Larchwood Court Limited

Copperfields Residential Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Copperfields Residential Home is a residential care home providing personal care to 15 older people. Some people were living with dementia and other people had a learning disability. The service can support up to 20 people.

People's experience of using this service
People could not be assured their choices about their care would be acted on as records were not always accurate.

Quality assurance processes were not always effective in identifying shortfalls in the service. People's views were not at the centre of looking at ways to improve the service. There had been limited consultation with people about their wishes at the end of their lives.

Although people had been supported appropriately when incidents had taken place, the Care Quality Commission (CQC) had not been notified of all important events, in line with legislation. This is necessary so CQC can be assured that when significant things happen, people's health, safety and welfare is maintained.

We have made a recommendation about the management of some medicines. This was because medicines guidance for administering some medicines was not always followed.

People and their relatives said staff helped them to feel safe. However, there were occasions when people had not felt safe. This was because some people displayed behaviours that challenged themselves and others, including physical aggression.

The outcomes for people using the service reflected the principles and values of Registering the Right Support by promoting choice and control, independence and inclusion. Staff faced challenges in making sure people's support focused on them having as many opportunities as possible to gain new skills and become more independent. This was because the supported people with a learning disability and older people. These two groups had different and complex needs which the service did not always find easy to balance.

Staff training was in progress to help ensure they had the necessary skills and knowledge to meet people's individual needs. Regular agency staff were employed to fill shortfalls in staffing levels. Staffing levels were reduced at the weekend but people and relatives said this did not have a significant impact on them.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People had access to health care services and staff worked with a range of health care professionals. People were supported to eat and drink enough to maintain their health.

Caring relationships had developed between people and staff. Staff showed patience and understanding when supporting people with their care. There was a structured programme of activities including sensory stimulation, giving people opportunities to get involved.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection: The last rating for this service was Requires Improvement (published 5 February 2019). At this inspection not enough improvement had been made and the provider was in breach of two regulations. This service has been rated Requires Improvement or Inadequate for the last four consecutive inspections.

Why we inspected
This was a planned inspection based on the rating at the last inspection.

Enforcement
We have identified breaches in relation to record keeping and informing CQC of significant events. at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 always safe.

Details are in our safe findings below for each of the domain areas.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below for each of the domain areas.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below for each of the domain areas.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below for each of the domain areas.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below for each of the domain areas.

Copperfields Residential Home

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was carried out by one inspector.

Service and service type:
Copperfields Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with CQC. The registered manager had been absent from the service for 6 months. The provider was managing the service and was legally responsible for how the service was run and for the quality and safety of the care provided.

Notice of inspection:
The inspection was unannounced.

What we did before the inspection:
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the

judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with three people and a relative about their experience of the care provided. We joined four people for breakfast and three people participating in a baking activity. We also spoke to a relative and visiting social care professional. We spoke with five members of staff including the provider, a senior care worker, a care worker, the laundry person and cook.

We reviewed a range of records. This included three people's care records and multiple medication records. We looked at the staff supervision and training programme and three staff recruitment files. We also saw a variety of records relating to the management of the service, such as health and safety, audits and records of meetings.

After the inspection:
We continued to seek clarification from the provider to validate evidence found. We sought feedback from the local authority and professionals who work with the service. We received feedback from a relative.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● Medicines guidance was not being consistently followed so people received their medicines as intended.

● One person had a medicine patch for pain relief. Information with the medicine stated the patch should be placed on a different area of skin each time it was applied. Also, that it should not to be applied to the same skin area for 3 to 4 weeks. This was to maintain the health of the person's skin. Staff had not made a record of where they applied the patch, in accordance with best practice. They told us they applied the patch to the same place on the person's skin. Staff told us this practice had not resulted in damage to the person's skin in the last month since it had been applied. However, staff were not aware of the medicines guidance or potential risks to the person's skin integrity if the current practice continued.

We recommend the provider consider current guidance on administering medicines and act to update their practice.

