Care Quality Commission

Chasewood Care Limited

Chasewood Lodge

Inspection report

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Ratings

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

Overall summary

This inspection took place on 12 November 2014 and was unannounced.

Chasewood Lodge is a large care home with a registration for 107 beds. Part of the home is not used, and at the time of our visit the home was providing care for 78 people.

The home has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in June 2014 we identified concerns in the care and welfare of people who used the service, the safety and suitability of equipment, and assessing and monitoring the quality of service. In September 2014 the provider sent us an action plan detailing what action they were taking to improve the service. At this inspection we found some improvements had been made.

We found medicines were not managed safely. Drugs which have stricter legal controls to prevent them being misused, causing harm or obtained illegally had not been handled or managed safely by staff. There were gaps in medication record charts, there was insufficient

Summary of findings

information for staff about when to give a 'when required' medicine and best interest decisions had not been followed for people who required their medicines concealed.

Recruitment practice was not always safe because staff had recently been recruited and started work before all the necessary checks required to support the safety of people, had been carried out. Induction procedures did not always ensure staff on the rota had the necessary skills and knowledge to support people effectively. Staff received training to support them in carrying out all essential tasks related to providing effective care.

Insufficient action was taken to identify trends or patterns relating to accidents or incidents to improve safety of people living at the home.

We found care records were not kept in a secure cupboard, and we found some private and confidential information about people on display.

Important quality and safety checks had not been carried out by staff who had been delegated this responsibility. The manager had not ensured their senior staff carried out these checks.

The manager had not sent all the statutory notifications required to the Care Quality Commission. These are notifications to inform us of deaths and incidents that affect the health, safety and welfare of people who live at the home. The manager had sent notifications to us about allegations of abuse.

People felt safe living at Chasewood Lodge. Staff knew what constituted abuse and knew their responsibilities to report safeguarding concerns to management. Management had demonstrated they understood their responsibilities to report safeguarding concerns to the local authority.

People were not unlawfully deprived of their liberty because the manager knew what to do to support them under the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

We have made a recommendation the provider seeks guidance about the completion of attempt to resuscitate forms to ensure they are acting within the legislation.

People were provided with food and drink to meet their nutritional needs. People told us they enjoyed their meals.

We saw staff were caring and kind to people who lived at Chasewood Lodge. We saw people's dignity was supported and they were treated with respect by staff.

Staff undertook some social activities with people but there was little for people to do in the home to support any social interests or hobbies they may previously have had.

There were mixed views from staff as to whether there was an open and transparent management culture.

You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires Improvement

The service was not consistently safe.

Some staff had started working at the home before all the necessary recruitment checks on their safety had been carried out. The recording, administration and storage of medicines was not safe. There was particular concern with the administration and storage of controlled drugs.

Accidents and incidents had not been effectively monitored with limited action taken to support people's safety. People who lived at the home felt safe with the staff who supported them.

Is the service effective?

Requires Improvement

The service was mostly effective.

Staff new to care work had a very short period of time shadowing experienced staff before being included on the rota. Staff had received training which provided them with skills and knowledge in delivering support to people.

People were provided with a good choice of food. Staff ensured people received the care and support necessary to manage any health care needs.

Is the service caring?

Good

The service was caring.

We saw positive and caring relationships between people who used the service and the staff who supported them. We saw people were treated with respect, staff ensured care was provided in private and people's dignity was fully considered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Activities took place at the home but they did not always reflect the needs, hobbies or interests of people living at Chasewood Lodge. Relatives and friends could visit the home at any time in the day or evening.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The registered manager had not ensured staff who had been delegated management duties had carried them out effectively. These included quality checks, safe recruitment practice and submitting notifications to the CQC.

Chasewood Lodge

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 was 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 12 November 2014. The inspection was unannounced. The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience used for this inspection had experience of older people and dementia care needs.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvement they plan to make. They did not return a PIR and told us they had not received the request.

We looked at the notifications sent to us by the provider. These are notifications the provider must send to us which inform of deaths in the home, and incidents that affect the health, safety and welfare of people who live at Chasewood Lodge. We spoke with the local authority contract monitoring officer who provided us with information they had received about the service.

During our inspection we spent time observing how staff interacted with people who lived in the home. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people who lived at the home, five visiting friends and relatives and 15 staff. These included kitchen staff, domestic staff, care staff, a deputy manager and the registered manager.

We looked at seven people's care records, records to demonstrate the registered manager monitored the quality of service provided (quality assurance checks), five staff records, and complaints, incident and accident records.

Is the service safe?

