Care Quality Commission

Birmingham City Council

Kenrick Centre

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?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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, and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This inspection was unannounced so that no one knew we were visiting the home. At our last inspection on 31 January 2014 we identified a breach in the regulations relating to people's care records. During this inspection we saw that improvements had been made to meet the requirement of the regulation we identified at that time.

The Kenrick centre is a purpose built centre, which is registered to provide two types of service. On the first floor there is an enablement service which provides personal care for 32 people for up to six weeks following discharge from hospital. The ground floor is registered to provide accommodation for persons who require nursing

Summary of findings

or personal care for 31 people. A registered manager is required to manage this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. The provider had chosen to register two separate managers; one for the residential service and one for the enablement service. At the time of this inspection the residential service was being managed by someone who was not registered to manage this service.

During our inspection we spoke with 21 people living in the home, three relatives, eighteen staff, two managers and eight health care professionals that visited the service.

We saw that the service needed to improve their systems so that people received safe care. We found that there was a breach in the regulations regarding staff practices in relation to the Mental Capacity Act and protecting the rights of people that lacked capacity to make informed decisions about their care. The provider had also not kept us informed of changes to the registered manager's role and other incidences that we should be kept informed about. You can see what action we told the provider to take at the back of the full version of the report.

We saw that the building was fully accessible and adapted to support people with restricted mobility and furnishings and fittings provided a pleasant environment at the centre. Safety issues were identified in the environment, which indicated that the environment was not fully maintained to ensure people's safety. We spoke with the fire service about fire safety issues that we saw and they told us they would visit the service.

All staff spoken with said they had all the required employment checks before commencing work and records confirmed this. We found that the provider had systems in place to ensure there were sufficient staff to meet people's needs. Although some people and staff told us that sometimes enough staff we not available, managers told us they were recruiting to fill vacant posts, to ensure a stable staff team.

Staff received supervision to enable them to do their job, and were knowledgeable about people's individual needs. However, training records showed that a number of staff had not received core training in many areas, which could potentially compromise the care people received.

People received sufficient food and fluids to ensure their nutritional needs were maintained. During the inspection we observed that not everyone was provided with adequate support to eat their meal. Everyone spoken with told us that there was a choice of food and drinks available throughout the day.

People's health care needs were maintained and people told us they saw the doctor when needed. Health professionals and relatives spoken with had no concerns about people's health needs.

We saw and people told us that they received the care they needed. Staff knew people well, so were able to provide care in a way that people wanted them to. People's independence and dignity was promoted.

Everyone that we spoke with said that they thought the staff were caring. Whilst we saw very little interactions between staff and people, the interactions we saw were good. Some people and relatives commented on the lack of activities that took place in the home.

The majority of the people spoken with felt they were able to raise concerns and they would be dealt with. One person using the enablement service said they had waited an unacceptable length of time for staff to respond when they called for help and felt staff did not listen to them.

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?

The service was not safe. The rights of people that lacked the capacity to make informed decisions about their care was not adequately safeguarded. Procedures were in place to safeguard people from abuse, but staff training records showed that training was not up to date.

All staff spoken with told us they were safely recruited into their role. We saw that the environment was not safely maintained.

Requires Improvement

Is the service effective?

The service was not effective. People were cared for by staff that knew them well. This was because each person had an allocated member of staff to be responsible for their care and their needs were assessed.

A training programme was in place to ensure staff had the necessary training to care for people effectively. However, gaps were seen in staff training records showing that a number of staff had not had all their core training needed to do their job.

People did not always receive the support they needed with eating their meals.

Requires Improvement

Is the service caring?

The service was not always caring. All the people and their relatives spoken with said that the staff were caring. Not everyone spoken with felt they were fully involved in making decisions about their care and support.

Although we saw very little interactions between staff and people, the interaction we did see was good. Staff were gentle, caring and respectful in their attitude towards people. We saw and people told us that their privacy and dignity was respected.

