forthcoming events. Information about daily activities was displayed on notice boards around the home.

People told us they would feel confident talking to a member of staff or the manager if they had a concern or wished to raise a complaint. One person told us, "I would definitely say something if I was concerned about anything." Relatives we spoke with were complimentary about the service and told us they would raise any concern with a member of staff or the manager if needed and be confident this would be taken seriously.

We looked at how the service managed complaints. The service had a policy and procedure for dealing with any complaints or concerns, which included the relevant time scales. We noted there was a complaints procedure displayed in the home and information about the procedure in the service user guide. We found a very professional approach had been taken to deal with the issues raised. The whole process from receiving the complaint to a resulting satisfactory conclusion had involved the complainant. All complaints were reviewed in order to identify any lessons learnt and enable strategies to be put into place to minimise the risk of a reoccurrence.

Good

Is the service well-led?

Our findings

We asked people using the service and relatives/visitors for their opinion of how the service was managed. People made some positive comments as to how the service was run and about the manager. They said, "I think she is very nice, we always see her about and we can talk to her. She gets involved and is interested in what we are doing." "I think the manager has everything sorted. Staff know what they are doing, it's nice here." Relatives we spoke with told us, "It's nice to see the home manager walking around. She is always present." "She most certainly has time to talk to us. I have raised issues I am not happy with and she has dealt with this very well. I have no problems at all."

The manager at the home was not registered with the CQC. However, she had only been at the home for 3 months and was going through the process to register. Staff were very complimentary about her and her approach. She was described as "visible and approachable". Staff explained that there was an open and transparent culture within the home which helped them share ideas and raise any concerns. Staff felt supported by the manager and management team, and they said that there was a good team approach to work in the home.

The leadership and governance systems were found to promote good quality care based on the assessed needs of people living at the home. Quality assurance processes now ensured that any risks or shortfalls in care were identified and dealt with in a timely fashion. Governance and performance management were reliable and effective. Systems were regularly reviewed, and risks were identified and managed. Staff completed on-going checks as part of their daily tasks to ensure people received the care they needed.

The manager and management team undertook a range of audits to ensure staff were providing safe and good quality care. Any actions were identified and completed. Feedback to staff was described as consistent and this meant that any instructions were clear about what was needed to bring about improvements. Policies and procedures were in place for staff to follow, and these were periodically reviewed to ensure staff had up to date guidance which was in line with national guidance and good practice.

We found a positive approach to sharing information with and obtaining the views of staff, people who use services, external partners and other stakeholders. Staff meetings took place regularly and people were encouraged to share their views and ideas for improving the service.
Minutes of the last residents' meeting showed that people discussed the things that were important to them, such as activities, décor and menus.

People using the service and relatives participated in an annual Customer Satisfaction Survey. The results were collated and analysed and shared with all staff, residents and relatives. There was an 'open door' policy which meant that people using the service, their relatives, professionals visiting the service and members of staff were welcome to speak with the manager at any time. People and their relatives had opportunities to provide feedback about their views of the care provided. The registered manager had a system where they sent out surveys to a range of stakeholders (i.e. people at the home, relatives, and professionals).

Staff told us that communication in the team was effective. They had a handover meeting so that staff coming on shift had up to date information about people and any incidents or changes to their care needs. There was a written copy of the handover so staff could refer to it, and a shift plan with allocated duties to be completed throughout the shift which ensured staff understood their responsibilities and the home ran smoothly.

Through discussion with the manager and staff we found that quality assurance arrangements were applied consistently. Action to introduce improvements were not just reactive or focused on the short term changes, but were planned in consultation with people at the home. For example, changes to the environment had been identified following discussions with the staff and people at the home.

The service had a collaborative and cooperative approach to working with external stakeholders and other services. Visiting healthcare professionals confirmed that the manager and staff always shared information effectively and appropriately. Data relating to people living at the home was shared as required with eternal agencies and this helped to showed there was good systems in place that promoted partnership working.

There were systems in place to ensure the CQC rating given to the home was displayed e.g. the provider's website, and on the noticed board within the home. The manager notified CQC of incidents such as safeguarding alerts, as required.