Our findings

People told us their medicines were administered to them safely by staff. One person told us, "I take tablets, I couldn't tell you what they are; I take them twice a day, morning and night. At night the times vary, eight or nine o'clock. I go to bed at 10pm. If I'm in pain, they are very good, I never have to wait." Another person told us, "My pills are always on time twice a day. I have asked for paracetamol when my heel hurts, they get them for me, I don't have to wait too long."

Whilst people we spoke with were satisfied with the way staff managed their medicines, when we looked at the management of medicines we found they were not managed safely. Medicines were not all stored, handled or managed safely by staff. CDs are medicines that require extra checks and special storage arrangements. One CD cabinet was not secured safely to the wall. We found that records for receipt, balance of stock available and the disposal of CDs were not accurate. There were no arrangements in place to check that CD records were completed accurately. These errors had not been identified by the service. Staff we spoke with were not aware of how to handle or record CDs safely.

We could not be assured people were always given their prescribed medicines as intended. For example, we found gaps in some people's medicine records (MAR) charts. This is when there is no staff signature to record the administration of a medicine or a reason documented to explain why the medicine had not been given. We also found some medicines had not been given to people. There was no reason documented to explain why. These medicine errors had not been identified by the service. Staff we spoke with were unable to explain why the medicine records were not accurate.

We looked at the records of six people who were prescribed a medicine to be given 'when necessary' or 'as required' for agitation. There was no information to explain to staff how they should assess behaviours to determine whether the medicines were required or necessary. When people were given a medicine prescribed for agitation, there was no record to explain why the medicine had been given.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

At our previous inspection, two staff recruitment files had gone missing. Prior to this inspection we had received information that a new member of staff was working at the home before appropriate checks had been made to ensure they were suitable to work with people who lived at the home. We asked to see the recruitment file for one member of staff who had recently started working at the home, but this could not be found. This meant we could not determine whether the provider had complied with safe recruitment practice.

Two staff told us they had started work before the checks from the Disclosure and Barring Service had been returned. We found during that time they had been providing personal care unsupervised. We looked at the recruitment files of more recent recruits. We found one person was providing personal care to people before their checks had been returned. We informed the registered manager of this. They told us they were unaware of this would take immediate action to ensure people were safe. They agreed to check the records of all recent recruits to ensure the necessary checks had been completed prior to them starting work.

This was in breach of Regulation 21 of the Health and Social Care Act 2008.

Five of the six people we spoke with told us there were enough staff available to meet their needs. One person told us, "I think there are enough staff, if I say I want to be up earlier, they will call me, the same at night." The person who felt there were not enough told us, "No definitely not. When I ask to go to the toilet, it's always, wait a minute, they always take a long time to come especially at night, there's only one person on at night." We spoke with night staff, they told us, "For the night shift, it feels like there is enough staff." A relative told us, "Between 2pm and 4pm, no, there is not enough staff."

Staff told us there were times when there were not enough staff to meet people's needs. We looked at the rota and found this was mostly due to staff sickness and the rota not being covered. One member of staff told us, "Yesterday, three people phoned in sick…this was covered by existing staff working an extra shift." The manager said they had instigated a new 'sickness policy' which was reducing the amount of sick leave in the home. Housekeeping and domestic staff who had received training to support with care tasks also helped when demand was higher. One staff member said, "My staff team will jump in and help out on

Is the service safe?

the floor if they are needed." The manager told us they always put on additional staff if people's needs required it. We saw sufficient staff to meet people's care needs. We saw two staff members supported people on each of the units and staff worked together to support each other.

We looked at the premises and the equipment to check they were safe and fit for purpose. Whilst the premises and most of the equipment were in reasonable condition, we saw chairs in lounges where the covers had been torn and foam was protruding out of them. This meant they could not be cleaned and were an infection control hazard.

Since our last inspection, an audit tool had been put in place which gave details of the number of incidents and accidents each month but there were no assessments to see whether there were patterns or trends to reduce the risks of these happening in the future. We were told by the manager this responsibility had been delegated to the deputy managers. We saw there were 32 accidents and incidents in August 2014, 18 in September and 15 in October 2014. The new deputy manager acknowledged no analysis had been taken in relation to accidents which involved people falling. They told us they were in the process of reviewing this and where appropriate would refer people to the falls clinic.

We asked people if they felt safe living at Chasewood Lodge. One person told us, "How can you not feel safe living here, I feel safe, no worries getting out of my chair." Another person said, "Safe, I feel quite safe here, there's nothing that makes me feel unsafe, I like the staff they are very good." A third person told us, "Yes, definitely, I'm very happy here, the staff are good, all of them." We saw the home had plans to evacuate people safely. The plans were accessible to the emergency services should the home need to be evacuated in an emergency.

