Diginew Limited

Amber Lodge Nursing 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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 8 & 10 March 2016 and was unannounced.

The service was last inspected on 17 March 2014 when we found the provider was compliant with the essential standards described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Amber Lodge Nursing Home is registered to provide nursing care for up to 40 older people living with dementia and or a physical disability. At the time of this inspection there were 35 people using the service. The service is located in the Osmaston area of Derby. Accommodation is provided over two floors with access via a stairwell and a passage lift. Communal living areas were located on both floors.

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

The provider was not clear on how to report safeguarding incidents to the relevant agencies. The registered manager had on occasion investigated allegations without making a referral to the safeguarding team at the local authority. This did not provide assurance that people living at the service were protected from harm. People using the service and relatives told us that they felt safe at the service. Staff we spoke with understood their responsibility in protecting people from the risk of harm. Staffing levels were adequate to meet people's needs, however people told us they were not always supported to pursue and develop their individual hobbies and interests. People told us that they were not supported to maintain and develop their social interests.

Recruitment procedures were not robust, as all the required pre-employment checks were not in place. This did not provide assurance that suitable staff were employed to work with the people who used the service.

Where risks had been identified, potential risks were not supported by a care plan which detailed how risks were to be managed by staff to promote people's welfare and safety.

Systems in place did not always ensure people were given their medicine as prescribed. We saw gaps on some people's medication administration records, so that It was not clear whether the medicines had been given or not. People were referred to healthcare professionals to maintain their health and wellbeing.

Staff told us they would benefit from regular supervisions with the registered manager, to discuss their training and development. Staff told us that they received training to support them to meet the needs of people.

The registered manager did not clearly understand their responsibility to comply with the requirements of

the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Applications had not been made for DoLS in line with legislation. However staff supported people to make their own decisions.

Staff were not always caring in their approach when supporting people. People told us they liked the staff but felt some staff were more caring than others.

People felt confident that they could raise any concerns with the registered manager. However one person felt that they did not want to get people into trouble and only complained if they really had to.

The leadership and management of the service and its governance systems were not robust, which impacted on the quality and consistency of care being provided. This further restricted the development of the service. Staff felt that management of the service was ineffective.

People enjoyed the meals provided and we found meals to be of a good quality, with people being offered choice.

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.

The provider did not have adequate procedures in place to ensure people were protected from the risk of abuse. Staff were not confident they would be protected when reporting concerns to the provider and identified concerns were not always reported to the appropriate authority for investigation.

Recruitment procedures did not ensure, as far as possible, that people were supported by staff who were of good character. This did not provide assurance that people were being cared for by suitable staff. People told us they felt safe and staff understood their responsibilities to keep people safe and protect them from harm.

People's medicines were managed safely. Staffing levels were adequate to meet the needs of the people who used the service.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always feel confident to fulfil their role because they did not receive supervision. Staff had completed training to meet the needs of people using the service. The registered manager did not fully understand the principles of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) so that people's best interests could be met. People's consent to care and treatment was sought by staff. People were supported to access health services as required. People enjoyed the meals provided and their dietary needs and preferences were met. However people were not always supported effectively during meal times.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw that on occasion, there was limited interaction between some staff and people as staff focus was on the completion of

tasks. Staff supported people to maintain their dignity and privacy. People told us they liked the staff. People were supported to maintain relationships which were important to them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not supported to maintain interests that they enjoyed. It was not clear as to whether people had received a response to the issues they had raised, as the service did not record the complaints centrally. The provider's complaints policy and procedure was accessible to people who lived at the home and their relatives.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Staff stated the management and leadership skills of the registered manager were ineffective. Governance and quality assurance systems were not robust and were not effective in determining the quality of the service provided and developing plans to bring about improvement. The service had a registered manager in post. People and relatives told us that the manager was approachable and visible.

Amber Lodge Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

This inspection took place on 8 and 10 March 2016 and was unannounced. On the first day of the inspection, the team consisted of two inspectors and one 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. On day two of the inspection, there was one inspector.

The provider completed 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 improvements they plan to make. As part of our planning we reviewed the information in the PIR.

We reviewed the information we held about the service, which included notifications. Notifications are changes, events or incidents that the registered provider must inform CQC about. We contacted commissioners and asked them for their views about the service. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with seven people who used the service and four relatives. We spoke with the registered manager and ten staff including nursing and care staff.