● Information was held about how people liked to take their medicines, what they were for and any side effects to look out for. Staff followed protocols which directed them when people should be given medicines prescribed as 'only when needed'.

● Medicines were stored safely. Medicine stocks and records were regularly checked to make sure people received all the medicines they had been prescribed.

Systems and processes to safeguard people from the risk of abuse

● People and their relatives said staff made them feel safe, but there had been times when they had not felt safe. They explained this was because some people could become upset and agitated which on occasions had led to physical aggression. The provider was working with a range of professionals to support people with behaviours that challenged themselves or others, and there had been no incidents in the last few months. However, the possibility that future incidents may occur was worrying for people and their relatives.

● Safeguarding was discussed at staff meetings and staff training in this area was refreshed. This was to help ensure staff knew what constituted abuse and poor practice.

● Staff knew how to whistle-blow (tell someone if they had concerns). They also understood their role in reporting any concerns to external agencies, if they were not acted upon. The telephone numbers of local safeguarding agencies were available to staff on the staff noticeboard.

Staffing and recruitment

● There were a number of gaps in the staff rota which were filled by staff from one agency. The local authority visited the service in January 2020 and found shortfalls in the providers checks on agency staff.

The provider was taking action to remedy these omissions to ensure agency staff were fit and suitable to support people.

● Checks on permanent new staff included obtaining a person's work references, identity, employment history and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable staff from working with people who use care and support services.

● Staffing levels reduced at the weekend as there was no Sunday cook or dedicated person responsible for activities. The provider said that recruitment for these posts was underway. People told us staff were available when they needed them. One person told us, "The staff here are all good. If you need any help they look around and see that you need help." A relative told us, "They have agency staff, but they are all staff that come here a lot, so I know them and recognise them."

Assessing risk, safety monitoring and management

● At the last inspection improvements in managing risks had not been in place long enough to demonstrate they could be sustained.

● At this inspection potential risks continued to be assessed and reviewed. This included risk's when people moved around their home, presenting behaviours that may challenge themselves or others and of choking. One person had a placemat which gave clear steps about what to do to prevent them choking and what to do if they did choke.

● Guidance was available to staff, so they knew how to support people in the right way. Moving and handling guidance detailed the type of assistance and equipment people needed for different types of transfer. We saw staff following this guidance when supporting a person to use a hoist. Behavioural charts were used to help identify any triggers and shared with relevant health care professionals.

● Regular checks were made on the environment and equipment to make sure it was safe and fit for purpose. Staff took part in fire drills and fire training to ensure they knew what to do in the event of a fire.

Learning lessons when things go wrong

● Accidents and incidents were recorded, monitored and analysed. This was so action could be taken to reduce the chance of the same things from happening again.

● All events including falls and safeguarding's were presented in graph format. This was so they could be tracked over time to see if there were any significant patterns or trends. One person who had had a number of falls had been moved to a downstairs room.

● Lessons learned from these events were discussed at staff meetings.

Preventing and controlling infection

● There were no domestic staff at the time of the inspection. However, the service was clean and free from unpleasant odours.

● Staff were trained in the prevention and control of infections. There were stocks of personal protective equipment such as gloves and aprons throughout the service.

● The laundry was well organised. There was a system to make sure people had clean clothes and bedding when they needed it. The provider's laundry procedures were followed to help prevent the spread of infection.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's physical, social, emotional, cultural and religious needs were assessed before they moved to the service. This was so the provider could be confident their needs and preferences could be met by the staff team.
- Assessments were undertaken in line with best practice. This included meeting people in their home or at hospital to undertake the assessment. Nationally recognised tools were used for identifying and monitoring people's skin condition, nutrition and hydration.