We checked with staff their understanding of how to safeguard people who lived in the home from abuse. We asked what they would do if they saw another member of staff shouting abusively at a person. All staff told us this was wrong and they would report this to the manager. From our monitoring of the service we were aware the manager understood and acted on safeguarding concerns.

Is the service effective?

Our findings

People told us staff, "Seem to know what they are doing." Another said, "Staff are wonderful, every minute of the day."

We looked at arrangements in the service to induct, support and train the staff. We found new staff worked two shifts where they 'shadowed' more experienced staff and were not included in the rota. The registered manager told us they felt this was sufficient, but if staff required more time, they would be given one or two more shifts to shadow.

We spoke with one member of staff who had no experience of working in a care setting before working at Chasewood Lodge. They told us they 'shadowed' staff for two shifts and were then put on the rota. They said they had a 13 week induction period during which time they had undertaken training considered essential to support the health and wellbeing of people. This included moving and handling people, fire safety and safeguarding people. They told us they did not support people with moving until they had received their training, which was within the first month of working at the home. Whilst there were sufficient numbers on the rota, staff were not always able to provide effective support to people because they were new, sometimes inexperienced, and had not received the training to provide full and effective care in a timely way. A member of staff told us the training of new staff was an issue. They said "People have been employed here and have spent up to a couple of months without any training. As a result this puts pressure on people like me." They explained if someone had not been provided with training in moving and handling, they would have to call on a member of staff from another unit to support them. This meant the person had to wait more time than they should to have the care and support they required and the other unit had to work short staffed for a period of time.

Staff we spoke with told us they had been trained and received work supervision to support them in their roles and had undertaken more extensive training in health and social care. For example, staff had undertaken diplomas in health and social care at levels two through to five (management level). This provided them with further knowledge about managing and supporting people's care needs.

We are required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Staff responsible for assessing people's capacity to consent to their care, demonstrated an awareness of the Deprivation of Liberty Safeguards (DoLS). This is a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted to keep them safe. There were people at Chasewood Lodge who were subject to formal authorisations to deprive their liberty at the time of this inspection. This meant the registered manager was working within the law to restrict people's liberty.

We looked at how the registered manager managed the administration of medicines to people who did not have the mental capacity to give this consent. One person, who had previously refused to take their medicines had them administered concealed in food or drink (covertly). We found that 'best interest' procedures had not been followed. We could not find why it was necessary for the person to be administered their medicines covertly to maintain their health and wellbeing or what specific medicines were to be concealed.

We looked at the care record of a person who had been assessed as not having full mental capacity to make decisions. We saw the care record detailed how staff could communicate with the person to help them understand and make day to day decisions. This meant staff could support the person to be as independent as possible.

On the day of our visit a person from an independent advocacy service had a meeting with the manager to look at how they could support a person who was subject to DoLS and best interest decisions. This was because the person had dementia and could not communicate their wishes. The independent advocate was invited to act on the person's behalf.

We saw the provider had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records in place for many people who lived at Chasewood Lodge. These had been completed in conjunction with the person's GP. The registered manager was not clear whether these forms had been completed for people where cardiac or respiratory arrest was a clear possibility for the person, or whether it was for all people who would not want to be resuscitated. It was also not clear that people had been involved in the decision to have a DNACPR.

Is the service effective?

We looked at whether people were supported to eat and drink enough and to maintain a balanced diet. We asked people if they liked the food provided by the home. People told us, "Yes, it was very nice", "Nice and tasty, thank you." Another said, "I told you I'm satisfied, I have my curry goat. I enjoy it." A third person told us, "The food here is lovely, beautifully presented. They have drinks all day." We saw people tell staff about the food they had. One person said, "Thanks for my lovely breakfast, I enjoyed it."

At each meal time people were provided with choice. For example, at breakfast we saw people had a range of choice such as cereals, toast, porridge and a cooked breakfast. We saw people had hot drinks with their breakfast. At lunchtime, in two of the three units we observed people had a choice of lunch. Staff encouraged people to make choices by showing them the different options and explained to them what was on each plate. In one unit, people were not supported to have a choice of main meal. We asked the care worker why they did not offer people the choice of sausage or turkey and they responded, "I usually ask them." We saw the same care worker provide people with a choice of dessert. They said to a person, "Would you like cherry pie or rice pudding", and showed them a sample of each dessert. One relative told us, "I've been here at mealtimes I don't recall [Person] choosing what to eat."