We observed how people were supported during their lunch and during individual tasks and activities. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed how people were supported during their lunch and during individual tasks and activities. We reviewed records which included three people's care records to see how their care and treatment was planned and delivered. We also looked at other records relating to people's care such as medicine records and fluid charts that showed what people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for three members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their professional development.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us that they felt safe at Amber Lodge Nursing Home. One person told us "I'm very happy here and I do feel safer." Another person told us they felt very much safe at the service and the staff were good to them. A relative told us they felt their family member was safe and said staff were "marvellous". Another relative said "I feel that [Name] was safe at the service ."

The registered manager informed us staff received training in how to safeguard people from abuse. This was confirmed by staff who we spoke with. Staff could tell us what actions they would take if they had concerns for the safety of people who used the service. However we saw that not all safeguarding concerns had been reported to the safeguarding team at the local authority for investigation by the registered manager. This did not provide assurance that potential safeguarding allegations were being investigated in line with local safeguarding policy and procedures. We discussed this with the registered manager who confirmed in future they would make safeguarding referrals to the correct authorities.

Staff were not always confident to use the provider's whistle-blowing (where a member of staff passes on information regarding poor practice) procedure to report concerns to external agencies. One member of staff told us that they felt they would not be protected by the providers whistle-blowing policy in an event they needed to raise concerns within their organisation regarding poor practice. We discussed this with the registered manager who was clear that staff would be protected under this procedure and told that he would raise this at the next staff meeting. The registered manager told us that concerns around poor practice would also be shared with relevant agencies such as the local authority.

Systems were in place to record incidents and or accidents. Staff we spoke with were aware of reporting incidents and completing the necessary documentation. The care staff told us that they reported any incident or accident to the nurse who was on duty. For example one member of staff said if a person had fell they would alert the nurse who would check the person and decide what action to take. This provided assurance that action was taken to ensure the person's safety and wellbeing.

The registered manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce the risks. The risk assessments that were in place were detailed, up to date and were reviewed regularly. Risk assessments gave staff clear instructions on how to minimise risks to people's health and wellbeing. For example, which included, fall risk assessments and nutritional and tissue viability assessments. However, we saw risk assessments were not always in place to instruct staff on how to manage and mitigate some risks associated with people's care and support needs. For example, for one person there was no risk assessment in place for the use of bed rails which the person had on their bed. For another person there was no moving and handling risk assessment in place to instruct staff on how they should be assisted to move around safely. In addition one person displayed signs of anxiety and aggression, and was at risk of causing themselves or others harm. We found there was no risk assessment in place to instruct staff on how their anxiety could be reduced so that they could be supported safely. However, the staff we spoke with were able to tell us how these risks were managed to reduce the risk of harm to the person. One member of staff told us that they would check with a

nurse if they needed to know what care a person needed.

We received mixed feedback from people and their relatives about whether there were enough care staff and nursing staff on duty at the home, to ensure people were cared for safely. One person told us "Generally there are staff around and they are supportive." Another person said "I sometimes have to wait for the toilet, as there are not enough staff." A relative when asked if there were enough staff said 'I think most of the time there are, but sometimes people have to wait to go to the toilet. I think they've got a few more staff over the last few months." Another person's relative stated "There are enough staff within reason, its virtually impossible for a one to one situation."

We spoke with staff about the staffing levels at the service. One member of staff said "The registered manager tends to put more staff on shift, as some people have higher needs than others." Another member of staff told us "At the moment the staffing levels are ok." However one member of staff said "There are not always enough staff, shifts are picked up by existing staff or agency to cover sickness." Another member of staff told us that there had been a turnover of staff and felt that staffing levels could change due to people's individual needs.

We discussed staffing requirements with the registered manager. We were told by the registered manager that there was no formal tool to calculate staff requirements. The registered manager told us that staffing levels were determined by people's needs and during the initial assessment process they were able to identify if additional staff were required on the rota. The registered manager told us that in an event that cover was required for unforeseeable circumstances such as unplanned absences, they used agency staff if required. The registered manager said that they used regular agency staff who had covered shifts before. Staff we spoke with confirmed this.

We looked at three staff recruitment files, to check that safe recruitment procedures were in operation, to ensure people were cared for by staff of good character. We found that the provider had not carried out a Disclosure and Barring Service (DBS) check for a member of staff working at the service. The DBS is a national agency that keeps records of criminal convictions. We discussed this with the registered manager who told us that the providers policy was to accept a DBS that was up to three months old. We asked the registered manager for the recruitment policy to confirm this, however we were informed by the registered manager that there was no recruitment policy in place and that this was an informal arrangement. This showed that recruitment processes were not always in place to ensure staff of a suitable character were employed to support people at the service. Following the inspection visit the registered manager told us that a DBS had been applied for and a risk assessment put into place. The provider checked that nursing staff had up to date registration with their professional body.