Staff support: induction, training, skills and experience

- Staff undertook relevant training courses, so they gained the skills and experience they required for their roles. New staff followed an in-house induction programme. This consisted of shadowing senior staff, reading people's care plans and completing essential training courses.
- The provider had identified staff training was not being refreshed as regularly as necessary. They had developed a training programme to make sure staff were updated in key areas such as first aid and moving and handling. Staff put this training in practice when using a hoist to move one person to another part of their home. Training included supporting people living with dementia and positive behavioural support (PBS). PBS is used to support people who present behaviours that may challenge in the most appropriate way.
- Staff were encouraged to undertake a Diploma in Health and Social Care level 2 or above. These are national standards that staff are expected to meet to work unsupervised in adult social care settings.
- Staff said they felt supported by the provider in the absence of the registered manager. There was a programme of regular staff supervisions, but annual appraisals had not taken place. The provider said these would be reinstated when the registered manager returned to work. Supervision and appraisal are processes which offer support, assurances and learning to help staff development.

Supporting people to eat and drink enough to maintain a balanced diet

- People told us they liked the meals provided and had enough to eat. At breakfast time people were asked if what they wanted to eat and later asked if they wanted anything else to eat. They were offered cereal, porridge and toast. Staff sat with one person who was reluctant to drink their drink. They talked with them about things they were interested in whilst offering encouragement.
- There was a rolling menu and the cook asked people each day for their food choices. In addition to a hot cooked lunch, people could choose homemade soup at suppertime. The cook knew about people's likes, dislikes, specialist diets and if they needed their food pureed or cut into small pieces. The cook was new to their role and planned to consult with people further, so the menu reflected their choices and preferences.

● Guidance from the speech and language therapists was available for people who required specialist support. This included how people should be positioned to eat and the consistency of their food.
● A record was kept of people's weights. Where there were significant changes in people's weights or eating patterns, referrals were made to relevant health care professionals.

Supporting people to live healthier lives, access healthcare services and support; Staff providing consistent, effective, timely care within and across organisations
● People's health care needs were identified and monitored by staff. A record was made of all medical appointments and their outcomes. People were supported to access health care services when they needed them.
● An external provider visited the service twice a month to support people to take part in gentle exercises.
● People's oral health care needs had been assessed in November 2019. Although some people had refused to comply with the assessment, care plans set out the support people needed with their oral health care. This included if people could squeeze out toothpaste from the tube and use their toothbrush.
● People with a learning disability had a hospital passport. This provides staff with important information about the person and their health should they be admitted to hospital.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● Staff sought people's consent before providing any care. They explained to people when they were going to assist them to move around their home. They waited for a person's verbal or physical agreement before providing the support needed.
● People's capacity to make specific decisions about their care and treatment had been assessed.
● DoLS applications had been made to the local authority to make sure any restrictions on people's freedom were lawful.

Adapting service, design, decoration to meet people's needs
● People were provided with two lounges with views of the garden. One lounge had a television and the other did not, so people could choose a quieter setting.
● People were helped to orientate themselves with their surroundings. There was signage throughout the service directing people to bathrooms and communal areas. There was also a display letting people know the date and the weather. This is useful for people living with dementia and a learning disability.
● The dining room and front garden had been adapted for people living with dementia. The dining room had been set out to look like an old-fashioned tea room. It displayed tea pots, scales and bunting. The front garden was dementia friendly. It includes a path in a figure of eight pattern to help people who liked to walk around. There were several seating areas where people could sit down for a rest.

- Adaptations such as handrails and bath seats were available for people with limited mobility.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has remained the same. People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity

- People were treated with kindness. A staff member gently touched a person's arm to let them know they were talking to them. This person's face immediately lit up indicating their pleasure in the contact. Whilst sharing a joke with a person, the person touched the staff member's arm and smiled to communicate their enjoyment.
- Positive relationships had developed between people and staff. One person told us about a member of staff, "He is the nicest man I know. We are friends. I have friends here." Another person said, "It is 100% good here. A1 for everything. The girls are wonderful: Wonderful because they are caring and treat us like human beings."
- Feedback from professionals was that, "Staff genuinely care" for the people they supported.