We saw some people who chose not to sit at a table, had their meals without a lap table. We were told this was their choice. Many of the lap tables and small tables people used when eating were not suitable because they could not be positioned to support people eating their meals comfortably and safely. For example, we saw people having to lean across to get their food, and the distance meant that food was dropped from their forks before people could eat it. We were concerned people had plates with hot food on their laps without any protection or a tray. We asked staff why people were eating their meals on their laps. We were told people preferred this.

We saw people were encouraged to eat and drink throughout the day. Staff had a good knowledge of people's preferences and dietary needs. For example, one person was vegetarian and the member of staff made sure the sausage was not put on their plate when they had a cooked breakfast. Two people required food which met their different cultural needs and these were provided.

During breakfast, we saw staff on one unit use the green paper hand towels to put people's toast on instead of providing people with a plate. We asked a member of staff why they were giving the toast on hand towels. They told us they always did it this way. The registered manager told us they were not aware this had been happening and acknowledged it was not acceptable practice. They told us they would ensure it did not continue. We saw at times staff did not ask people if they would like to wear a cover to stop food from spilling on their clothes. Those who were provided with protection were provided with plastic aprons.

We looked at people's health care needs. A relative told us, "The doctor visits [relation] and the chiropodist." We saw the appropriate professionals were contacted to support people's changing health care. On the day of our visit we saw the district nurses attending to a person. We were informed the GP was in regular attendance. We saw records which confirmed other health care professionals such as the speech and language therapists and chiropodists had worked with people in the home.

We have made a recommendation the provider seeks guidance about the completion of attempt to resuscitate forms to ensure they are acting within the legislation.

Is the service caring?

Our findings

People we spoke with made many positive comments about the care they received. For example, people who lived at the home told us, "The care here is great," "Overall I am satisfied with my care" and, "This is the best place in the world." Visitors we spoke with also told us staff were caring. They told us, "I would give the staff 8/10. I have never seen them impatient with anyone." "The staff are always caring when speaking to my [relation] or to me. I notice they are the same when they talk to other people here."

The home was split into three units on both floors. We saw people were able to move around the home at their own will and use any of the lounges or dining areas.

When we arrived at 7am we saw most people were still asleep in bed. We saw people gradually getting up and having breakfast in their own time. One person told us, "Nobody has ever told me when to get up. I've never been told when to go to bed." We saw staff assumed people had the ability to make their own decisions about their daily lives and gave people choices in a way they could understand. They also gave people the time to express their wishes and respected the decisions they made.

We sat in on a handover meeting in one of the units when night staff informed day staff of the care provided to people throughout the night. We heard staff speak in a caring way about people and noted that night staff had responded to individual needs well. For example, one person had woken up at 2am feeling hungry and thirsty. The night staff had made them a cup of tea and given them some biscuits.

We saw people were treated in a caring and kind way. Staff were friendly, patient and discreet when providing support to people. Staff took the time to speak with people as they supported them. We saw people and staff enjoying each other's company and sharing jokes with each other. One person said to us, "It's alright here. I listen to the chattering. I don't have that at home. They are not rude, they are laughing with me, they enjoy it and I enjoy it."

We saw a member of staff approach a person a number of times to find out what their choice was for breakfast. The person did not communicate their preference the first three times the staff member asked, but the staff member patiently tried again. On the fourth attempt the person told them what they wanted to eat.

Whilst we observed staff worked well to ensure people expressed their views, some people told us staff did not always routinely involve them in decisions about their care. One person said, "They don't really ask me, they just do it." Another said, "I'm happy to let them do it, they know best." A third said, "They are very efficient, they decide for me."

We found staff supported people to maintain their dignity. One relative told us, "I have never seen anything embarrassing; they always take the residents away to do personal things." Staff told us, "I'd take them into their rooms, lock the door and make them feel at ease. If using the toilet, I would close the toilet door until they call to say they are finished." We heard one care worker say to a person, "Hi [Person] can I help you, do you want to stand up and go to the toilet…don't worry, I won't be with you, I will wait outside." This demonstrated the staff understood how to promote dignity. A person who lived at the home confirmed this. They told us, "I'm disabled, when they wash me they are very respectful, they cover me with a towel when they wash me." Staff also told us people had a choice of male or female care workers to support them with personal care.

Is the service responsive?