We checked the providers arrangements for managing people's medicines. People told us that they received their medicines on time. People's medicines were managed safely and only administered by staff who were trained and continually assessed as competent to do so. Regularly prescribed medicines were delivered by the local pharmacy with an accompanying medicines administration record (MAR). Each person's MAR included their photograph, the name of each medicine and the frequency and time of day it should be taken, which minimised the risks of errors We saw medicines were stored securely and were not accessible to people who were unauthorised to access them. Medicines were stored at the correct temperatures. The MAR we looked at, showed that there were some gaps so that it was not clear whether the medicines had been given or not. We discussed this with the nurse who told us that it would be the responsibility of the nurse on the shift to check that a person had received their medicines or record a reason for the gap. The nurse also stated the registered manager carried out medication competency assessment, but this had not taken place for some time. This did not provide assurance that the provider had safe systems in place to

ensure people received their medicines as prescribed.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us that they did not have the opportunity to regularly reflect upon their working practices with the registered manager to identify future development and training to enable them to deliver effective care to people. One member of staff said "Supervisions (regular meetings with a manager to discuss any issues and receive feedback on their performance) are not planned, they only happen when things happen." Another member of staff said "It has been more than a year since I have had an appraisal or any supervision with [Name]. We discussed this with the registered manager who confirmed they did not have a schedule of planned staff supervisions in place. The registered manager also stated that the arrangements for supervision were very informal and that these were not formally recorded. This demonstrated that the provider was unable to assure themselves that people were being cared for effectively by staff who had the appropriate skills and knowledge. Staff told us that they received the training they needed to care for people at the service.

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 people lack mental capacity to take particular decisions, any decisions 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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are 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 were being met. The provider did not have effective arrangements in place to ensure staff knew what to do when people were unable to give valid consent. Information regarding people's capacity to consent in different areas of daily living had not been assessed. For example in one person's care records we looked at it stated "[Name} has short term memory problems and is unable to make simple choices." We saw no associated capacity assessment, confirming when the person required support to make decisions. We were unable to see how the registered manger determined whether a person lacked capacity. Our observations showed that staff sought consent before supporting people. For example, we saw one member of staff ask a person at the service if they wanted support them with their meal at lunch time.

The registered manager told us that they had identified 19 people at the service who had restrictions placed on them due to their health conditions. At the time of our inspection the registered manager told us no DoLS applications had been submitted to the local authority for the authorisation to implement these restrictions. Staff had a basic understanding of the requirements of the MCA.

Our observations showed that people at the service had access to drinks and snacks throughout the inspection visit. People were provided with a choice of hot or cold drinks. People who were able to communicate with us told that the food was fine and that they were offered a choice at meal times. One person said "You do have a choice of meals, but I have not seen a menu." A relative said "[Name] is diabetic,

the staff have knowledge of the meals [Name] could have." People's food preferences and dietary needs were recorded, which the catering staff were aware of.

We observed the lunch time meal and saw that people who needed assistance were offered this. We saw that staff were patient whilst they offered people support and assisted people at their own pace. However we saw in the upstairs lounge one member of staff moved between two people whilst assisting them with their meals. One person became agitated each time the member of staff offered them food, without actually speaking with the person. We saw another member of staff intervened and started to support this person. The member of staff interacted with the person, who then appeared settled whilst being supported with their meal. We also observed lunch in the dining room on the ground floor. Staff were observed engaging with people throughout the meal. Comments from people expressing satisfaction with their meal included "I was ready for that, very nice." Another person said "[Name] is too busy enjoying the lunch to talk." We saw staff showing people the food choices on offer so that they could make their own choice. The dining room was a relaxed place, with people enjoying their meal at their own pace.

Records showed people's nutritional needs were assessed, and where required advice was sought from health care professionals to ensure risks were managed. The nursing staff and registered manager told us that that people received support from other health professionals such as GP's and dieticians in order to manage their nutritional needs if there were concerns about a person's food and fluid intake.

People had access to health care services. A relative told us that the manager contacted the GP if their family member was unwell. They felt access to the GP was quick, as the surgery was next door.

We identified that staff were not following care plans, as daily monitoring forms were not consistently or accurately completed. Care records showed one person required repositioning every 2 hours to prevent them from damaging their skin. Records that were completed by staff to show when the person was repositioned had not been consistently completed. Records we looked at showed that the person had not been turned on several occasions at the required intervals as specified on their pressure care management regime. For another person their records showed that their blood sugar levels were required to be checked twice daily. However we saw that on five occasions between 24 February 2016 and 5 March 2016, this had not happened. The lack of recording meant that staff did not understand the importance of recording the care people received to ensure it was consistent and effectively monitored .