Requires Improvement

Is the service responsive?

The service was not always responsive. Of the 21 people using the service that we spoke with, one person said that staff did not respond to them in a timely manner when called and did not listen to them.

Some people that we spoke with also told us that they did not do much during the day. We didn't see any activities taking place during our inspection. Staff spoken with told us that they had time to provide the care, but no time for social interactions.

Requires Improvement

Summary of findings

There was a complaints procedure in place and the majority of people and their relatives were confident that their concerns would be addressed and action taken where necessary. We saw a number of compliment cards that people had sent expressing their satisfaction with the service.

Is the service well-led?

Requires Improvement

The service was not well led. The registered manager for the residential home had been replaced with another manager and we had not been informed of this. We were not notified that someone at the home was subjected to a DoLS. The provider is required by law to notify us of both these events.

There were systems in place to monitor the quality of service that people received and reporting mechanisms to ensure that senior managers had an overview of the service. There was no evidence of how these systems were used to improve the service.

Kenrick Centre

Detailed findings

Background to this inspection

The inspection team consisted of two inspectors, an expert by experience who had experience of using services for older people and people with dementia and a specialist advisor who had experience of patient safety and intermediate care services. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. A specialist advisor is someone who has current and up to date practice in a specific area.

Before our inspection we looked at the information we hold about the service. This included notifications received from the provider about deaths, accidents and safeguarding alerts. The provider sent us a provider information return. This is information we asked the provider to send us about how the service was run, what they do well and what improvements they are making.

During our inspection we spoke with 21 people that used the service, three relatives, eight health care professionals that visited the home and the local authority commissioners. We spoke with 18 members of staff of different grades and two managers. We looked at the care records of four people and carried out general observations throughout the inspection. This included observation of the mid-day meal. Other records looked at included two staff recruitment files, training and supervision matrix, staff rotas, menus and quality assurance records.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

All the people that lived at the home and relatives that we spoke with told us that they received a safe service. A person that lived at the home told us, "Oh yes I feel safe here." A relative told us, "On the whole the care is safe." This showed that people who used the service felt they received a safe service.

The mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

Information received from the provider before the inspection stated that no one that lived at the home was the subject of a (DoLS). During the inspection the person managing the residential service confirmed that no one in the service was subjected to DoLS. We were told that restrictions were in place for two people because they wanted to go outside the home and would try to leave with visitors and that one of these people was prone to falls. The manager told us that neither of these people had the capacity to make informed decisions. We asked to see the care records for the two people. We saw that an urgent application had been made and was granted for one of these people on 17 June 2014. It was concerning to note that neither the manager nor care staff spoken with were aware of this. This meant that staff were restricting this person's care without knowing the lawful restrictions in place, so that their rights had been protected.

We were told that a best interest meeting had taken place and it was decided that the second person was not being deprived of their liberty. We asked to see confirmation of this. The record that we saw showed that a best interest meeting had taken place, but this was in regards to the person's behaviour and not their need to go outside. This meant there had not been a consideration about the restrictions on their liberty to go out. We looked at the staff training plan and saw that Mental Capacity Act and DoLS training was part of the core training for staff who worked in the enablement service. However, this did not form part of the training plan for the residential service and staff spoken with did not know about Mental Capacity and DoLS.

This meant that although the provider had processes in place to protect the rights of people, the fact that staff did not know that those procedures had been implemented but had imposed restrictions on people meant that people's rights under the DoLS were not properly safeguarded. This is a breach of Regulation11 of the Health and Social Care Act 2008(Regulated Activities) Regulations.

We spoke with two new members of staff about how they were recruited into their role. They told us that all the required recruitment checks were undertaken before they started working and that they received an induction into their role. Other staff spoken with told us that Disclosure and Barring Service (DBS) checks were updated every three years. Recruitment records for two new staff looked at confirmed that all relevant checks had been undertaken. This indicated that the provider had ensured that staff were properly recruited and suitable to care for people and keep them safe.