Our findings

We saw staff responded to people's personal care needs but did not have enough time to be as responsive to people's individual social care needs. People told us, "We get bored stiff here." A visitor told us, "I would say they know what they like and need, I never see much going on. I have seen [relation] doing jigsaws twice over the last two months. I haven't seen any activities going on." Another visitor told us, "I think they know [person's] likes and dislikes. There was a sing song last week. I see them doing puzzles and jigsaws." A third visitor said, "There should be more stimulation and communication, the staff are always busy doing other things."

Activities were not planned to meet the needs or interests of people who lived at the home. We saw some staff involved people with puzzles and jigsaws when they had the time but not all people showed an interest in these activities. We were told the registered manager had people on the rota to provide activities two days a week. Staff told us they could, "Fit activities in between 10am and 12pm, 2pm and 4pm and 5pm and 7pm." They told us they did painting, soft ball, catch and jigsaws. We did not see staff routinely use information about the person to support them in undertaking interests, hobbies or activities that were personal to them. One relative told us a person with dementia had been making Christmas cards in September and was very confused because it had not been explained to them.

Many people living at Chasewood Lodge, because of their dementia, were not able to tell us if staff supported them as detailed in their care plan. Because of this, we checked a sample of seven care records to confirm people were getting the support they wanted. We saw some gaps in the records. For example, it was recorded that one person only had two showers in July, one in August, and one in October. The member of staff we spoke with told us the person was getting more frequent showers but staff were not recording this. The person could not tell us whether this was the case.

People were encouraged and supported to maintain relationships with people that mattered to them. There were no restrictions on visitors and we saw visitors arrive at different times during the day and evening.

We asked people if they knew how to complain if they were not happy with any aspect of their life at Chasewood Lodge. People told us they had felt no need to complain. One person said, "There's no need to complain, it's so good."

We saw there had been complaints made to the home and the provider had responded to the formal complaints in line with their complaints policy and procedures. We were told there had been three formal complaints within the last six months. Two were in relation to laundry and had been addressed to the satisfaction of the complainants, and the third was under investigation.

Is the service well-led?

Our findings

The manager at Chasewood Lodge was registered with us. They have been the manager of the home for 19 years.

The manager is registered to manage two homes for the provider. This meant they had legal responsibility for ensuring the standard of care in each home met the Regulations. The registered manager was not always present at Chasewood Lodge and delegated the responsibility for many of the quality assurance checks and recruitment, to their deputy managers. They told us they had not been as present at Chasewood Lodge because unexpected issues impacting on the other home had taken up a large proportion of their time. They had delegated many of their duties to their deputy managers.

The registered manager had a legal responsibility to notify us of any incidents that affect people who use services. At our last inspection in June 2014 the provider was in breach of Regulation 16 and 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009, because we had not received any notifications since September 2013. These notifications included deaths of people who used the service and other incidents which affected the health, safety and welfare of people who lived in the home

At this inspection we found a continued breach of the Regulation. We had received notifications of three events however we should have received notification of nine deaths and 26 hospital admissions since June 2014. The manager had delegated the responsibility of notifying the CQC to one of their deputies and expected their deputy to have informed us of the events. The deputy had not done so. This meant we did not receive all the information required to help us assess whether action needed to be taken. This was a continued breach of Regulation 16 and 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The manager informed us that other quality and safety checks including medication, care planning, accident and incidents, and recruitment had also been delegated to their deputy managers. They acknowledged they had not provided sufficient management oversight to check the delegated duties had been carried out appropriately.

We saw that care records were not stored safely and securely. Each unit stored the care records in a kitchen cupboard within the unit. These did not have locks on them. In one unit the door had fallen off the cupboard which meant anyone walking into the lounge or dining room of this unit could see personal records were stored there. We also found two notes on the wall of one unit; both gave personal details about people. One note fully identified the person with their name and the other gave information about people and used their initials. Both could easily be seen by any person living on the unit or visiting. These were removed as soon as the registered manager was informed.

Staff provided a mix response in relation to whether they felt there was an open and fair culture of management at the home. Some staff felt management was open and supportive, for example one member of staff said, “I get on well with [manager], she is lovely and understanding. If you do anything wrong she will pull you up on it.”

Some staff felt their thoughts and views about the service were not listened to. For example, “I wish the manager would listen more to the concerns raised by staff. If someone has raised an issue, you expect the manager to look at both sides. She comes down hard without giving people a hearing.” All staff told us they worked well as a team and provided good support to each other.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People who used the service were not protected against the risks associated with the unsafe management of medicines.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person did not operate effective recruitment procedures.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 CQC (Registration) Regulations 2009 Notification of death of a person who uses services **The registered person did not notify us of deaths of people who lived in the home.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person did not notify us of other incidents that occurred whilst the regulated activity was being carried out.**