Information in care records showed that referrals were made to healthcare professionals. We saw documented evidence of visits from GP's and Chiropody services. A member of staff told us that due to a person's specific skin condition the service had liaised with the GP and a tissue viability nurse, ensuring the condition was managed effectively. This showed that people had access to health care services.

Requires Improvement

Is the service caring?

Our findings

People told us they felt the staff were caring. Comments included "I do have the same carers they remember my name, when they walk past my door they call "Hello." A relative said "These staff do care about the people at the service."

Relatives we spoke with were complimentary about the care and support which their family members received by the staff at Amber Lodge Nursing Home. One person said "The staff seem very happy." A relative described the service as "Absolutely fantastic." Another relative told us "The staff are absolutely marvellous, couldn't ask for better staff."

Whilst staff spoke positively about the importance of caring for the people at the service, we saw staff did not always consider people as an individual or provide person centred care and support. One person told us, "Some of them [Staff] have a caring manner and depending on what they have to do, they sometimes respond quickly." We saw examples of staff focus being on the completion of tasks rather than the support needed, for example at the lunch meal we observed. In the upstairs lounge we saw very limited interaction between the staff member and the three people using the lounge. The member of staff was not interacting with the people, until we spoke with a person. The member of staff then approached the person and wiped their face, without telling them what they were going to do.

We did see some positive interactions between people using the service and staff, for example staff spent time talking with people on the ground floor lounge. We saw that people were supported to maintain their dignity. We observed people who were being assisted to move with the use of a hoist, and saw that their dignity was promoted whilst being transferred.

We saw privacy and dignity was respected when people were receiving care and support during our visit. We observed staff knock at a person's door before entering. When staff attended to the person they closed the door. Staff were able to give us examples of how they respected people's privacy and dignity. For example staff told us they knocked on people's bedroom doors before entering and they ensured personal care was carried out in people's rooms or the bathroom.

Relatives we spoke with told us they could visit at any time and were always made to feel welcome by the staff team. One relative said, "Oh yes I can visit anytime, there's no restrictions at all." Another relative said "I can come any time I like, they [Staff] love me."

Requires Improvement

Is the service responsive?

Our findings

People told us they were not always supported to take part in activities or interests they enjoyed. We asked people if there were activities, one person said "No, none at all." Another person said "No I get fed up." A member of staff said "I feel that the only thing lacking at the home is the activities. There is not enough for people to do, they sit around doing nothing." Another member of staff told us "We are really busy with care related tasks and don't always have time for social interaction." Our observation showed there was limited social interaction taking place. We saw that people were sitting in the downstairs lounge with the television on, some people were snoozing and one person had a visitor. We also saw a member of staff painting one person's finger nails. In the upstairs lounge the television was on, which the people were not watching.

A monthly newsletter was provided for people living at the home. This included historical facts, a quiz, entertainment for the month and forth coming birthdays of people living at the service. The newsletter was available for people and their relatives and was placed in the reception area. A relative told us that they had seen the newsletter.

People's care records showed that pre admission assessments had been completed before they used the service and used to develop their care plan. This had been done by gathering information from people's relatives and other health and social care professionals. One person told us that they had not been involved in their care plan. One relative told us that they were sometimes involved in the care that was provided to their family member.

During the inspection we observed a person living at the service, calling out "Nurse, nurse." We approached the person's bedroom, the person was in a chair and the nurse call buzzer was not accessible to them. We found a member of staff and alerted them that the person was requesting assistance and had been calling out for staff. We showed the member of staff that the nurse call buzzer had not been left by the person. We discussed this with the registered manager who told us that they would look into this and that when the person is in their room staff should be leaving the buzzer with the person.

Staff told us a handover took place at the start of each shift, so staff could be updated about people's needs and if any changes in their care had been identified. Staff felt this gave them an opportunity to share information about the people using the service with the staff who were coming on shift. Daily logs were kept on each person's care record. However one member of staff said communication between staff was sometimes a problem. They said if someone was off for a few days then it meant staff were not sure what was happening with a person using the service until the member of staff returned to work as the information had not been recorded

People told us they knew how to make a complaint. Comments included "Only complain when I'm really upset don't like getting people in trouble." Relatives told us they were aware of the complaints procedure and knew how to raise any concerns with the registered manager. One relative said 'I have not made a complaint since [Name] has been in here. We haven't had to complain about anything yet." Another relative said "'Only when [Name] first came in. They have not done anything wrong since then, they are marvellous

carers." We discussed this incident with the registered manager who, provided us with assurance that the incident was looked into and resolved.