All the staff that we spoke with knew the procedures for keeping people safe from abuse. They knew the types of situations that would be classified as abuse and what to look out for. They were clear about the reporting procedures internally and were aware of external agencies that they could contact, should they believe the provider was not acting to safeguard people. Some staff told us that they had not received safeguarding training and training records looked at confirmed that not all staff had been trained in this area. Information sent to us which is required by law from the service showed that safeguarding incidences were managed well. This showed that although staff training in safeguarding needed to improved, staff knew what action to take if they suspected abuse was taking place.

At our last inspection we identified that the residential service was not keeping relevant records pertaining to the care of people. This particularly related to risk assessments about the needs of people. Records we looked at during this inspection showed that risk assessments were in place. However, they were not always reviewed. For example, one person that lived in the residential home who was prone to falls had not had a review of their risk assessment for over a year. This meant that an up to date assessment of the risks was not available to inform staff practices and the person continued to have falls. Care staff told us that they were required to read all care plans and risk assessments to

Requires Improvement

Is the service safe?

ensure they were up to date with people's needs and risks, so if risk assessments were not updated staff would not have the most up to date information to enable them to care for people safely.

A person that lived in the residential home and a relative told us sometimes there were not enough staff for some shifts. A person that lived at the home told us, "I get the feeling there isn't enough staff as there are times when there isn't a soul about." Two staff mentioned that the service could benefit from having more staff. The residential service had recently recruited a number of care staff to prevent reliance on agency staff. All the staff working on the residential service that we spoke with told us that there were enough staff to offer the basic care safely. The manager for the residential service told us that the staffing numbers were calculated on a basis of 1 staff to 5 people that lived in the home, and this took account of the changing needs of people. Staff rotas looked at confirmed that staffing numbers were maintained as described by the manager. A member of staff on the enablement service told us that often they do not have the full complement of staff to support the care needs of people using the service. The registered manager for this service told us that there were five staff vacancies that were unfilled. They told us that they relied on regular agency staff to support the care provided. The registered manager for this service said that on some occasions they were unable to get agency staff to cover shifts. This had happened on the first day of our inspection and a member of staff had pointed this out to us. The manager told us that they worked on a system of allocated number of staffing hours to support the service; this was based on the dependency needs of people referred to the service. After the inspection we spoke with the registered manager who confirmed that they were recruiting to fill the vacant posts and this would ensure a full complement of staff and prevent reliance on agency staff. This meant that the provider was taking action to ensure that there were sufficient staff to meet the needs of both services.

We saw that a fire exit in one of the lounges on the ground floor was blocked by two chairs although there was a sign saying "fire door to be kept clear at all times." On the first floor we saw that a fire exit was not adequately marked. We spoke with one of the managers about this. They said the fire officers had visited and did not identify this as an issue. However, the maintenance person said that a fire visit had not taken place. We contacted the fire service and spoke with a fire officer about this; they advised they would visit the service to determine if improvements were needed in respect of the signage.

On the first floor we found several incidences where skirting boards were loose and one incidence where pipes under the sink were exposed. Dirt had accumulated behind them. In the Assessment kitchen area there was a broken kettle and rubbish stored on the work tops. A towel and plastic basin were found lying on top of the macerator in the sluice room. Individual electric fires were provided for the bedrooms. These had not been recently risk assessed and were not attached to the wall to prevent them from falling over. No safety covers were fitted and no record had been kept of the cleaning routine. In one room we found that ribbon/string had been attached to the call bell so that it could stretch to the bed, if the string became unattached the call bell would be out of reach. This meant that the environment in the enablement service was not maintained to ensure that people were fully safe from harm.

We observed that in the laundry room on the first floor people's clothes were on the chair and floor all mixed up together. One person and a relative told us they had lost items of clothing. This meant that people's belongings were not always treated with respect, people's dignity could be affected if they received other people's clothing and there was an increased risk of cross infection.