Respecting and promoting people's privacy, dignity and independence

- Staff showed patience in supporting people to maintain their mobility. A staff member tried to encourage a person to stand and walk with their frame. The staff member was very patient and respectful. After a while, the staff member left the person and then came back a few moments later to speak to them again. The person still did not stand up, so rather than use equipment to move the person, another staff member spoke to them. The person immediately stood up and started to walk towards the lounge. Both staff members treated the person with dignity and were very positive and cheerful in their interactions with the person.
- Care plans set out what people could do for themselves and when they needed support. Staff followed this guidance to support people to maintain their independence.
- Staff knew how to maintain people's privacy. One person forgot to close the toilet door, so staff closed the door for them to maintain their privacy. Ensuring people's privacy was discussed at staff meetings. At the last staff meeting in December 2019 staff had been reminded to knock on bathroom doors before entering.

Supporting people to express their views and be involved in making decisions about their care

- People were involved in day to day decisions about their care such as what to wear, what to eat and how to spend their time. One person told us, "There are no rules. You can decide when you want to get up and go to bed."
- Some people had communication needs or hearing impairments. Information about the best way to communicate with people was available in their care plans. Some people made their needs known by facial expressions and gestures. When staff did not understand what a person was trying to say, they asked staff who knew the person well and who could understand what people were expressing. For people who had difficulty hearing, staff made sure they were at the same level as the person to help the person understand.

- Some people had advocates. An advocate can help a person express their needs and wishes and weight up and take decision about the best options available to them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant people's needs were not always met.

End of life care and support

● There had been limited consultation with people about their wishes at the end of their lives. This was required to provide a clear plan which set out where people would like to live in their last days and any important things and people they would like to be around them. The registered manager agreed this was an area where improvement was needed.

● The provider gave an example of when they had worked with healthcare professionals, so people experienced a comfortable, dignified and pain-free death.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● Staff faced challenges in responding to the needs of older people due to their wide range of needs. Some people were living with dementia, some people had a physical disability and some people had a learning disability. People with a learning disability had associated complex needs including communication needs and/or behaviours that challenged. The provider was working towards providing personalised care with input from a range of social and health care professionals.

● Care plans included information about a person's life history, preferences and any cultural or religious needs so they could support people in a personalised way. However, it was not always clear what people's goals were and how they were being supported over time to achieve them.

● Staff had received a card of thanks for the care they had provided. 'Thank you to you and all the staff at Copperfield's for the care they took of X. Although they didn't always make things easy, you looked after them and made sure he was always comfortable and well cared for.'

● People and their family members were involved in planning their care. A relative said they had been invited to meeting to discuss their relative's care. This relative told us, "We all read through my family member's care plan. There have been a lot of changes in their care. It is all there and very detailed."

Improving care quality in response to complaints or concerns

● There were mixed responses from relatives about how the provider dealt with any concerns they raised. One relative said, "As soon as I mentioned to staff what I was worried out, they did what I suggested". Another relative reported to us that the service had, "Failed spectacularly to respond well to any of my concerns." This relative's concerns had been resolved at the time of the inspection.

● People and their relatives were given information about how to complain when they first started to use the service.