The registered manager told us that complaints were logged on people's individual care records. As complaints were not recorded centrally it was not possible to establish that complaints received by the service had been investigated and responded to appropriately. Also whether or not the complainant was satisfied with the outcome and if any learning took place from the issues raised.

A complaints procedure was in place. Staff we spoke with knew how to respond to complaints if they arose. They told us if anyone raised a concern with them, they would share this with the registered manager. We saw there was a copy of the complaints policy on display at the service.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with and their relatives spoke positively about the registered manager at the service. One person using the service said "I've met [Name], he seems a nice chap." Another person said that did not know the manager. A relative said that "You always see the manager, he always speaks to you and he is very nice." Another relative told us "The manager does listen to you."

People told us that the atmosphere at the service was nice. One person said "It's friendly." A relative stated "'Its lovely and peaceful. The staff seem very happy."

Prior to the inspection visit we received information of concern which suggested that staff morale was low due to conflict we explored the reasons for this at this inspection and discussed it with the registered manager. Staff we spoke with told us that they liked the registered manager. However they felt that the registered managers leadership skills needed to be stronger. Two members of staff expressed "Frustration about the organisation of the service," despite this they told us that they looked beyond this to make sure people received good care. Another member of staff said "The manager needs a second pair of hands, someone to take the pressure off." The staffing structure consisted of the registered manager, nurses, senior carer, carers, kitchen and domestic staff. The registered manager told us that the service currently did not have a deputy manager and that discussions were taking place with the providers around future management arrangements for the service.

The registered manager told us that they were aware of the issues of concern and had taken action to address this. For example, they told us that staff meetings had been recently introduced. Some staff felt that the meetings were helpful to raise things and make suggestions. Staff meeting minutes recorded that issues around staff morale had been discussed. A member of staff said "Staff morale has been an issue. Staff have had a recent discussion and agreed we need to get on as we are here for the people using the service." Another member of staff told us "It's a good team to work with." Staff felt that things were improving. On the day of the inspection visit we observed staff effectively interacting with one another.

People and relatives told us that they were asked about their views regarding the care and supported provided by the service. They were unable to recall if they were asked to complete satisfaction questionnaires. The registered manager told us that annual satisfaction surveys were given to people and their relatives to complete, to establish their views on the running of the service. The registered manager was unable to locate the survey results for 2015. We were shown a blank satisfaction questionnaire template, which included questions on the environment, activities and care provided. The registered told us that no resident or relatives meetings were taking place, but he did regularly ask people for their views on the service.

The registered manager told us they kept a record of the checks they made of the quality of the care, this included infection control, medicines management and care plan reviews. The infection control audit we looked at showed that it had been completed and improvements made where actions had been identified. For example replacing a bath, which we saw had been replaced and further plans to fully refurbish the

bathroom. The registered manager told us some audits had not recently taken place which included medication and care plan reviews. At this inspection visit we identified gaps on the medication administration records, which had not been identified by the registered manager until we pointed them out. This showed us that continuous monitoring was not being undertaken to identify where improvements were needed and addressed. We found that the registered manager did not have organised systems in place for storing and retrieving information. For example he was not able to locate completed satisfaction surveys. Through the providers quality assurance process the registered manager had not picked up that care records were not kept up to date.

There was no evidence to show that learning from incidents took place and that appropriate changes were put in place to minimise risks to people using the service and others. For example the registered manager did not complete a review of all accidents and incidents in the service, which looked at any patterns or issues that could be addressed to avoid recurrence.

A fire risk assessment had been undertaken February 2016. It highlighted a number of risks which needed attention. We discussed this with the registered manager who confirmed that the report had only just been received by the service. The registered manager told us that he would be addressing the actions left shortly, no timescale were confirmed for the completion of the required actions.

The passenger lift was not working during the morning of the inspection, staff told us it happened quite often. By the afternoon the lift was working. This meant that people with limited mobility were not always able to access all areas of the service, whilst ensuring their individual and staff safety. We spoke with the registered manager who told us that the lift engineer had been called out to repair the lift. The registered manager had not taken into account how people would access the ground floor or the first floor when the passenger lift was not working.

The provider was not clear about their CQC registration requirements in relation to submitting notifications about any changes, events or incidents that they must inform CQC about.