All staff spoken with knew what action to take in an emergency such as incident and accident or in the event of a fire. All staff knew where the procedures were located and had access to them for reference. This showed that the provider had systems in place for foreseeable emergencies and events.

Requires Improvement

Is the service effective?

Our findings

All the people and their relatives that we spoke with said that their needs were being met effectively. A relative of someone using the enablement service told us, "I don't know exactly what they have done but they have certainly enabled her. Her mobility has improved so much since she came here from hospital." The relative explained that the green tag on her trolley meant that she was independent and she had been downstairs to the hairdresser in the lift and to a fitness class." One person that lived in the home told us, "Yes they are looking after me well." Another person said, "Oh yes definitely, they are meeting my needs. But I do most things for myself as I am able to." This showed that people's needs were being met and they were supported to remain as independent as possible.

All the staff that we spoke with were knowledgeable about the individual needs of people that used the service. There were training plans in place to support staff's core training and any service specific training needed. However, training records we were given showed significant gaps in staff training for the residential service. This showed that of 32 staff members 19 had not received safe people handling training, 18 had not received safeguarding, 23 had not received infection control training, 30 people had not received food hygiene and 31 had not received health and safety training. The manager for the residential service was aware of the gaps in training and showed us emails that she had sent requesting training for staff. However, there was no clear plan in place to show how the gaps in staff training would be addressed. All staff spoken with said they received supervision and appraisal and team meetings as part of the on-going support to ensure they performed their role well. This meant that although staff spoken with were knowledgeable about the individual needs of people they cared for, they were not always provided with the necessary core training to support them to do their job well. Therefore there was a potential risk of people receiving unsafe and ineffective care.

At our last inspection on 31 January 2014 we identified that people using the enablement service did not receive a prompt assessment of their needs to enable staff to offer them effective support. We saw that the provider had addressed this issue in line with their action plan. Everyone that we spoke with said they were happy with the standard of food provided. One person told us, "The food is marvellous and you get some good cooked dinners. There is always a choice and they ask us what we would like." Another person said, "There is plenty of food and you get tea and biscuits mid-morning." We saw a member of staff going round with the menu so that people could choose their preferences for the next day. In all the kitchenette areas we saw a variety of cereals, biscuits and drinks and one person said, "You can ask for a drink any time and they'll get you one." This showed that people had a choice of foods available to them and drinks and fluids were available throughout the day.

We saw that people received enough food and drink to maintain their health. We observed the lunch time meal in both services. In the residential home we saw that people waited for a long time for their meal to be served, and people sitting on the same table were served at different times. This meant that they had nearly finished eating before everyone was served. We saw that some staff supported people well, for example in the conservatory area we saw that staff talked to people and interacted with them whilst serving their meals. In other dining areas the interactions were limited. All staff spoken with knew what action to take should they identify that people were at risk of poor nutrition. However, we saw that two people had only eaten their potatoes and vegetables. Staff did not offer to help them with cutting up their meat, offer encouragement to them to eat, or ask if they were happy with the meal or if they wanted an alternative so that they ate a nutritionally balanced meal. This indicated that staff did not always check with people to see if they required support with eating their meal and meant people's nutritional needs could be compromised.

We saw that people were provided with additional calories by way of adding cream and butter to foods and meal supplement drinks where needed. People at risk of choking were provided with thickened drinks and soft and pureed meals so that they could eat and drink safely. Where people needed support to eat and drink we saw that this was done in a respectful and sensitive way. Records were maintained of the food and fluid intake for people, so that staff could monitor that people were eating well. We saw that people's weight was monitored on a regular basis so that actions could be taken if needed to boost or reduce their dietary intake. This meant that people's diverse dietary needs were met.

Requires Improvement

Is the service effective?