● The provider had a complaints policy. This set out a complaint was investigated and the timescales in which they could be expected to be informed of the outcome.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● People supported had a learning disability or were living with dementia. People may therefore benefit from their care plans being written using short sentences and/or pictures to help understand their content. However, there was inconsistency in how care plans had been adapted to respond to these communication needs.
● Pictures and photographs displayed at the service to help people understand who was supporting them and what was happening. Photographs of staff were displayed alongside their names and the activities programme was displayed using pictures of each activity.
● An activity diary was in development for each person. They contained photographs and a description of the activities in which people had participated. The intention was to share these diaries with people and their visitors to talk about things they had done and enjoyed.
● The best ways to communicate with people were recorded in their care plans. It had been identified that one person found it easier to understand if people spoke into their right ear. We saw a staff member adjust themselves, so they were at the right level to speak directly into their ear.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● There was a structured programme of activities during the week, which care staff were responsible for delivering. The provider said they were advertising for a dedicated member of staff to take over this role. Activities included nail painting, exercises and arts and crafts. In the morning three people helped mix ingredients for a cake and fill fairy cake papers. Staff also supported one person to go for a short walk. In the afternoon people in the quiet lounge took part in a bean bag throwing game.
● One staff member was trained to deliver a specialist education and healthcare programme. The programme was based on imagination, music therapy, relaxation skills, nature awareness, communication skills and sensory stimulation. One person told us they had enjoyed the panto which had taken place in their home at Christmas time.
● People were supported to develop and maintain relationships with people who were important to them. One person's relative was not able to visit so staff supported the person to visit them.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- At the last inspection improvements in quality monitoring systems had not been fully embedded to demonstrate they could be sustained. At this inspection we found quality checks and audits were not always effective in identifying shortfalls in the quality of care. This included medicines management, staff recruitment and end of life care.
- The provider had identified improvements were required in record keeping, but these remained an issue at the inspection.
- One person's care plan stated they did not want resuscitation to be attempted (DNAR). There was no DNAR document at the front of their care plan to alert health care professionals to this person's wishes. The provider obtained a new DNAR for this person after the inspection.
- Information about who had the authority to make decisions on people's behalf was not accurate. One person's record stated that family members had authority to make decisions about their health and welfare. However, the Power of Attorney granting legal authority for this decision was not in their care notes. The provider told us that this person's family did not have the necessary authority to make decisions on their behalf.

The provider had failed to ensure there were effective systems to assess, improve and monitor the quality of care. Also to ensure there were accurate records which reflected people's decisions and choices about their care and treatment. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

- Resident meetings had not taken place since the last inspection in December 2019. The provider said people's views were regularly sought at meetings with their keyworkers. However, these meetings were not recorded. Therefore, it was not possible to assess if people were satisfied with their care or improvements were needed.

The provider had failed to seek and act on the feedback of people using the service for the purpose of continually evaluating and improving the service.
This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives were engaged in the service through meetings and survey questionnaires. The last relatives meeting had been held in December 2019. At this time survey questionnaires had been sent to relatives. One had been returned to date, which was positive about the quality of care provided.
● Staff felt supported through regular attendance at supervision sessions and staff meetings. They said the provider was available for guidance and support when they needed it. The provider said they were giving out staff survey questionnaires at the staff meeting planned for the following day.
● The provider worked in partnership with a range of health and social care professionals. This included the community mental health team and community learning disability team.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The provider had not informed us of significant events that had occurred at the service. It is important that the Care Quality Commission (CQC) has a clear overview of all incidents at the service, so we can check that the provider has taken appropriate action. We had not been informed when a person had been found on the floor and taken to hospital by ambulance.

The provider failed to notify the Care Quality Commission of notifiable incidents. This was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

We were only notified about the return of the registered manager to the service after we reminded the provider of their responsibility to do so.

The provider failed to notify the Care Quality Commission of notifiable events. This was a breach of regulation 14 (Notification of absence) of the Care Quality Commission (Registration) Regulations 2009.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility culture and aims
● The provider continued to employ a consultant in working towards their aim of promoting person-centred care. The consultant supported the provider in the absence of the registered manager and had helped with the development and monitoring of an action plan.
● The ongoing monitoring of all aspects of the service such as medicines, falls, accidents and infection control audits were discussed at staff meetings. This was to involve and engage staff and inform them of areas where they were doing well and areas which required improving.
● Staff reported there was a positive culture at the service and they understood the aims of the service to provide personalised care.
● The provider had discussed everyone's responsibility with regards to the Duty of Candour at staff meetings. Staff understood the importance of being open and honest. They said that if things with people's care had not gone right, they needed to be discussed with the relevant people, so they could be better supported.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 Registration Regulations 2009 Notifications – notices of absence The provider had failed to notify us of changes to the management of the service. 14 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify us of all all incidents with regards to people's health, safety and welfare. 18(1)(2)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective systems to assess, improve and monitor the quality of care. Also to ensure there were accurate records which reflected people's decisions and choices about their care and treatment. 17 (1) (2) (a) (C)