We saw that people's needs were assessed before they started using the service so that it was known whether people's needs could be met. Care plans were developed for people so that staff had the information they needed to support people. Relatives spoken with said they thought staff had the skills and knowledge to care for the people using the service and that staff understood people's needs. In one person's room we saw a picture story of the person, this told staff about the person's lifestyle before moving into the home and their likes and dislikes. This meant that staff had important information about the person, so they could treat them as an individual.

We saw that people's health needs were monitored and actions taken ensured that appropriate treatment was provided when needed. One person that used the service told us, "If I am unwell they get the doctor. When I had a fall they got the ambulance." We spoke with district nurses, an optician, occupational therapists and physiotherapists that visited the service. They told us they had no concerns about how the service managed people's care. They told us that staff were helpful and followed their guidance and instructions relating to people's care. This meant that people's health care needs were met.

Requires Improvement

Is the service caring?

Our findings

All the people and their relatives spoken with said that the staff were caring. One person that used the service told us, "That lovely lady, she's an angel she'll do anything for you." Another person said, "Yes I think they are caring. They will do things for you if it needs doing." A relative told us, "The regular staff are definitely caring and they are always helpful." A health care professional that visited the service often told us, "Overall I would say they are caring staff." This showed that people thought the staff were caring.

We saw that people were dressed in individual styles of clothing reflecting their age, gender and weather. One health care professional told us that people were well looked after and always looked clean. This meant that people's dignity was respected and staff ensured that they were dressed appropriately.

Throughout the day we did observe some positive interactions. For example we observed staff speaking to people in a respectful and courteous manner. We saw a member of staff supporting a very frail, partially sighted person to have a hot drink. We noted that the member of staff was extremely gentle and patient as they coaxed the person to take sips from the beaker. We saw the same staff member interacting with other people during lunch and later offered to make them hot drinks and again the interaction was patient and respectful. This showed that staff treated people with patience and courtesy.

All staff spoken with said they involved people in their care and always ensured they asked people how they wanted their care provided. Some people spoken said they felt involved in decisions about their care, but other people told us they did not feel fully involved. A relative of a person that lived in the residential home told us that they were not always kept informed about changes to their relative needs. One person that used the enablement service thought they could be more involved in the meal time activities. Two other people that used the enablement service told us they had not been included in the discussion about their discharge planning. They said they did not know what support would be available when they went home. This meant that not everyone that used the service and their relatives felt they were fully involved in decisions about their care.

People that used the enablement service felt their independence was being supported. We observed people preparing their own hot drinks from the kitchen without requiring supervision. One person we spoke with said that they felt very much supported and valued the input from the staff. We were shown a flat which had been commissioned to promote people's independence but was being used as a storage area, so was inaccessible for this use.

We saw that people were treated with dignity and their privacy was respected. We saw staff knocked on bedroom doors before entering. All the people spoken with told us they were treated with dignity and respect. All staff spoken with gave good examples of how they ensured that people's privacy and dignity was respected whilst providing care and support.

Relatives spoken with told us that they were able to visit the residential home at any time. We were told that there was a restriction on visiting times for the enablement service. This was due to people receiving therapy. The manager confirmed that this was flexible and if a relative could not come at the designated time they would still be able to visit.

Requires Improvement

Is the service responsive?

Our findings

All the people spoken with said they received care and support in a way that was personalised to them. There were assessment processes in place to ensure that people received an assessment of their needs. Care plans were developed to support people's care based on their individual needs. All staff spoken with knew the individual needs of people that we asked them about. Where we had discussions with staff about people's needs, records that we looked at confirmed what staff told us. Staff knew people's preferences likes and dislikes, personal histories and how they wanted their care delivered. A relative spoken with told us that they felt that staff knew their mother well and responded to her needs. One person told us, "I don't like having a shower; I think most of the staff know that, so I decide whether I have a bath or a wash each day." This indicated that staff knew people well and provided care in a way that suited them.

Of the 21 people spoken with over both service areas 20 people told us that staff usually responded if they were called. One person that used the enablement service told us that recently they had waited over an hour for night staff to assist them onto the toilet. The person said that staff had disagreed with them saying that they had not waited an hour. The person told us, "The clock is there right in front of me. I could see how long I waited." During the inspection we saw that call bells were answered promptly when used and any concerns raised by people that used the service were dealt with quickly.

Two members of staff told us that they had time to provide the basic care, but very little time for interacting with people that used the service. Throughout the inspection we observed staff sitting at their desk inputting data into the computer. This meant that they were not available for social interactions with people.

Across both services we noted a lack of social activities taking place during our inspection. Some people that used the service and a relative spoken with said that there was a lack of activities taking place. One person that lived in the residential home told us that they had previously been at another home where they had played bingo and skittles but said, "There's nothing like that here. I would love a game of bingo or something. It gets boring but what can you do." This meant that people felt that there was a lack of opportunities for social interactions within the services.

There was a complaints procedure in place and people using the service knew how to use it. Everyone spoken with said they would raise any concerns they had with the staff. A relative told us, that they had raised a concern and although it had taken a long time to investigate the complaint was dealt with to their satisfaction. This showed that people's concerns and complaints were responded to and dealt with. We saw a number of compliment cards that people had sent expressing their satisfaction with the service they received.

Requires Improvement

Is the service well-led?

Our findings

The provider had chosen to register two separate managers; one for the residential service and one for the enablement service.

The registered manager for the residential service had left and a new person had been managing the home since April 2014. We had not been notified of this important change. During this inspection, we also became aware of a situation where we had not been notified of a DoLS application that had been granted for a person using the service. These are breaches of Regulations15 &18 of The Care Quality Commission (Registration) Regulations 2009. This demonstrated that the leadership team did not fully understand their responsibilities in order to meet what is required of them in law.

Before we inspected the service we asked the provider to send us a report about the service. We received a report about the residential service only. On the day of the inspection the registered manager for the enablement service told us that they did not know we had requested a report about the service. This meant that we did not receive all the information requested about the service.

Some people that lived in the residential home did not know who the manager was and a relative told us that they thought the manager had changed recently. This meant that people were not sure about who was managing the service. During the inspection we saw that the managers were not visible in the service areas and we discussed this with them when we fed back information about our findings from the inspection.

Records seen showed that there were systems in place to monitor the quality of the service. Each manager completed a report to the senior managers so that the service could be monitored at a senior level. This report included the numbers of falls and incidents, complaints, safeguarding and supervisions. A manager from a different part of the organisation undertook regular audits of the service, identifying where there were any shortfalls in systems and processes. The manager told us that she had started to address the shortfalls identified from the last audit, but there was not a documented plan in place to do this as yet. This showed that systems were in place to monitor the quality of the service, but there was no evidence the systems were used to make improvements and respond to findings.

We noted that whilst events and incidents were monitored, the monitoring process did not include an analysis of these events. For example falls, safeguarding and complaints were not analysed for trends so they can be used to inform the service plans. The checking systems that were in place were not identifying shortfalls, for example the system for checking that all current staff working in the residential service have a DBS check were incomplete and the monitoring system had not identified this. In addition the person managing the service did not know whether or not these staff had a DBS check. This meant that monitoring systems were not as effective as they should be.

None of the people and their relatives that we spoke with had been involved in meetings about how the home was run. However, we saw minutes of meetings that had taken place with people and staff. People and their relatives were able to give feedback on the quality of the service, by way of completing questionnaires. These were analysed for trends and the result put on display for people to see. This indicated that people were able to comment on the quality of service they received.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Suitable arrangements were not in place to protect people using the service against the risks of control being unlawful or excessive. Regulation 11 (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents An urgent request had been made and granted for a Deprivation of liberty safeguard for a person that lived at the home and we were not notified by the registered person. Regulation 18 (2) (4A) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes The registered manager had ceased to manage the regulated activity and we were not notified. Someone other than the registered manager was managing the regulated activity and we were not notified. Regulation 15 (1) (a) (b)